OASIS ITEM

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No assessment conducted **[*Go to M1306*]**
- ☐ 1 - Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool
- ☐ 2 - Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)

ITEM INTENT

Identifies whether the home health agency care providers assessed the patient's risk of developing pressure ulcers. CMS does not require the use of standardized, validated tools, nor does it endorse one particular tool.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- Select Response 0 if the patient was not assessed for pressure ulcer risk.
- In order to select Response 1 or 2, the pressure ulcer risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.
- Select Response 1 if the patient's risk for pressure ulcer development was clinically assessed, but no formal pressure ulcer screening tool was used.
- Select Response 2 only if the patient was screened using a standardized, validated screening tool. This is defined as a tool that 1) has been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, noninstitutionalized adults with disabilities); and 2) includes a standard response scale. The tool must be appropriately administered per the tool's instructions.
- If both a standardized, validated screening tool and an evaluation of clinical factors are utilized, select Response 2.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Physician
- See link in Chapter 5 of this manual to the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale

OASIS ITEM

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?

☐ 0 - No
☐ 1 - Yes

ITEM INTENT

Identifies if the patient is at risk for developing pressure ulcers. This item should be skipped if Response 0 was selected for M1300 (no pressure ulcer risk assessment).

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- If pressure ulcer risk was assessed using a standardized, validated screening tool, use the scoring parameters specified for the tool to identify if a patient is at risk for developing pressure ulcers. If the evaluation was based on clinical factors (without a validated standardized screening tool), then the agency or care provider may define what constitutes risk.
- A validated standardized screening tool is a tool that 1) has been scientifically tested and evaluated with a population with characteristics similar to the patient who is being evaluated and shown to be effective in identifying people at risk for developing pressure ulcers; and 2) includes a standard response scale. The standardized, validated tool must be appropriately administered per the tool's instructions.
- If both a standardized, validated screening tool and an evaluation of clinical factors are utilized, select Response 1-Yes, if either assessment is positive for risk.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Physician
- Standardized, validated pressure ulcer risk tools include the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale. Links can be found in Chapter 5 of this manual.

OASIS ITEM

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as Unstageable? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

☐ 0 - No **[*Go to M1322*]**

☐ 1 - Yes

ITEM INTENT

Identifies the presence or absence of Unstageable or unhealed **Stage II or higher** pressure ulcers only.

TIME POINTS ITEM(S) COMPLETED

Start of care
Resumption of care
Follow-up
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- The NPUAP definition of pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
- Select Response 0 – No, if the only pressure ulcer(s) is/are Stage I OR if a former Stage II pressure ulcer has healed AND the patient has no other pressure ulcers.
- Select Response 1 – Yes, if the patient has an unhealed Stage II, OR a Stage III, OR Stage IV pressure ulcer at any healing status level OR if the patient has an Unstageable ulcer(s), defined as:
  - Pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings (for example, patient report of discomfort, past history of skin breakdown in the same area), but that are unobservable due to dressings or devices (for example, casts) that cannot be removed to assess the skin underneath.
  - Pressure ulcers that the care provider suspects may be present based on clinical assessment, but that cannot be staged because no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible, and some degree of necrotic tissue (eschar or slough) or scabbing is present that the clinician believes may be obscuring the visualization of Stage IV structures.
  - Suspected deep tissue injury in evolution, which is defined by the NPUAP as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.
- In 2004, based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it was determined that Stage I and Stage II (partial thickness) pressure ulcers can heal through the process of regeneration of the epidermis across a wound surface, known as epithelialization.
- Stage III and IV (full thickness) pressure ulcers heal through a process of contraction, granulation, and epithelialization. They can never be considered "fully healed" but they can be considered closed when they are fully granulated and the wound surface is covered with new epithelial tissue.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M1306)

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Physician
- Consult published guidelines of NPUAP for additional clarification and/or resources for training. Other resources can be found in Chapter 5 of this manual.

OASIS ITEM

(M1307) The **Oldest Stage II Pressure Ulcer** that is present at discharge: (Excludes healed Stage II Pressure Ulcers)

☐ 1 - Was present at the most recent SOC/ROC assessment

☐ 2 - Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: __ __ /__ __ /__ __ __ __
month / day / year

☐ NA - No Stage II pressure ulcers are present at discharge

ITEM INTENT

The intent of this item is to a) identify the oldest Stage II pressure ulcer that is present at the time of discharge and is not fully epithelialized, b) assess the length of time this ulcer remained unhealed while the patient received care from the home health agency and c) identify patients who develop Stage II pressure ulcers while under the care of the agency.

