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.