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, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- ☐ 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

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 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 validated standardized 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, etc.); and 2) includes a standard response scale. The standardized tool must be appropriately administered as indicated in the instructions.

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

Guidance for this item updated 12/2011

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 validated standardized screening tool, use the scoring parameters specified for the tool to identify if a patient is at risk for developing pressure ulcers. If the tool does not define levels of risk or 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 tool must be appropriately administered as indicated in the instructions.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Physician
- Established, 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"?

☐ 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 Stage 1 OR if a former Stage 2 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 (e.g., patient report of discomfort, past history of skin breakdown in the same area, etc.), but that are unobservable due to dressings or devices (e.g., casts) that cannot be removed to assess the skin underneath.
  - Pressure ulcers that the care provider suspects may be present based on clinical assessment findings (e.g., patient report of discomfort, past history of skin breakdown in the same area), but that cannot be staged due to full thickness tissue loss in which the true wound depth is obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.
  - 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 Non-epithelialized Stage II Pressure Ulcer that is present at discharge

☐ 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 non-epithelialized 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, and 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

- THIS ITEM REFERS **ONLY** TO NONEPITHELIALIZED STAGE II PRESSURE ULCERS. DO NOT CONSIDER STAGE III OR IV ULCERS WHEN ANSWERING THIS ITEM.
- 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 that is not fully epithelialized was already present when the SOC/ROC assessment was completed.
- Select Response 2 if the oldest Stage II pressure ulcer that is not fully epithelialized was first identified since the most recent SOC/ROC visit (i.e., 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 (e.g., September is 09), single-digit dates should begin with 0, and use four digits to indicate the year (e.g., September 2, 2009 be 09/02/2009).
- Select Response "NA" if the patient has no Stage II pressure ulcers at the time of discharge, or all Stage II pressure ulcers have been fully epithelialized.
- An ulcer that is suspected of being a Stage II, but is unstageable, should not 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 (e.g., patient report of discomfort, past history of skin breakdown in the same area), but that are unobservable due to dressings or devices (e.g., 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 (non epithelialized) Pressure Ulcers at Each Stage:
(*Enter "0" if none; excludes Stage I pressure ulcers)*

	COLUMN 1 Complete at **SOC/ROC/FU & D/C**	**COLUMN 2** Complete at **FU & D/C**
Stage description – unhealed pressure ulcers	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
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 not reported in this item.

TIME POINTS ITEM(S) COMPLETED

Start of care – Column 1

Resumption of care – Column 1

Follow-up – Columns 1 and 2

Discharge from agency – not to inpatient facility – Columns 1 and 2

Guidance for this item updated 12/2012

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

- For Column 1, report the number of Stage II or higher pressure ulcers on the current day of assessment. This column must be completed at Start of Care, Resumption of Care, Follow-up, and Discharge.
- For Column 2, report the number of Stage II or higher pressure ulcers that were identified in Column 1 and were present on the most recent SOC/ROC, **even if it was at a different stage.**.
  - Example 1: Patient has no Stage II pressure ulcers on admission, but develops one during the first episode that is present at the time of follow-up. In this case, row a, column 1 would be "0" at SOC. At follow-up, row a, column 1 would be "1" and row a column 2 would be "0," indicating the pressure ulcer was not present on admission.
  - Example 2: Patient has a Stage III pressure ulcer on admission that is assessed to be a Stage IV at follow-up. In this case, row b, column 1 would be "1" at SOC. At follow-up, row b, columns 1 and 2 would both be "0," as the patient no longer has a Stage III ulcer. Row c, column 1 would be "1" and column 2 would be "1" indicating the ulcer was present on admission, **even though it was at a different stage**.
  - Example 3: Patient has a Stage II pressure ulcer on admission that heals within the first 2 weeks, but then develops another Stage II pressure ulcer prior to discharge at week 4. In this case, row a, column 1 would be "1" at SOC. At Follow-up, row a, column 1 would be "1" and row a, column 2 would be "0", indicating the pressure ulcer that is present at follow up or discharge was not present on admission.
- Column 2 is left blank when the ROC assessment is completed during the 5-day recertification window.