TIME POINTS ITEM(S) COMPLETED

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Do not reverse stage pressure ulcers.
- Based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it has been determined that Stage II (partial thickness) pressure ulcers can heal through epithelialization (the process of regeneration of the epidermis across a wound surface).
- Select Response 1 if the oldest Stage II pressure ulcer was already present when the SOC/ROC assessment was completed.
- Select Response 2 if the oldest Stage II pressure ulcer was first identified since the most recent SOC/ROC visit (that is, since the last time the patient was admitted to home care or had a resumption of care after an inpatient stay).
- If Response 2 is selected, specify the date of onset. Use two digits to indicate the month (for example, May is 05), single-digit dates should begin with 0, and use four digits to indicate the year (for example, May 4, 2014 would be 05/04/2014).
- Select Response "NA" if the patient has no Stage II pressure ulcers at the time of discharge, or all Stage II pressure ulcers have healed.
- An ulcer that is suspected of being a Stage II, but is Unstageable, should <u>not</u> be identified as the "oldest Stage II pressure ulcer." For this item, Unstageable refers to pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings (for example, patient report of discomfort, past history of skin breakdown in the same area), but that are unobservable due to dressings or devices (for example, casts) that cannot be removed to assess the skin underneath.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Clinical Record
- Consult published guidelines of NPUAP for additional clarification and/or resources for training. Other resources can be found in Chapter 5 of this manual.

OASIS ITEM

(M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:
(Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

Stage Descriptions—unhealed pressure ulcers	Number Currently Present
a. **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	___
b. **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	___
c. **Stage IV:** Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	___
d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device	___
d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	___

ITEM INTENT

Identifies the number of Stage II or higher pressure ulcers at each stage present at the time of assessment. Stage I pressure ulcers are <u>not</u> reported in this item.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Report the number of Stage II or higher pressure ulcers that are present on the current day of assessment.
  - Mark a response for each row of this item: a, b, c, d1, d2, and d3. If there are NO ulcers at a given stage, enter "0" for that stage.

  Stage I ulcers are not reported in this item.
- **Stage II ulcers**
  - Stage II ulcers that have healed are not reported in this item.
  - Stage II pressure ulcers are described as "partial thickness" ulcers. Based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it has been determined that Stage II (partial thickness) pressure ulcers can heal through the process of regeneration of the epidermis across a wound surface known as epithelialization.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1308)

- **Stage III and IV ulcers**
  - Stage III and IV ulcers are described as "full thickness" ulcers. Stage IV ulcers involve full thickness skin loss with extensive destruction accompanied by tissue necrosis with damage to muscle, bone, tendon, or joint capsule. Stage III and IV (full thickness) pressure ulcers close through a process of granulation, contraction, and epithelialization. They can never be considered "fully healed" but they can be considered closed when they are fully granulated and the wound surface is covered with new epithelial tissue.
  - A closed Stage III or Stage IV pressure ulcer should be reported as a pressure ulcer at its worst stage. Reverse staging of granulating Stage III and Stage IV pressure ulcers is NOT an appropriate clinical practice according to the NPUAP. For example, if a pressure ulcer is Stage III at SOC and is granulating at the follow-up visit, the ulcer remains a Stage III ulcer.
  - A previously closed Stage III or Stage IV pressure ulcer **that is currently open again** should also be reported at its worst stage.
  - If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst. An ulcer's stage can worsen, and this item should be answered appropriately if this occurs.

- A muscle flap, skin advancement flap, or rotational flap (defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply) performed to surgically replace a pressure ulcer is a surgical wound. It should not be reported as a pressure ulcer on M1308.

- A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) remains a pressure ulcer and should not be reported as a surgical wound on M1342. Until the graft edges completely heal, the grafted pressure ulcer should be reported on M1308 as d.1 (Unstageable) pressure ulcer. The number of pressure ulcers meeting these definitions should be counted to determine the response to d.1. Once the graft edges heal, the closed Stage III or Stage IV pressure ulcer would continue to be regarded as a pressure ulcer at its worst stage.

- A pressure ulcer that has been surgically debrided remains a pressure ulcer and should not be reported as a surgical wound on M1342.

- Pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings (for example, patient report of discomfort, past history of skin breakdown in the same area), but that are Unstageable due to dressings or devices (for example, casts) that cannot be removed to assess the skin underneath should be reported as d.1 (Unstageable).

- Response d.2 refers to pressure ulcers that the care provider suspects may be present based on clinical assessment findings, but that cannot be staged because no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible, and some degree of necrotic tissue (eschar or slough) or scabbing is present that the clinician believes may be obscuring the visualization of Stage IV structures. The number of pressure ulcers meeting this definition should be counted to determine the response to d.2.

- Response d.3 refers to a suspected deep tissue injury in evolution, which is defined by the NPUAP as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. The number of pressure ulcers meeting this definition should be counted to determine the response to d.3. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M1308)

- Patient/caregiver interview
- Observation
- Physical Assessment
- Clinical record
- Referral documentation
- Physician
- Consult published guidelines of NPUAP for additional clarification and/or resources for training. Resources and links can be found in Chapter 5 of this manual.
- See Chapter 5 of this manual for NPUAP staging illustrations.

OASIS ITEM

(M1309) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	___
b. Stage III	___
c. Stage IV	___

Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	___

ITEM INTENT

This item documents the number of pressure ulcers that are new or have "worsened" (increased in numerical stage) since the most recent Start or Resumption of Care assessment. Definitions of pressure ulcer stages are derived from the National Pressure Ulcer Advisory Panel (NPUAP).

TIME POINTS ITEM(S) COMPLETED

Discharge

RESPONSE—SPECIFIC INSTRUCTIONS

- Review the history of each current pressure ulcer. Specifically, compare the current stage of the pressure ulcer to the stage of that ulcer at the most recent SOC/ROC to determine whether the pressure ulcer currently present is new or worsened when compared to the presence or stage of that pressure ulcer at the most recent SOC/ROC.
- For definitions of pressure ulcer stages, see M1308 and the NPUAP staging system.
- For pressure ulcers that are currently Stage II, III or IV (rows a, b and c):
  - Mark a response for each row of this item: a, b, and c. If there are NO ulcers at a given stage, enter "0" for that stage/row.
  - Report the number of current pressure ulcers at each stage that are new or have worsened since the most recent SOC/ROC assessment.
  - For pressure ulcers that are currently Stage II, III or IV, "worsening" refers to a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of I-IV (the NPUAP staging system) at the time of discharge in comparison to the most recent SOC/ROC assessment.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1309)

- For row a: Stage II. Enter the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage II, that were not present or were a Stage I at most recent SOC/ROC. Enter "0" if there are no current Stage II pressure ulcers or no Stage II pressure ulcers that have worsened since most recent SOC/ROC.
- For row b: Stage III. Enter the number of current pressure ulcers at discharge whose deepest anatomical stage is Stage III, that were not present or were a Stage I or II at the most recent SOC/ROC. Enter "0" if there are no current Stage III pressure ulcers or no Stage III pressure ulcers that have worsened since most recent SOC/ROC.
- For row c: Stage IV. Enter the number of current pressure ulcers at discharge whose deepest anatomical stage is Stage IV, that were not present or were at Stage I, II, or III at the most recent SOC/ROC. Enter "0" if there are no current Stage IV pressure ulcers or no Stage IV pressure ulcers that have worsened since most recent SOC/ROC.

- For pressure ulcers that are currently Unstageable due to coverage of wound bed by slough or eschar, row d:
  - Pressure ulcers that are Unstageable due to slough or eschar are those in which the wound bed is not visible due to some degree of necrotic tissue or scabbing that the clinician believes may be obscuring the visualization of bone, muscle, tendon or joint capsule (Stage IV structures). Note that if a Stage IV structure is visible, the pressure ulcer is not considered Unstageable – it is a Stage IV even if slough or eschar is present.
  - For pressure ulcers that are currently Unstageable due to slough or eschar, "worsening" refers to a pressure ulcer that was either not present or was a Stage I or II pressure ulcer at the most recent SOC/ROC and is now Unstageable due to slough or eschar. Pressure ulcers that are currently Unstageable due to presence of slough or eschar and were Stage III or IV at the most recent SOC/ROC are not considered worsened.
  - Enter "0" if
    - there are currently no pressure ulcers that are Unstageable due to slough or eschar.
    - all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC.
- See the following page for a reporting algorithm.
- Reverse staging of pressure ulcers is NOT an appropriate clinical practice according to NPUAP. A closed Stage III or Stage IV pressure ulcer continues to be regarded as a pressure ulcer at its worst stage. A previously closed Stage III or Stage IV pressure ulcer that breaks down again should be staged at its worst stage.
- Pressure ulcers that were Unstageable for any reason at the most recent SOC/ROC cannot be reported as new or worsened.
- Pressure ulcers that are Unstageable at discharge due to dressings or devices (for example, casts) that cannot be removed to assess the skin underneath cannot be reported as new or worsened.
- Suspected deep tissue injuries in evolution that are present at SOC/ROC or discharge cannot be reported as new or worsened.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Clinical record
- Referral documentation
- Physician
- Consult published guidelines of NPUAP for additional clarification and/or resources for training. Resources and links can be found in Chapter 5 of this manual. A link to NPUAP staging illustrations can be found in Chapter 5.