For both Columns 1 and 2:

- 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 and II ulcers**
  - Stage I and 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 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 I ulcers are not reported in this item.
  - Stage II ulcers that have healed are not reported in this item.
- **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.
  - Reverse staging of granulating Stage III and Stage IV pressure ulcers is NOT an appropriate clinical practice according to the NPUAP. If a pressure ulcer is Stage III at SOC and is granulating at the follow-up visit, the ulcer remains a Stage III ulcer.
  - Although the wording in M1308 includes the term "non epithelialized," for this item, a closed Stage III or Stage IV pressure ulcer should be reported as a pressure ulcer at its worst stage, even if it has re-epithelialized.
  - 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.

Guidance for this item updated 12/2012

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

- 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 (e.g., patient report of discomfort, past history of skin breakdown in the same area), but that are unstageable due to dressings or devices (e.g., 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 (e.g., patient report of discomfort, past history of skin breakdown in the same area), but cannot be staged due to full thickness tissue loss in which the true wound depth is obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. 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

- 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

Directions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length "head-to-toe" | ___ | ___ | . | ___ | (cm)

(M1312) Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length

| ___ | ___ | . | ___ | (cm)

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area

| ___ | ___ | . | ___ | (cm)

ITEM INTENT

Identifies the length, width, and depth of the pressure ulcer with the largest surface area (length x width) that is also an unhealed Stage III or IV pressure ulcer or pressure ulcer unstageable due to the presence of slough or eschar (as reported in M1308 d.2).

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to inpatient facility

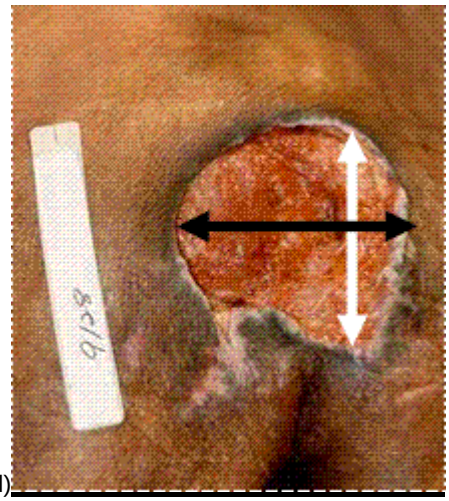
RESPONSE—SPECIFIC INSTRUCTIONS

- Complete these items only if M1308 Column 1, rows b, c, or d.2 is greater than 0. Otherwise, leave these items blank.
- Identify the pressure ulcer reported in M1308, Column 1, rows b, c, or d.2, with the largest surface dimension (length x width) and record in centimeters.
- If all existing Stage III or IV pressure ulcers are closed (completely re-epithelialized) and the patient has no pressure ulcers that are unstageable due to coverage of the wound bed by slough and/or eschar, enter 00.0 for M1310, M1312, and M1314.
- Measure every existing non-epithelialized stage III or IV pressure ulcer or pressure ulcer that is unstageable due to the presence of slough or eschar (as reported in M1308 d.2) to determine which has the largest surface dimension (length x width). Depth should not be considered in determining which pressure ulcer is largest.
- Once the largest pressure ulcer has been determined, report length (M1310), width (M1312), and depth (M1314) dimensions for that pressure ulcer. Depth for a wound covered/filled with eschar can be entered as 00.0.
  - Report the depth from the visible surface to the deepest area in the base of the wound. Do not include the depth of any tunneling present.
- Measurement should be based on observation of the pressure ulcer after the dressing and any exudate are removed.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Items M1310, M1312, and M1314)