OASIS ITEM
Reporting algorithm for M1309

CURRENT STAGE *at Discharge*	*Look back to most recent SOC/ROC*	**PRIOR STAGE** *at most recent SOC/ROC*		*REPORT AS NEW OR WORSENED?*
a. Stage II *at discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	**Not present** **Stage I**	⇨	**YES**
		Stage II	→	NO
		Stage III Stage IV	→	NA (reverse staging not allowed)
		Unstageable	→	NO
b. Stage III *at discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	**Not present** **Stage I** **Stage II**	⇨	**YES**
		Stage III	→	NO
		Stage IV	→	NA (reverse staging not allowed)
		Unstageable	→	NO
c. Stage IV *at discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	**Not present** **Stage I** **Stage II** **Stage III**	⇨	**YES**
		Stage IV Unstageable	→	NO
d. Unstageable due to slough or eschar *at discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	**Not present** **Stage I** **Stage II**	⇨	**YES**
		Stage III Stage IV Unstageable	→	NO

OASIS ITEM

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

- ☐ 0 - Newly epithelialized
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable pressure ulcer

ITEM INTENT

Identifies the degree of closure visible in the most problematic observable pressure ulcer, Stage II or higher. Please note, Stage I pressure ulcers are not considered for this item.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Determine which pressure ulcer(s) are observable:
  - Includes all Stage II or higher pressure ulcers that are not covered with a non-removable dressing or device, even if Unstageable
  - When determining the healing status of a pressure ulcer for answering M1320, the presence of necrotic tissue does NOT make the pressure ulcer "NA – No observable pressure ulcer."
- Determine which observable pressure ulcer is most problematic:
  - "Most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.
  - If the patient has only one observable pressure ulcer, that ulcer is the most problematic.
- Utilize the WOCN Guidance to determine status of the most problematic observable pressure ulcer:
  - Response 0 – Newly Epithelialized: wound bed completely covered with new epithelium, no exudate, no avascular tissue (eschar and/or slough); no signs or symptoms of infection.
  - Response 1 – Fully Granulating: wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue (eschar and/or slough); no signs or symptoms of infection; wound edges are open
  - Response 2 – Early/Partial Granulation: wound with ≥25% of the wound bed covered with granulation tissue; <25% of the wound bed covered with avascular tissue (eschar and/or slough); may have dead space; no signs or symptoms of infection; wound edges open.
  - Response 3 – Not Healing: wound with ≥25% avascular tissue (eschar and/or slough) OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.
- Because Stage II ulcers do not granulate and newly epithelialized Stage II ulcers are not counted, the only appropriate response for a Stage II ulcer is 3 – Not Healing.
- Since a suspected Deep Tissue Injury in evolution does not granulate and would not be covered with new epithelial tissue, the only appropriate response for a suspected Deep Tissue Injury is 3 – Not Healing.
- A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is either Response 2 – Early/Partial Granulation if necrotic or avascular tissue covers <25% of the wound bed, or Response 3 - Not Healing, if the wound has ≥25% necrotic or avascular tissue.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1320)

- Reference the WOCN Guidance on OASIS-C Integumentary Items and CMS OASIS Q&As (links in Chapter 5) for complete guidance on selecting a response for M1320

DATA SOURCES / RESOURCES

- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- Additional resources for the WOCN and NPUAP can be found in Chapter 5 of this manual.

OASIS ITEM

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

ITEM INTENT

Identifies the presence and number of Stage I pressure ulcers.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- NPUAP defines a Stage I pressure ulcer as follows: “Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.”
- Further description: The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- See Chapter 5 of this manual for more information regarding NPUAP staging illustrations.

OASIS ITEM

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

☐ 1 - Stage I
☐ 2 - Stage II
☐ 3 - Stage III
☐ 4 - Stage IV
☐ NA - Patient has no pressure ulcers or no stageable pressure ulcers

ITEM INTENT

Identifies the stage of the most problematic stageable pressure ulcer. Definitions of pressure ulcer stages derived from the National Pressure Ulcer Advisory Panel.

TIME POINTS ITEM(S) COMPLETED

Start of Care
Resumption of Care
Follow-up
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Determine which pressure ulcer(s) are stageable or Unstageable. A pressure ulcer is considered Unstageable if:
  - it is covered with a non-removable dressing or device that cannot be removed such as a cast,
  - it is a suspected deep tissue injury in evolution, or
  - the wound bed is obscured by some degree of necrotic tissue or scabbing AND no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible. Note that if a Stage IV structure is visible, the pressure ulcer is reportable as a Stage IV even if slough or eschar is present.
- Determine which stageable pressure ulcer is the most problematic.
  - "Most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.
  - If the patient has only one stageable pressure ulcer, then that ulcer is the most problematic.
- Mark the response that most accurately describes the stage of the most problematic stageable pressure ulcer using the definitions of stage in M1308 that were derived from the National Pressure Ulcer Advisory Panel (NPUAP) staging system.
  - Select "NA" if the patient has NO pressure ulcers or only has pressure ulcers that are Unstageable as defined above.
  - Reverse staging of pressure ulcers is NOT an appropriate clinical practice according to the NPUAP. If a pressure ulcer is Stage IV at SOC and is granulating at the follow-up visit, the ulcer remains a Stage IV ulcer. A closed Stage III or Stage IV pressure ulcer continues to be regarded as a pressure ulcer at its worst stage. However, an unhealed active ulcer at a lower stage may be the most problematic ulcer. A previously closed Stage III or Stage IV pressure ulcer that breaks down again should be staged at its worst stage.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral documentation
- Review of health history
- Physician
- See Chapter 5 of this manual for links to published guidelines of NPUAP, NPUAP staging illustrations, and WOCN guidelines.

OASIS ITEM

(M1330) Does this patient have a **Stasis Ulcer**?

- ☐ 0 - No **[*Go to M1340*]**
- ☐ 1 - Yes, patient has BOTH observable and unobservable stasis ulcers
- ☐ 2 - Yes, patient has observable stasis ulcers ONLY
- ☐ 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[*Go to M1340*]**

ITEM INTENT

Identifies patients with ulcers caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis.

Stasis ulcers DO NOT include arterial lesions or arterial ulcers.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- A response of "Yes" identifies the presence of an ulcer caused by inadequate venous circulation in the area affected (usually lower legs).
- It is important to differentiate stasis ulcers from other types of skin lesions, and only report stasis ulcers in this item.
- Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer.
- Select Response 1 if the patient has both an observable stasis ulcer AND a reported stasis ulcer that cannot be observed because of a cast or dressing/device (for example, Unna boot) that cannot be removed. Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.
- Select Response 3 ONLY if the patient has a reported stasis ulcer that cannot be observed because of a cast or dressing/device (for example, Unna boot) that cannot be removed, and has no observable stasis ulcers. Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician's orders
- Referral information
- Review of health history
- Observation
- Physical assessment
- A link to the Clinical Fact Sheet – Quick Assessment of Leg Ulcers can be found in Chapter 5 of this manual.

OASIS ITEM

(M1332) Current Number of Stasis Ulcer(s) that are Observable:

☐ 1 - One

☐ 2 - Two

☐ 3 - Three

☐ 4 - Four or more

ITEM INTENT

Identifies the number of visible (observable) stasis ulcers.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- All stasis ulcers except those that are covered by a non-removable dressing/device or cast are considered observable.