- To measure pressure ulcers, use a disposable measuring device, a cotton-tipped applicator, a camera, or other wound technology that calculates measurements. If using a cotton-tipped applicator, mark on the applicator the distance between healthy skin tissue at each margin and lay the applicator next to a centimeter ruler to determine length, width, and depth. Round the measurement to the nearest tenth of a centimeter. Any wound or pressure ulcer that you are able to visualize even if all you see is a wound bed that is 100% covered with slough/eschar needs to be measured.
- Determine longest length head to toe (white line) and longest width (black line) of each pressure ulcer (see picture below). Width is measured at the widest width perpendicular (i.e., at a 90 degree angle) to the length forming a cross, side to side).
  - Pressure ulcers that lie diagonally or slanted are also measured head to toe for length and the width measurement is perpendicular to the length. You may choose to include other measurements in your clinical documentation, for situations where the OASIS requirement does not meet your needs.

(picture attached)



DATA SOURCES / RESOURCES

- Observation
- Physical assessment

OASIS ITEM

(M1320) Status of Most Problematic (Observable) Pressure Ulcer:

- ☐ 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 the most problematic pressure ulcer. Visualization of the wound is necessary to identify the degree of healing evident in the ulcer identified in M1320.
- "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, then that ulcer is the most problematic.
- Mark the response that most accurately describes the healing process you see occurring in the most problematic pressure ulcer.
- Stage III and IV pressure ulcers close by contraction, granulation, and epithelialization. Epithelialization is regeneration of the epidermis across a wound surface.
- Mark response 0 – Newly epithelialized – when epithelial tissue has completely covered the wound surface of the pressure ulcer, regardless of how long the pressure ulcer has been re-epithelialized. This is an appropriate response for Stage III and IV pressure ulcers, but not for Stage II ulcers as fully epithelialized Stage II ulcers should not be reported.
- Response 1 – Fully Granulating – is the appropriate response for a Stage III or IV pressure ulcer that is fully granulated, but epithelial tissue has not completely covered the wound surface.
- Because Stage II ulcers do not granulate and newly epithelialized Stage II ulcers are not counted, the only appropriate response for Stage II ulcers is 3 – Not healing.
- Since suspected deep tissue injury (DTI) does not granulate and would not be covered with new epithelial tissue, the status of "Not healing" is the most appropriate response.
- "No observable pressure ulcer" includes only those that cannot be observed due to the presence of a dressing or device that cannot be removed (including casts). (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.)
- 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.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M1320)

- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- Additional resources for the WOCN, the NPUAP, and the NQF 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 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 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 (Observable) Pressure Ulcer:

☐ 1 - Stage I
☐ 2 - Stage II
☐ 3 - Stage III
☐ 4 - Stage IV
☐ NA - No observable pressure ulcer or unhealed pressure ulcer

ITEM INTENT

Identifies the stage of the most problematic observable Stage 1 or higher 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 the most problematic pressure ulcer. Visualization of the wound base is necessary to identify the degree of healing evident in the ulcer.
- "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.
- Mark the response that most accurately describes the stage of the most problematic pressure ulcer.
- If the patient has only one observable pressure ulcer, then that ulcer is the most problematic.
- Use the NPUAP definitions to determine the stage of the most problematic pressure ulcer.
- Until suspected deep tissue injury (DTI) evolves and opens, the stage will be considered "NA," as the wound bed cannot be visualized.
- Select "NA" if the patient has NO pressure ulcers or has pressure ulcers that cannot be observed due to the presence of necrotic tissue (including eschar or slough) that obscures visualization of the wound base, or a dressing or device that cannot be removed (e.g., a cast).
- Reverse staging of pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). 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 healed 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 healed 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.

Guidance for this item updated 12/2012

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) **[** *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. If the home health clinician conducting the assessment is not sure the wound fits the definition of a stasis ulcer, the clinician should contact the physician for clarification.

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 (e.g., 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 (e.g., 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.

Guidance for this item updated 12/2011

OASIS ITEM

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

☐ 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 nonremovable dressing 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 (Observable) Stasis Ulcer:

- ☐ 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 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

- If the patient has only one stasis ulcer, that ulcer is the most problematic.
- Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer. The response option "Newly epithelialized" should not be selected for a healed stasis ulcer, as a completely epithelialized (healed) stasis ulcer is not reported as a stasis ulcer on OASIS.

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.

Guidance for this item updated 12/2011

OASIS ITEM

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

☐ 0 - No **[** *Go to M1350* **]**
☐ 1 - Yes, patient has at least one (observable) surgical wound
☐ 2 - Surgical wound known but not observable due to non-removable dressing **[** *Go to M1350* **]**

ITEM INTENT

Identifies the presence of any 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 a wound is not observable. A wound is considered not observable if it is covered by a dressing (or 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. If the home health clinician conducting the assessment is not sure the wound fits the definition of a surgical incision, the clinician should contact the physician for clarification.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer. It does not 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, illeostomy, gastrostomy, etc. These may be reported in M1350 if the home health agency is providing intervention specific to the ostomy.

Guidance for this item updated 12/2012

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

- Orthopedic pin sites, central line sites, 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, 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.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- See Chapter 5 of this manual for resource links.

OASIS ITEM

(M1342) Status of Most Problematic (Observable) Surgical Wound:

☐ 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

- If the patient has only one observable surgical wound, that wound is the most problematic. The "most problematic" surgical wound may be the largest, the most resistant to treatment, an infected surgical wound, etc., depending on the specific situation.
- 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.
- The presence of a scab does not automatically equate to a "not healing" response. The clinician must first assess if the wound is healing entirely by primary intention (complete closure with no openings), or if there is a portion healing by secondary intention, due to dehiscence or interruption of the incision.
  - Primary Intention: Surgical incisions healing by primary intention do not granulate, therefore the only appropriate responses would be 0-Newly epithelialized or 3-Not healing. If the wound is healing solely by primary intention, observe if the incision line has re-epithelialized. (If there is no interruption in the healing process, this generally takes within a matter of hours to three days.) 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 by primary intention.
  - Secondary Intention: If it is determined that there is incisional separation, healing will be by secondary intention, and the clinician will then have to determine the status of healing. Surgical incisions healing by secondary intention do granulate, therefore may be reported as "Not healing," "Early/partial granulation," "Fully granulating," and eventually "Newly epithelialized."
- "Epidermal resurfacing" 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 for implanted venous access devices and infusion devices when the insertion site is healed. Epithelialization is regeneration of the epidermis across a wound surface.
- At follow-up, skip this item if the patient no longer has surgical wounds(s).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- Links to the Wound, Ostomy, and Continence Nurses' guidelines are provided in Chapter 5 of this manual.

Guidance for this item updated 12/2011

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

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- A lesion is a broad term used to describe an area of pathologically altered tissue. Sores, skin tears, burns, ulcers, rashes, etc., are all considered lesions. All alterations in skin integrity are considered to be lesions, except for bowel ostomies (which are reported in OASIS item M1630). Persistent redness without a break in the skin is also considered a lesion.
- Skin lesions or open wounds that are not receiving clinical intervention from the home health agency should not be considered when responding to this question.
- If the patient has any skin condition that is being clinically assessed on an ongoing basis as indicated on the home health agency's plan of care (e.g., wound measurements), then the lesion or wound is receiving clinical intervention and this item should be answered "Yes."
- Response 1 – Yes refers to those types of other wounds NOT described in detail by other specific OASIS items (burns, diabetic ulcers, cellulitis, abscesses, wounds caused by trauma of various kinds, etc.).
- PICC line and peripheral IV sites are considered skin lesions / open wounds.
- Ostomies other than bowel ostomies for elimination (e.g., tracheostomies, thoracostomies, urostomies, jejunostomies, gastrostomies) ARE considered to be skin lesions or open wounds if clinical interventions (e.g., cleansing, dressing changes, assessment) are being provided by the home health agency during the care episode.
- This item does not address cataract surgery of the eye, surgery to mucosal membranes, or gynecological surgical procedures by a vaginal approach.
- This item does not include 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.

DATA SOURCES / RESOURCES

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