DATA SOURCES / RESOURCES

- Observation
- Physical Assessment
- Review of health history
- Physician
- Referral information

OASIS ITEM

(M1334) Status of Most Problematic Stasis Ulcer that is Observable:

☐ 1 - Fully granulating

☐ 2 - Early/partial granulation

☐ 3 - Not healing

ITEM INTENT

Identifies the degree of healing present in the most problematic, observable stasis ulcer. The "most problematic" ulcer may be the largest, the most resistant to treatment, an ulcer that is infected, etc., depending on the specific situation.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Determine which stasis ulcers are observable. Includes all stasis ulcers that are not covered with a non-removable dressing/device or cast
- Determine which observable stasis ulcer is the most problematic.
  - "Most problematic" may be based on healing status, size, difficulty in accessing for treatment, etc., depending on the specific situation.
  - If the patient has only one observable stasis ulcer, that ulcer is the most problematic.
- Utilize the WOCN Guidance to determine status of the most problematic observable stasis ulcer:
  - Response 1 – Fully Granulating: Mark 1 when a stasis ulcer has a wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open
  - Response 2 – Early/Partial Granulation: Mark 2 when ≥ 25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (that is, <25% of the wound bed is covered with avascular tissue); may have dead space; no signs or symptoms of infection; wound edges open.
  - Response 3 – Not Healing: Mark 3 when wound has ≥25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.
- Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer.

DATA SOURCES / RESOURCES

- Observation
- Physical Assessment
- Review of health history
- To determine healing status of the stasis ulcer, further resource links can be found in Chapter 5 of this manual.

OASIS ITEM

(M1340) Does this patient have a **Surgical Wound?**

☐ 0 - No [*At SOC/ROC, go to M1350; At FU//DC, go to M1400*]

☐ 1 - Yes, patient has at least one observable surgical wound

☐ 2 - Surgical wound known but not observable due to non-removable dressing/device *[At SOC/ROC, go to M1350; At FU/DC, go to M1400]*

ITEM INTENT

Identifies the presence of a wound resulting from a surgical procedure.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds and should not be included in this item.
- If the patient has both an observable and an unobservable wound, the best response is 1 – Yes, patient has at least one observable surgical wound.
- Select Response 2 if the only surgical wound(s) is/are not observable. A wound is considered not observable if it is covered by a dressing/device (such as a cast) which is not to be removed **per physician order**.
- For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and should not be included in this item.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer. It <u>does not</u> become a surgical wound.
- A muscle flap, skin advancement flap, or rotational flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer.
- Debridement or the placement of a skin graft does not create a surgical wound, as these are treatments performed to an existing wound. The wound would continue to be defined as the type of wound previously identified.
- A bowel ostomy is excluded as a surgical wound, unless a "take-down" procedure of a previous bowel ostomy is performed, in which case the surgical take-down produces a surgical wound. A bowel ostomy being allowed to close on its own is excluded as a surgical wound.
- All other ostomies are excluded from consideration under this item and should not be counted as surgical wounds. There are many types of "ostomies," all of which involve a surgically formed opening from outside the body to an internal organ or cavity. Examples include cystostomy, urostomy, thoracostomy, tracheostomy, ileostomy, gastrostomy, etc. These may be reported in M1350 if the home health agency is providing intervention specific to the ostomy.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1340)

- Orthopedic pin sites, central line sites (centrally-inserted venous catheters), stapled or sutured incisions, and wounds with drains are all considered surgical wounds. Medi-port sites and other implanted infusion devices or venous access devices are considered surgical wounds.
- A PICC line (peripherally-inserted venous catheter), either tunneled or non-tunneled, is NOT a surgical wound, as it is peripherally inserted.
- Cataract surgery of the eye, surgery to the mucosal membranes, or a gynecological surgical procedure via a vaginal approach does not create a surgical wound for the purpose of this item.
- For additional guidance on questions related to surgical wounds, please see Q&As for M1340.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- CMS OASIS Q&As can be accessed through the CMS OASIS web page.
- See Chapter 5 of this manual for resource links.

OASIS ITEM

(M1342) Status of Most Problematic Surgical Wound that is Observable

☐ 0 - Newly epithelialized
☐ 1 - Fully granulating
☐ 2 - Early/partial granulation
☐ 3 - Not healing

ITEM INTENT

Identifies the degree of healing present in the most problematic, observable surgical wound.

TIME POINTS ITEM(S) COMPLETED

Start of Care
Resumption of Care
Follow-up
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Determine which surgical wounds are observable
  - Includes all surgical wounds (as defined in M1340 guidance) that are not covered with a non-removable dressing/device or cast
  - For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and no longer a surgical wound.
- Identify the most problematic observable surgical wound.
  - The “most problematic” surgical wound may be the largest, the most resistant to treatment, an infected surgical wound, etc., depending on the specific situation.
  - If the patient has only one observable surgical wound, that wound is the most problematic.
- Determine status of the most problematic surgical wound using WOCN guidance:
  - The clinician must first assess if the wound is healing entirely by primary intention (well-approximated with no dehiscence), or if there is a portion healing by secondary intention, (due to dehiscence, interruption of the incision, or intentional secondary healing).
  - Surgical wounds healing by **primary intention** (approximated incisions) do not granulate, therefore the only appropriate responses would be Response 0 - Newly epithelialized or Response 3 - Not healing. If the wound is healing solely by primary intention, observe if the incision line has re-epithelialized. Epithelialization is regeneration of the epidermis across a wound surface. (If there is no interruption in the healing process, this generally takes within a matter of hours to three days post-operatively.) If there is not full epithelial resurfacing such as in the case of a scab adhering to underlying tissue, the correct response would be "Not healing" for the wound healing exclusively by primary intention.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1342)

- **Secondary Intention**: If it is determined that there is incisional separation, healing will be by secondary intention. Surgical incisions healing by secondary intention do granulate, therefore may be reported as "Not healing," "Early/partial granulation," "Fully granulating," and eventually "Newly epithelialized."
- Response 0 – Newly epithelialized: Select 0 when the wound bed has completely covered with new epithelium; no exudate; no avascular tissue (eschar and/or slough); no signs or symptoms or infection. Epithelialization is characterized by "Epidermal resurfacing" and means the opening created during the surgery is covered by epithelial cells. If epidermal resurfacing has occurred completely, the correct response in the OASIS would be "Newly epithelialized" until 30 days have passed without complication, at which time it is no longer a reportable surgical wound.
- Select Response 0 – Newly epithelialized for implanted venous access devices and infusion devices when the insertion site is healed and without signs and symptoms of infection.
- Response 1 – Fully Granulating: Select 1 when a surgical wound has a wound bed filled with granulation tissue to the level of the surrounding skin; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open
- Response 2 – Early/Partial Granulation: Select 2 when ≥25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (that is, <25% of the wound bed is covered with avascular tissue); no signs or symptoms of infection; wound edges open.
- Response 3 – Not Healing: Select 3 when wound has ≥25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- CMS OASIS Q&As can be accessed through the CMS OASIS web page.
- Links to the Wound, Ostomy, and Continence Nurses' guidelines are provided in Chapter 5 of this manual.

OASIS ITEM

(M1350) Does this patient have a **Skin Lesion** or **Open Wound** (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?

☐ 0 - No

☐ 1 - Yes

ITEM INTENT

Identifies the presence or absence of a skin lesion or open wound NOT ALREADY ADDRESSED IN PREVIOUS ITEMS that is receiving clinical assessment or intervention from the home health agency.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- A lesion is a broad term used to describe an area of pathologically altered tissue. All alterations in skin integrity are considered to be lesions. Examples of lesions include but are not limited to sores, skin tears, burns, ulcers, rashes, edema, and persistent redness without a break in the skin.
- Certain open wounds/lesions are not included in this item. These include:
  - bowel ostomies (which are reported in OASIS item M1630)
  - wounds resulting from cataract surgery, surgery to mucosal membranes, or gynecological surgical procedures by a vaginal approach
  - tattoos, piercings, and other skin alterations unless ongoing assessment and/or clinical intervention by the home health agency is a part of the planned/provided care
  - any other skin lesions or open wounds that are not receiving clinical intervention from the home health agency. "Receiving clinical assessment or intervention from the home health agency" means the lesion is being clinically assessed on an ongoing basis as indicated on the home health agency's Plan of Care (for example, wound measurements for a traumatic laceration)
- Response 0 – "No" should be selected if:
  - the patient does not have any open wounds/skin lesions (as defined above), or
  - all of the patient's open wounds/skin lesions have been addressed in other OASIS-C1 Integumentary Items (pressure ulcer, stasis ulcer, or surgical wound)
  - the patient's open wounds/skin lesions are not receiving clinical intervention from the home health agency (as defined above)
- Response 1 – "Yes" should be selected for all types of other open wounds/skin lesions that are part of the agency's planned/provided care but are NOT addressed in other OASIS-C1 Integumentary Items. Examples include but are not limited to:
  - burns, diabetic ulcers, cellulitis, abscesses, edema, wounds caused by trauma of various kinds
  - PICC line and peripheral IV sites
  - non-bowel ostomies (for example, tracheostomies, thoracostomies, urostomies, jejunostomies, gastrostomies) if clinical interventions (for example, cleansing, dressing changes, assessment) are being provided by the home health agency during the care episode

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician