



Welcome to the Centers for Medicare & Medicaid Services OASIS-C Online Training. This module will provide foundational education on items related to pressure ulcers in the Integumentary Status domain of the OASIS data set. The Integumentary Status domain module as related to pressure ulcers is divided into two parts. Part 1 will focus on items M1300–M1307, and Part 2 will focus on items M1308–M1324.

Introduction

This program provides an introduction to OASIS-C items related to pressure ulcers found in the Integumentary Status domain.

Discussion includes relevant guidance found in Chapter 3 of the December 2011 OASIS-C Guidance Manual.

The following information is provided in this lesson::

- Specific OASIS conventions that apply to the domain
- Item intent for each specific item
- Time points for item completion
- Response-specific item instructions
- Data sources and resources



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This program provides an introduction to OASIS-C items related to pressure ulcers found in the Integumentary Status domain. Discussion in this lesson includes relevant guidance found in Chapter 3 of the December 2011 version of the OASIS-C Guidance Manual, which contains OASIS item-specific guidance. For the OASIS items contained in the Integumentary Status domain, the following information will be presented: specific OASIS conventions that apply to the Integumentary Status domain, item intent or clarification about what each specific item is intended to report, time points when each item should be completed, response-specific item instructions clarifying the differences between the various responses which could be selected for each item, data sources and resources related to Integumentary Status domain items.

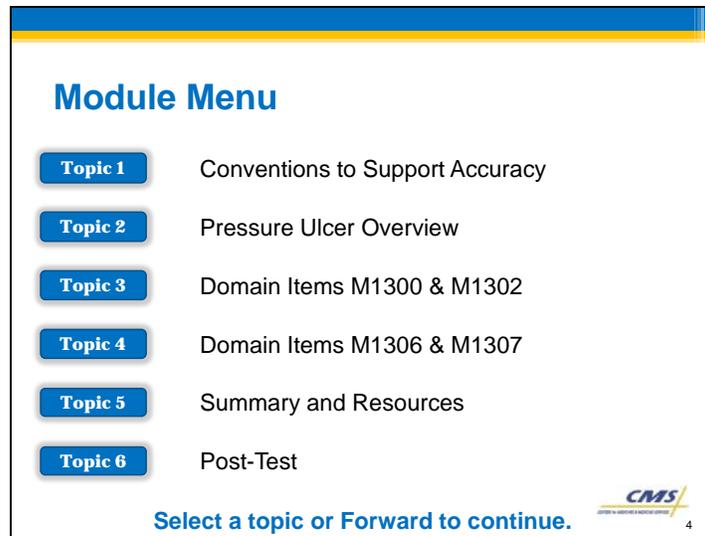
Module Objectives

- Identify specific OASIS conventions that apply to the pressure ulcer items in the Integumentary Status domain.
- Define the Pressure Ulcer Stages per the National Pressure Ulcer Advisory Panel Updated Staging System.
- Identify appropriate healing status of pressure ulcers based upon Wound Ostomy Continence Nurses Society Guidance.
- Apply item-specific guidance when selecting correct responses to pressure ulcer items in the Integumentary Status domain.
- Identify data sources for each item in the Integumentary Status domain.



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After completing this OASIS-C Online Training module, you will be able to identify specific OASIS conventions that apply to the pressure ulcer items in the Integumentary Status domain, define the Pressure Ulcer Stages per the National Pressure Ulcer Advisory Panel guidance, identify appropriate healing status of pressure ulcers based upon Wound Ostomy Continence Nurses Society Guidance, apply item-specific guidance when selecting correct responses to pressure ulcer items in the Integumentary Status domain, and identify data sources for each item in the Integumentary Status domain.



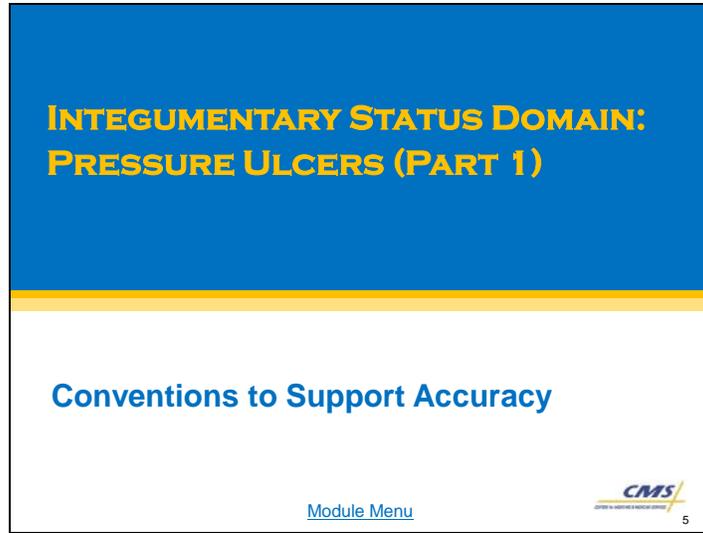
The screenshot shows a 'Module Menu' with six topics listed in blue buttons. The topics are: Topic 1: Conventions to Support Accuracy; Topic 2: Pressure Ulcer Overview; Topic 3: Domain Items M1300 & M1302; Topic 4: Domain Items M1306 & M1307; Topic 5: Summary and Resources; Topic 6: Post-Test. At the bottom, there is a blue link that says 'Select a topic or Forward to continue.' and the CMS logo.

Topic	Description
Topic 1	Conventions to Support Accuracy
Topic 2	Pressure Ulcer Overview
Topic 3	Domain Items M1300 & M1302
Topic 4	Domain Items M1306 & M1307
Topic 5	Summary and Resources
Topic 6	Post-Test

Select a topic or Forward to continue.

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Select the Forward button to review the entire module, or you may select a topic from the Module Menu to review a specific topic of interest.



This topic addresses conventions to support OASIS-C data accuracy.

Time Period Under Consideration

- Understand the time period under consideration for each item.
 - Majority of items direct to report what is true on the day of the assessment.
 - Defined as the time spent in the home and the previous 24 hours.



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There are specific conventions or general rules that you should follow when completing OASIS-C items. Although all the conventions are important to observe and apply when appropriate, there are several that will be especially important to remember when reporting OASIS-C items in the Integumentary Status domain.

The first convention to understand is what is meant by the time period under consideration. In other words, how far back into the past should you consider when assessing the patient's pressure ulcer status. The majority of items in this domain direct you to report what is true on the day of assessment. This is defined as the time spent in the home and the previous 24 hours.

Patient's Current Status

- Understand the time period under consideration for each item.
 - Majority of items direct to report what is true on the day of the assessment.
 - Defined as the time spent in the home and the previous 24 hours.
- Respond to items based on a patient's current status.
 - Do not refer to prior assessments unless directed to do so.
 - Guidance is provided within the item.



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The next convention to consider directs you to respond to items that document a patient's current status based on independent observation of the patient's condition at the time of assessment without referring back to prior assessments. For process items that require documentation of prior status or care, the item will direct you how far back into the patient's past to consider in order to select an appropriate response. For example, you will indicate if current pressure ulcers were present at the most recent Start of Care assessment or Resumption of Care assessment. When reference to prior status is appropriate, this guidance will be found within the item itself.

Use Multiple Strategies

- Combine observation, interview, and other relevant strategies to complete OASIS items.
- Recognize opportunities to gather information from multiple sources.



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The next convention to remember when collecting data for OASIS items in the Integumentary Status domain is the importance of combining observation, interview, and other relevant strategies to complete OASIS data items as needed. For accuracy of data collection in this domain, it will be important to recognize opportunities to gather data from multiple sources such as patient observation, physical assessment, and interview with caregivers or physicians.

Definitions and Rules

- Combine observation, interview, and other relevant strategies to complete OASIS items.
- Recognize opportunities to gather information from multiple sources.
- Understand definitions of words as used in the OASIS-C.
- Follow rules included in the item-specific guidance.

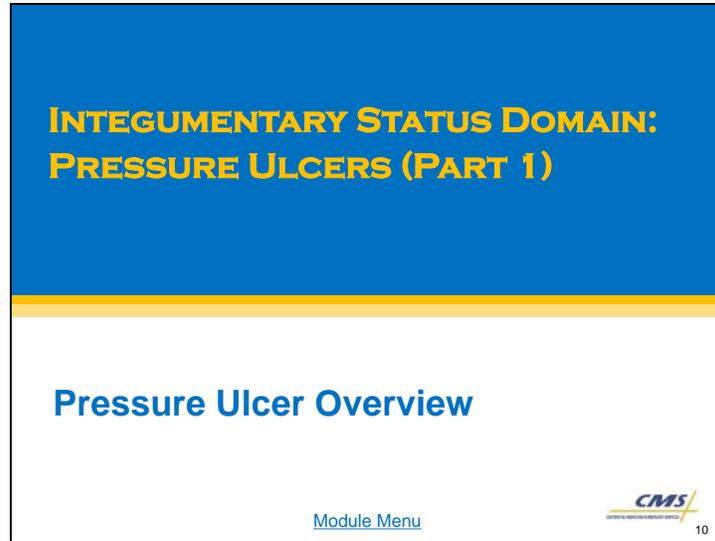
[Module Menu](#)



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As we discuss the items in this domain, pay careful attention to the definition of terms. For example, consider the stages of pressures ulcers and definitions of terms related to healing status. There are very specific definitions of these terms provided in the item-specific guidance.

As always, be sure to follow the rules included in the item-specific guidance. There are several instances in this domain where item-specific guidance provides direction for data collection accuracy.



Before we review the OASIS items, let's review the National Pressure Ulcer Advisory Panel's (NPUAP) definition for a pressure ulcer and other terms associated with pressure ulcers.

Definition of a Pressure Ulcer

“A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure in combination with shear and/or friction.”



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Staging of pressure ulcers is located at http://www.wocn.org/resource/resmgr/docs/guidance_oasis-c.pdf



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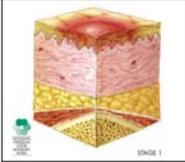
According to the NPUAP, a pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure in combination with shear and/or friction. Pressure ulcer staging is defined by the NPUAP. The definition of pressure ulcer stages was revised in 2007. The following slides provide the NPUAP definitions of pressure ulcer stages. You will need to understand these definitions in order to accurately select a response for the OASIS pressure ulcer items.

A full description of the OASIS guidance based upon the NPUAP guidance is also included in a document by the Wound Ostomy Continence Nurses Society (WOCN) located at the web address referenced here.

Pressure Ulcer Stages: Stage I

STAGE I

- Intact skin with non-blanching redness of a localized area
- Usually over a bony prominence
- May be painful, firm, soft, warmer, or cooler compared to other tissue.



Stage I Pressure Ulcer 

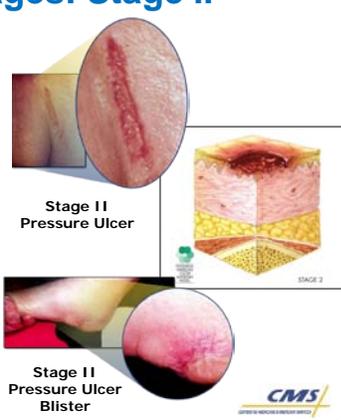
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Stage I pressure ulcers have intact skin with non-blanching redness of a localized area. Usually Stage I ulcers are found over bony prominences. Stage I ulcers may be painful, firm, soft, warmer, or cooler to other tissue when palpated. Stage I pressure ulcers may be difficult to detect in individuals with dark skin tones.

Pressure Ulcer Stages: Stage II

STAGE II

- Partial thickness tissue loss of dermis
- Shallow open ulcer with red pink wound bed WITHOUT slough or bruising
- May also present as an intact or open/ruptured serum-filled blister



Stage II Pressure Ulcer

Stage II Pressure Ulcer Blister

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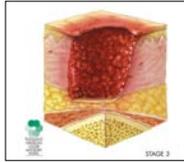
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Stage II pressure ulcers have partial thickness tissue loss of the dermis layer of tissue. Typically, there is a shallow, open ulcer area with a red pink wound bed without any slough or bruising. A Stage II pressure ulcer may also present as an intact or open/ruptured serum-filled blister. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation. If bruising is present, it may indicate a suspected deep tissue injury.

Pressure Ulcer Stages: Stage III

STAGE III

- Full thickness tissue loss
- Subcutaneous fat may be visible
- Bone, tendon, or muscle not exposed
- Slough may be present but does NOT obscure the depth of the tissue loss
- May include tunneling and undermining




Stage III Pressure Ulcer 

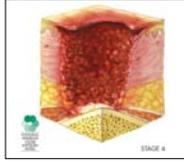
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Stage III pressure ulcers have full thickness tissue loss. Subcutaneous fat may be visible, but the bone, tendon, or muscle is not exposed. Slough may be present, but it does not obscure the depth of the tissue loss. There may be tunneling and undermining areas with Stage III pressure ulcers. As you can see from the illustration, Stage III pressures ulcers can be deep, but the depth varies based upon anatomical location. For example, the bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and Stage III ulcers can be shallow in these locations.

Pressure Ulcer Stages: Stage IV

STAGE IV

- Full thickness tissue with exposed bone, tendon, or muscle
- Slough or eschar may be present on some parts of the wound bed
- Often includes undermining and tunneling



Stage IV Pressure Ulcer

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Stage IV pressure ulcers not only have full thickness tissue loss but also exposed bone, tendon, or muscle. Slough or eschar may be present in some of the wound bed, and there may also be undermining and tunneling into the wound.

Pressure Ulcer Stages: DTI

SUSPECTED DEEP TISSUE INJURY (DTI)

- Purple or maroon localized area of discolored intact skin or blood-filled blister
- Related to damage to underlying soft tissue
- May be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue



Suspected Deep Tissue Injury

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Suspected deep tissue injury, or DTI, may present as a purple or maroon localized area of discolored intact skin or as a blood-filled blister. This is related to damaged underlying soft tissue. The tissue may be painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

Suspected deep tissue injury is more difficult to visualize in dark-pigmented skin. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by a thin layer of eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Pressure Ulcer Stages: Unstageable

UNSTAGEABLE

- Full thickness tissue loss
- Bed of the ulcer covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black)
- True depth and stage of the wound is unstageable until enough slough & eschar is removed



Slough Eschar

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Unstageable pressure ulcers present with full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar. The actual depth and stage of the pressure ulcer is not able to be determined until enough of the slough and eschar is removed. Notice the illustration of the pressure ulcer on this slide shows eschar obscuring the depth of the wound bed so that staging is not possible.

Healed vs. Closed

HEALED

- Stage I & Stage II pressure ulcers heal through the process of epithelialization.
- Stage I ulcers are NOT AT RISK for future ulcer development.
- Stage II ulcers are at MINIMAL RISK.
- No longer reported once healed.



Epithelial Tissue



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When referring to the healing process of pressure ulcers, it is important to understand two concepts and terminology.

In 2004, it was determined that Stage I and Stage II pressure ulcers can “heal” through the process of regeneration of the epidermis across a wound surface known as “epithelialization.” This determination was based upon advances in wound care research and the opinion of the NPUAP. Once Stage I and Stage II pressure ulcers are completely re-epithelialized, they are considered healed, and no longer reported as current pressure ulcers.

Healed vs. Closed, cont'd

CLOSED

- Stage III & Stage IV pressure ulcers heal through the process of contraction, granulation, and epithelialization.
- CLOSE but DO NOT heal.
- ALWAYS remain at risk.
- Continue to report after complete epithelialization.
- NEVER reverse stage.



Names: _____

Stage IV Pressure Ulcer



Closed Stage IV Pressure Ulcer



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Stage III and IV (full thickness) pressure ulcers close through a process of contraction, granulation, and epithelialization. They can never be considered “fully healed.” They can be considered “closed” when they are fully granulated and the wound surface is covered with new epithelial tissue. Stage III and Stage IV pressure ulcers are reported at their worst stage even after they have completely re-epithelialized. A closed Stage III or Stage IV pressure ulcer will continue to be reported in OASIS-C as a current Stage III or IV pressure ulcer and will have the healing status reported as “newly epithelialized.” As a Stage IV pressure ulcer closes, it should not be reported as a Stage III, then a Stage II, and so on. This practice of reverse staging (or "back staging") is not an appropriate clinical practice. As a Stage IV pressure ulcer closes, it continues to be reported as a Stage IV ulcer, with improvement captured through reporting its healing status. Understanding these concepts will help you to select the appropriate responses when answering pressure ulcer items.

Pressure Ulcer Staging Quiz

1. Review the images on the following screens.
2. Determine the appropriate stage of the pressure ulcer.
3. Select the correct answer from the choices provided.
4. Select the Submit button to enter your answer.
5. You may attempt to answer each question as often as you wish.

This quiz is not graded. The goal of this activity is to give you an opportunity to practice staging pressure ulcers by applying these definitions.



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Now that we have reviewed the definitions of each pressure ulcer stage and the various types of unstageable pressure ulcers, let's practice applying these definitions to stage some actual pressure ulcers. You will be presented with a series of pressure ulcers. Based on the image, select the appropriate stage.

Pressure Ulcer Quiz #1

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable - slough or eschar
- F. Suspected deep tissue injury



Full thickness tissue loss as evidenced by exposed muscle



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Select the correct stage for this pressure ulcer.

The correct answer is D. Stage IV. Although this is a shallow pressure ulcer, the pressure ulcer demonstrates full thickness tissue loss with exposed muscle due to its location behind the ear.

Pressure Ulcer Quiz #2

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable -
slough or eschar
- F. Suspected deep
tissue injury



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Select the correct stage for this pressure ulcer.

The correct answer is E, Unstageable due to slough or eschar. This pressure ulcer is unstageable. The wound bed is covered by eschar, making it impossible to stage accurately.

Pressure Ulcer Quiz #3

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable - slough or eschar
- F. Suspected deep tissue injury



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Select the correct stage for this pressure ulcer.

The correct answer is D. Stage IV. Although there is quite an amount of slough covering this wound, the part of the wound bed that is visible indicates that it is deep into muscle

Pressure Ulcer Quiz #4

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable - slough or eschar
- F. Suspected deep tissue injury



Slough/eschar on the right buttock



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Select the correct stage for this pressure ulcer.

The correct answer is Unstageable due to slough or eschar. This pressure ulcer is unstageable. The wound bed is covered by slough and eschar, making it impossible to stage accurately.

Pressure Ulcer Quiz #5

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable - slough or eschar
- F. Suspected deep tissue injury



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Select the correct stage for this pressure ulcer.

The correct answer is D. Stage IV. This full thickness wound is deep into muscle as illustrated by the undermining and tunneling.

Pressure Ulcer Quiz #6

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable - slough or eschar
- F. Suspected deep tissue injury



Blood-filled blister due to pressure



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Select the correct stage for this pressure ulcer.

The correct answer is F. Suspected Deep Tissue Injury. This pressure-related blood blister ulcer that appears on the upper (right) heel needs to be assessed further as there is a possibility that this wound is a suspected deep tissue injury.

Pressure Ulcer Quiz #7

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable - slough or eschar
- F. Suspected deep tissue injury



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Select the correct stage for this pressure ulcer.

The correct answer is E. Unstageable due to slough or eschar. This pressure ulcer is unstageable. The wound bed is covered by eschar, making it impossible to stage accurately.

Pressure Ulcer Quiz #8

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable - slough or eschar
- F. Suspected deep tissue injury



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Select the correct stage for this pressure ulcer.

The correct answer is F. Suspected deep tissue injury. Dark purple, intact skin is characteristic of a typical suspected deep tissue injury.

Pressure Ulcer Quiz #9

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable - slough or eschar
- F. Suspected deep tissue injury



No slough present. Residual wound dressing debris remains on the wound.

Submit



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Select the correct stage for this pressure ulcer.

The correct answer is B. Stage II. This wound retains some residual dressing appearing to be slough. But the wound demonstrates partial thickness tissue loss characteristic of a Stage II pressure ulcer.

Pressure Ulcer Summary

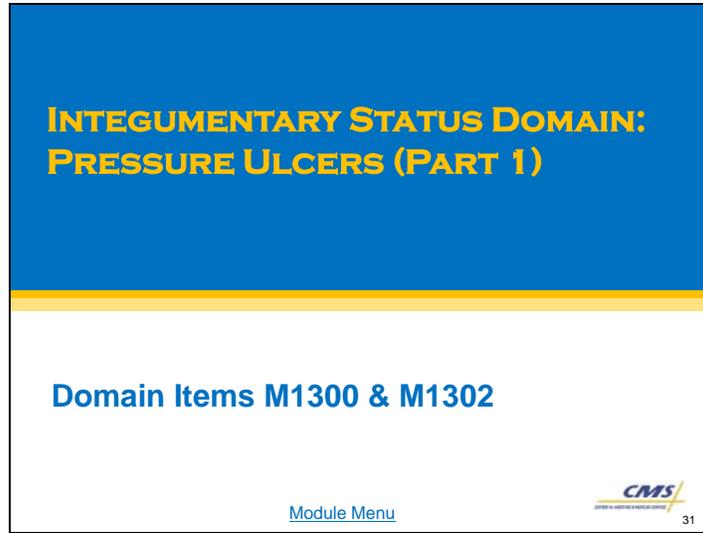
Hopefully, this quiz has helped your understanding of the NPUAP pressure ulcer definitions and of the importance of applying these definitions in order to stage pressure ulcers accurately.

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Hopefully, this quiz has helped your understanding of the NPUAP pressure ulcer definitions and of the importance of applying these definitions in order to stage pressure ulcers accurately.



In this topic, we will review Integumentary Status domain items M1300 and M1302.

Summary of M- Items

- **M1300 Pressure Ulcer Assessment**
- **M1302 Risk of Developing a Pressure Ulcer**
- M1306 Does the Patient have at least One Unhealed Pressure Ulcer?
- M1307 Oldest Unhealed Stage II at Discharge
- M1308 Number of Unhealed Pressure Ulcers
- M1310/M1312/M1314 Length, Width, Depth
- M1320 Healing Status of Pressure Ulcer
- M1322 Number Stage I Pressure Ulcers
- M1324 Stage of Pressure Ulcer



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There are eleven OASIS items in the Integumentary Status domain related to pressure ulcers. This topic addresses two items: M1300 Pressure Ulcer Assessment and M1302 Risk of Developing a Pressure Ulcer.

**M1300 Pressure Ulcer Assessment
Item Intent & Time Points**

(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

Collected at SOC & ROC

Item Intent Time Points Response-Specific Instructions Data Sources/Resources

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The first OASIS-C item that we will be discussing is M1300 Pressure Ulcer Assessment. The intent of this item is to identify if the assessing clinician assessed the patient’s risk of developing pressure ulcers. Notice that the item is reported if the patient was assessed for risk for developing pressure ulcers. It is NOT reporting if pressure ulcer risk was identified – that question will be asked with M1302. The OASIS data collection rules specify the time points at which each OASIS item should be collected. M1300 Pressure Ulcer Assessment is collected at the Start of Care and Resumption of Care assessments.

M1300 Calculating Process Measures		
(0) No	(1) Yes – Clinical Factors	(2) Yes – Standardized Tool
<ul style="list-style-type: none"> No assessment conducted 	<ul style="list-style-type: none"> Evaluation of clinical factors Examples: <ul style="list-style-type: none"> Mobility Incontinence Nutrition etc. 	<ul style="list-style-type: none"> Standardized tool Examples: <ul style="list-style-type: none"> Braden Scale Norton Assessment Other validated standardized screening tools

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Item M1300 Pressure Ulcer Assessment is used in the calculation of the process measure that captures the agency’s use of best practices following the completion of the comprehensive assessment. Specifically, it identifies if the assessing clinician assessed the patient’s risk for pressure ulcers using clinical factors or used a standardized tool. The Centers for Medicare & Medicaid Services, or CMS, does not require the use of a standardized tool nor does it endorse one particular tool. The best practices stated in this item are not necessarily required in the Conditions of Participation.

The best practice under focus here is to identify if the patient was assessed for the risk of developing pressure ulcers, and if so, identify if the clinician assessed the patient using either clinical factors or a standardized tool. Since the item provides the option of using either method to assess pressure ulcer risk, it is important for us to understand what is meant by each option.

**M1300 Pressure Ulcer Assessment
Response-Specific Instructions**

(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 _____ Time Points _____ **Response-Specific Instructions** _____ Data Sources/ Resources  35

Select Response 0 - No when no assessment was completed to determine if the patient is at risk of pressure ulcers.

Select Response 1 - Yes if the patient was evaluated for risk of pressure ulcers using an evaluation of clinical factors. Examples of clinical factors include mobility, incontinence, nutrition, and any other factors to indicate patient is at risk for pressure ulcers.

**M1300 Pressure Ulcer Assessment
Response-Specific Instructions, cont'd**

(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 _____ Time Points _____ **Response-Specific Instructions** _____ Data Sources/
Resources  36

Select Response 2 - Yes the patient was assessed for risk of pressure ulcers **only** if the patient was screened using a validated standardized screening tool. A standardized tool must meet two criteria. 1) It has to be scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, non-institutionalized adults with disabilities, etc.). 2) It includes a standard response scale. The standardized tool must be appropriately administered as indicated in the instructions.

M1300 Pressure Ulcer Assessment Data Sources / Resources

- Gather information from various sources.
 - Patient or caregiver interview
 - Direct observation of the patient during the assessment
 - Physical examination
 - Referral information received at the time of the assessment
- Follow protocols for administering a standardized tool if one is used.
- Refer to [Chapter 5 of the OASIS-C Guidance Manual](#).

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____  37

When performing the pressure ulcer assessment, the data may be gathered from various sources depending upon the method used for assessment. Information may be collected through patient or caregiver interview, direct observation of the patient during the assessment, or physical examination. Information may also be collected from referral information that is received at the time of assessment or obtained from the physician. If a standardized tool is used, be sure you are aware of and follow the administration protocols for that particular tool.

You can find links to resources for established, validated pressure ulcer risk tools including the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale in Chapter 5 of the OASIS-C Guidance Manual.

M1302 Risk of Pressure Ulcers Item Intent & Time Points

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

0 – No

1 – Yes

Collected at SOC & ROC

Item IntentTime PointsResponse-Specific InstructionsData Sources/
Resources

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The next item in the Integumentary Status domain is M1302 Risk of Developing Pressure Ulcers. This item identifies if the patient is at risk for developing pressure ulcers. If you did not perform a pressure ulcer risk assessment in the previous item, M1300 Pressure Ulcer Assessment, then skip this item.

The specific time points for data collection for this item are the Start of Care and Resumption of Care assessments.

M1302 Risk of Pressure Ulcers Response-Specific Instructions

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

0 – No
 1 – Yes

- Follow response-specific instructions for this item.
- Response determined by results of the assessment for item M1300.

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources  39

To accurately select the correct response for M1302, the assessing clinician must be aware of the response-specific instructions related to this item. The response you select for this item is determined by the results of the assessment that was performed for M1300.

M1302 Risk of Pressure Ulcers
Response-Specific Instructions, cont'd

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

0 – No
 1 – Yes

- Conducted a pressure ulcer risk assessment using a validated standardized screening tool.
- Use the specific scoring parameters for that tool to determine if the patient is at risk of developing a pressure ulcer.

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources _____

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For example, let's assume you assessed pressure ulcer risk using a validated standardized screening tool (M1300 is scored as Response 2). In this case, use the specific scoring parameters for that tool to identify if the patient is at risk for developing a pressure ulcer.

M1302 Risk of Pressure Ulcers
Response-Specific Instructions, cont'd

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

0 – No
 1 – Yes

- Define what constitutes a risk if:
 - The tool used to perform a risk assessment does not define levels of risk.
 - Your evaluation was based upon clinical factors.
- Select a response accordingly.

Item Intent Time Points Response-Specific Instructions Data Sources/Resources  41

If the tool you used does not define levels of risk or if your evaluation was based upon clinical factors (M1300 is scored as Response 1), then the agency or assessing clinician may define what constitutes a risk. Select a response for M1302 accordingly.

M1302 Risk of Pressure Ulcers Data Sources / Resources

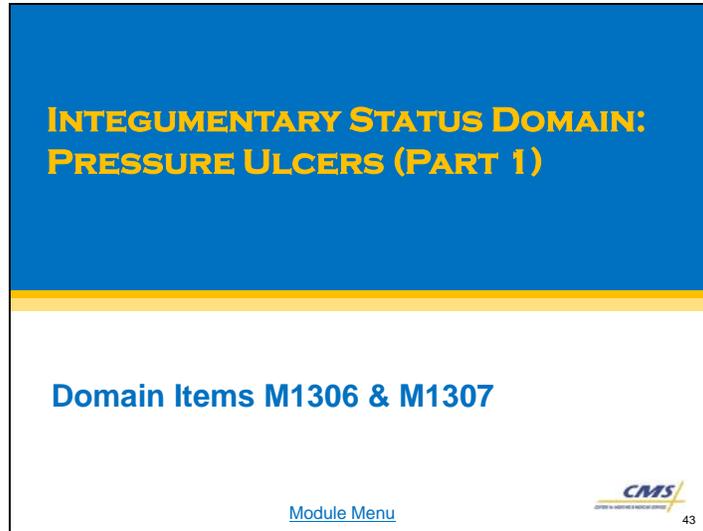
- Gather information from various sources:
 - Patient or caregiver interview
 - Direct observation of the patient during the assessment
 - Physical examination
 - Referral information received at the time of the assessment
- Follow protocols for administering a standardized tool if one is used.
- Links to resources for established, validated pressure ulcer risk tools are available in [Chapter 5 of the OASIS-C Guidance Manual](#).

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Item Intent
Time Points
Response-Specific Instructions
**Data Sources/
Resources**
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When identifying the risk of developing pressure ulcers, the data may be gathered from various sources depending upon the method used for assessment. Information may be collected through patient or caregiver interview, direct observation of the patient during the assessment, and physical examination. Information may be collected from referral information that is received at the time of the assessment or obtained from the physician. If a standardized tool is used, be sure you are aware of and follow administration protocols for that particular tool.

You can find links to resources for established, validated pressure ulcer risk tools including the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale in Chapter 5 of the OASIS-C Guidance Manual.



In this topic, we will review Integumentary Status domain items M1306 and M1307.

Summary of M-Items

- M1300 Pressure Ulcer Assessment
- M1302 Risk of Developing a Pressure Ulcer
- **M1306 Does the Patient have at least One Unhealed Pressure Ulcer?**
- **M1307 Oldest Unhealed Stage II at Discharge**
- M1308 Number of Unhealed Pressure Ulcers
- M1310/M1312/M1314 Length, Width, Depth
- M1320 Healing Status of Pressure Ulcer
- M1322 Number Stage I Pressure Ulcers
- M1324 Stage of Pressure Ulcer



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There are eleven OASIS items in the Integumentary Status domain related to pressure ulcers. This topic addresses two items: M1306 Does the Patient have at least One Unhealed Pressure Ulcer? and M1307 Oldest Unhealed Stage II at Discharge. The other items in this domain are addressed in Part 2 of this module.

**M1306 Unhealed Pressure Ulcers
Item Intent and Time Points**

(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

Collected at SOC, ROC, Follow-up & DC Not to Inpatient

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____  45

Item M1306 asks Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as “unstageable”? This item is intended to identify the presence or absence of unstageable or unhealed Stage II or higher pressure ulcers only. Stage I pressure ulcers are not included in this item.

The data collection time points for this item include at Start of Care, Resumption of Care, Follow-up, and Discharge from the agency but not to an inpatient facility.

OASIS-C & Unstageable Pressure Ulcers

- OASIS-C defines unstageable pressure ulcers as:



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To score this item accurately, we must make sure we understand how unstageable pressure ulcers are defined in OASIS-C. Let's review the definitions of unstageable pressure ulcers we learned earlier in this module.

OASIS-C & Unstageable Pressure Ulcers

- OASIS-C defines unstageable pressure ulcers as:
 - Pressure ulcers known or suspected to be present but unobservable due to a non-removable dressing or device.



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Unstageable pressure ulcers are defined as pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings. These findings may include patient report of discomfort, past history of skin breakdown in the same area, etc. The suspected pressure ulcer, however, is unobservable due to dressings or devices (e.g., casts) that cannot be removed to assess the skin underneath.

OASIS-C & Unstageable Pressure Ulcers

- OASIS-C defines unstageable pressure ulcers as:
 - Pressure ulcers known or suspected to be present but unobservable due to a non-removable dressing or device.
 - Full thickness tissue loss in which the true wound depth is obscured by slough or eschar in the wound bed.



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Unstageable pressure ulcers also include pressure ulcers that the care provider suspects may be present based on clinical assessment findings but that cannot be staged due to full thickness tissue loss in which the true wound depth is obscured by slough, which is yellow, tan, gray, green, or brown tissue, and/or eschar, which is tan, brown, or black tissue, in the wound bed.

OASIS-C & Unstageable Pressure Ulcers

- OASIS-C defines unstageable pressure ulcers as:
 - Pressure ulcers known or suspected to be present but unobservable due to a non-removable dressing or device
 - Full thickness tissue loss in which the true wound depth is obscured by slough or eschar in the wound bed
 - Suspected deep tissue injury in evolution



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Unstageable pressure ulcers also include suspected deep tissue injury in evolution. This is defined by the National Pressure Ulcer Advisory Panel as a purple or maroon localized area of discolored intact skin or a blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.

M1306 Unhealed Pressure Ulcers Response-Specific Instructions

(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

- Select Response 0 if the patient has:
 - A Stage I pressure ulcer only
- OR
- A former Stage II pressure ulcer that has healed
- AND
- No other pressure ulcers
- Skip to item M1322.

Item Intent _____ Time Points _____
Response-Specific Instructions
Data Sources/ Resources
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This item considers only Stage II and higher or unstageable pressure ulcers. The OASIS-C Guidance Manual directs you to select Response 0 – No if the patient has only a Stage I pressure ulcer OR if a former Stage II pressure ulcer has healed AND the patient has no other pressure ulcers. Notice that you will skip to M1322 if you select this response.

M1306 Unhealed Pressure Ulcers
Response-Specific Instructions, cont'd

(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

- Select response 1 if the patient has:
 - An unhealed Stage II pressure ulcer.
- OR
- A Stage III or Stage IV pressure ulcer at any healing status (open or closed)
- OR
- An unstageable pressure ulcer

Item Intent Time Points **Response-Specific Instructions** Data Sources/
Resources

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Select Response 1 - Yes if the patient has an unhealed Stage II pressure ulcer OR a Stage III or Stage IV pressure ulcer at any healing status level (open or closed) OR if the patient has an unstageable ulcer according to the definitions we just reviewed.

M1306 Unhealed Pressure Ulcers
Data Sources / Resources

- Gather information from various sources:
 - Observe the patient during the assessment.
 - Conduct a physical examination.
 - Patient or caregiver interview may supplement physical assessment findings.
 - Collect referral information received at the time of admission or from the physician.
- Refer to [Chapter 5 of the OASIS-C Guidance Manual](#).

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources  52

When determining if the patient has unhealed pressure ulcers, data may be gathered and supplemented from various sources. Observe the patient during the assessment, and conduct a physical examination. Information gathered through patient or caregiver interview during the assessment may supplement physical assessment findings. Information may also be collected from referral information that is received at the time of admission or obtained from the physician.

Consult the published guidelines of the National Pressure Ulcer Advisory Panel for clarification and/or resources for training. Other resources can be found in Chapter 5 of the OASIS-C Guidance Manual.

M1306 Scenario

While performing the comprehensive assessment, you notice that your patient has a 3 cm x 4 cm scar on his left hip.

When questioned the patient states that he had a “bed sore” there several years ago that was so deep you could see his tendons and muscle.

You do not observe any other ulcers or lesions.



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Let's practice applying some of the data collection guidelines that we have discussed. While performing the comprehensive assessment, you notice that your patient has a 3 cm X 4 cm scar on his left hip. When questioned the patient states that he had a “bed sore” there several years ago that was so deep you could see his tendons and muscle. You do not observe any other ulcers or lesions.

M1306 Scenario Question

How would you score M1306 Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as “unstageable”?

(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

Select the correct response for this scenario.

[Review Scenario](#)



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How would you score M1306 Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as “unstageable”?

M1306 Scenario Answer

How would you score M1306 Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as “unstageable”?

(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

That is correct! Based upon the guidance we learned earlier, Stage IV pressure ulcers are reported as current pressure ulcers even after they have epithelialized and completely closed. Remember this guidance only applies to Stage III and Stage IV pressure ulcers.

[Review Scenario](#)  55

That is correct. Based upon the guidance we learned earlier, Stage IV pressure ulcers are reported as current pressure ulcers even after they have epithelialized and completely closed. Remember this guidance only applies to Stage III and IV pressure ulcers.

M1307 Oldest Non-epithelialized Stage II Item Intent & Time Points

(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

Collected at DC Not to Inpatient

Item Intent
Time Points
Response-Specific Instructions
Data Sources/ Resources


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M1307 The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge reports details about the oldest non-epithelialized Stage II pressure ulcer. This does not include Stage I, Stage III, Stage IV, or unstageable pressure ulcers – just Stage II pressure ulcers that are present at discharge.

The intent of this item is to identify the oldest Stage II that is present at the time of discharge and is NOT fully epithelialized. Also this item is looking at the length of time that the ulcer remains unhealed while the patient is receiving care from the home health agency and potentially to identify patients who develop Stage II pressure ulcers while under the care of the home health agency. M1307 is completed on discharge from homecare when not to an inpatient facility.

M1307 Oldest Non-epithelialized Stage II Response-Specific Instructions

(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 _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources _____

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To select the correct response for M1307 Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge, read all the response options then determine which response most accurately reflects the patient’s situation. The response-specific instructions provide the necessary guidance for answering this item correctly. Remember, this item refers only to non-epithelialized Stage II pressure ulcers. Do not consider Stage III or IV pressure ulcers when answering this item.

**M1307 Oldest Non-epithelialized Stage II
Response-Specific Instructions, cont'd**

**(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 Time Points Response-Specific Instructions Data Sources/Resources

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Select Response 1 when the oldest non-epithelialized Stage II pressure ulcer was already present when the most recent Start of Care or Resumption of Care assessment occurred.

Select Response 2 when the oldest non-epithelialized Stage II pressure ulcer present at discharge developed after the most recent Start of Care assessment or a Resumption of Care assessment was completed. For example, a Stage II pressure ulcer developed midway through the episode and remains present at discharge, and no older Stage II pressure ulcers are present. The Stage II pressure ulcer wound would be reported in Response 2, including the date the pressure ulcer was identified.

**M1307 Oldest Non-epithelialized Stage II
Response-Specific Instructions, cont'd**

(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 Time Points Response-Specific Instructions Data Sources/ Resources



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Select Response NA if the patient does not have a Stage II pressure ulcer at the time of discharge or all Stage II pressure ulcers have been fully epithelialized.

If an ulcer is suspected as being a Stage II but is unstageable, it 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, but that are unobservable due to dressings or devices that cannot be removed to assess the skin underneath.

M1307 Oldest Non-epithelialized Stage II Data Sources / Resources

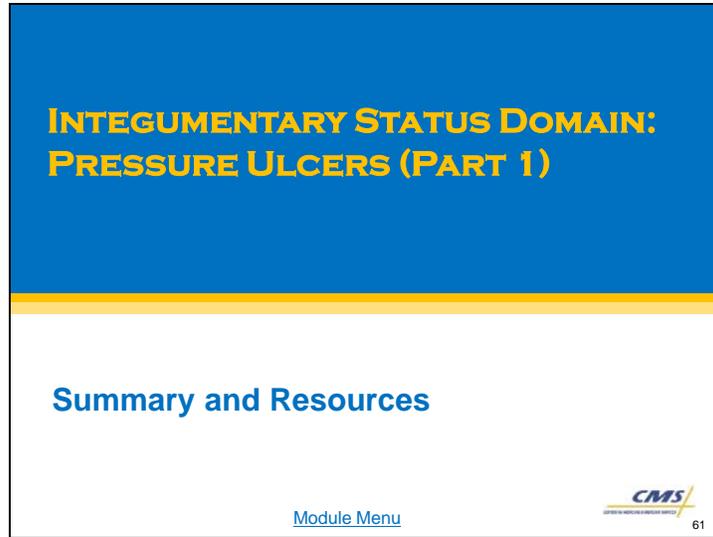
- Use information from several sources:
 - Interview the patient and caregiver during the discharge assessment.
 - Observe the patient directly.
 - Conduct a physical assessment of the patient.
 - Review the patient’s record to determine when the Stage II pressure ulcer developed.
- Refer to [Chapter 5 of the OASIS-C Guidance Manual](#).

[Module Menu](#)

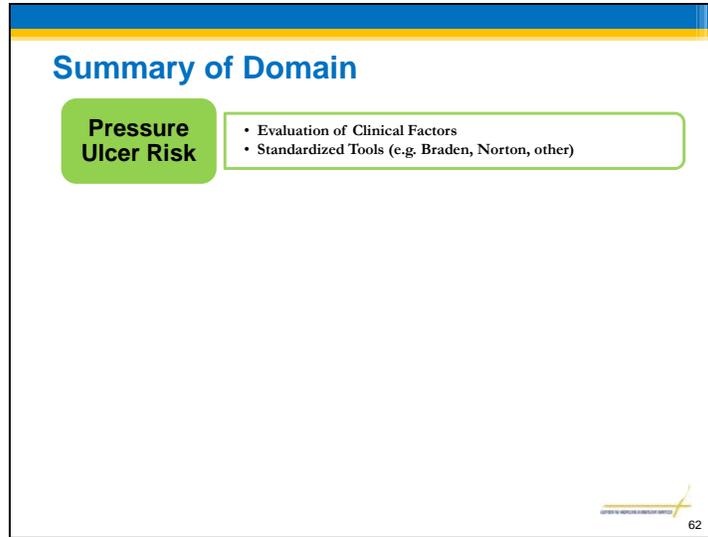
Item Intent Time Points Response-Specific Instructions **Data Sources/ Resources**  60

When assessing your patient’s oldest non-epithelialized Stage II pressure ulcer, use information from several sources to help you select an appropriate response. You can interview the patient and caregiver during the Discharge assessment, observe the patient directly, and conduct a physical assessment of the patient. Also review the patient’s record to identify when the Stage II pressure ulcer developed.

Consult the published guidelines of the National Pressure Ulcer Advisory Panel for clarification and/or resources for training. Other resources can be found in Chapter 5 of the OASIS-C Guidance Manual.



We have covered a lot of material in this education session. You may want to review the material again or refer to the CMS OASIS-C Guidance and Questions and Answers. Let's recap some highlights of what we learned in this module.



Summary of Domain

Pressure Ulcer Risk

- Evaluation of Clinical Factors
- Standardized Tools (e.g. Braden, Norton, other)

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The slide features a blue header bar at the top. Below it, the title 'Summary of Domain' is written in blue. A green rounded rectangle contains the text 'Pressure Ulcer Risk'. To its right, a white rounded rectangle with a green border contains a bulleted list of two items: 'Evaluation of Clinical Factors' and 'Standardized Tools (e.g. Braden, Norton, other)'. In the bottom right corner, there is a small logo consisting of a yellow and blue line graphic above the number '62'.

Patients can be assessed for risk status for developing pressure ulcers using either clinical factors or with standardized tools for the homecare environment.

Summary of Domain

Pressure Ulcer Risk

- Evaluation of Clinical Factors
- Standardized Tools (e.g. Braden, Norton, other)

Staging

- National Pressure Ulcer Advisory Panel (NPUAP)
- Stages I, II, III, IV, Unstageable & Suspected Deep Tissue Injury
- Never reverse stage
- Non-observable = non-removable dressing or device or necrotic tissue

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We have reviewed the National Pressure Ulcer Advisory Panel’s current staging system and learned that pressure ulcers never reverse stage. Remember that a non-removable dressing or device or a wound covered with necrotic tissue makes the pressure ulcer non-observable for staging.

Summary of Domain

Pressure Ulcer Risk	<ul style="list-style-type: none">• Evaluation of Clinical Factors• Standardized Tools (e.g. Braden, Norton, other)
Staging	<ul style="list-style-type: none">• National Pressure Ulcer Advisory Panel (NPUAP)• Stages I, II, III, IV, Unstageable & Suspected Deep Tissue Injury• Never reverse stage• Non-observable = non-removable dressing or device or necrotic tissue
Healed vs. Closed	<ul style="list-style-type: none">• Stage I & II ulcers can “<u>Heal</u>” and are no longer ulcers• Stage III & IV ulcers can “<u>Close</u>” but always remain a pressure ulcer at its worst stage

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Stage I and Stage II pressure ulcers can “heal” and then are no longer considered pressure ulcers based upon the scientific research. But Stage III and Stage IV pressure ulcers can “close,” but they will never “heal.” They will always remain pressure ulcers at their worst stage.

Summary of Domain

Pressure Ulcer Risk	<ul style="list-style-type: none"> • Evaluation of Clinical Factors • Standardized Tools (e.g. Braden, Norton, other)
Staging	<ul style="list-style-type: none"> • National Pressure Ulcer Advisory Panel (NPUAP) • Stages I, II, III, IV, Unstageable & Suspected Deep Tissue Injury • Never reverse stage • Non-observable = non-removable dressing or device or necrotic tissue
Healed vs. Closed	<ul style="list-style-type: none"> • Stage I & II ulcers can “<u>Heal</u>” and are no longer ulcers • Stage III & IV ulcers can “<u>Close</u>” but always remain a pressure ulcer at its worst stage
Status	<ul style="list-style-type: none"> • Follow the WOCN Guidance for defining healing status of pressure ulcers • Stage II, III & IV ulcers only • Not observable = non-removable dressing or device only

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When determining the status of the most problematic observable pressure ulcer, only consider Stage II, Stage III, and Stage IV ulcers. Do not include Stage I ulcers. Utilize the WOCN Guidance for defining the healing status of pressure ulcers and remember that the definition of non-observable for healing status only includes a non-removable dressing or device.

Resources / References

- OASIS-C Guidance Manual
 - www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html
 - Chapter 3 provides guidance on OASIS-C questions.
 - Chapter 5 provides the Updated Staging System of the National Pressure Ulcer Advisory Panel (NPUAP), including illustrations.
- Wound, Ostomy and Continence Nurses Society (WOCN)
 - <http://www.wocn.org/?page=oasis>
 - Guidance on OASIS-C Integumentary Items
- OASIS Answers, Inc.
 - www.oasisanswers.com



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The resources and references that were used for this educational program are listed on this slide. Additionally, there are several organizations that provide accurate, evidence-based, or best practices that would assist with OASIS accuracy and improving patient outcomes.

Questions

- Talk with your clinical managers.
- Email OASIS training feedback site.
 - oasisctrainingfeedback@cms.hhs.gov
- Check the CMS Q & As.
 - www.qtso.com/hhdownload.html
- Check the Quarterly Q & As.
 - www.oasisanswers.com
- Contact State OASIS Education Coordinators.
 - www.cms.gov/OASIS/Downloads/OASISeducationalcoordinators.pdf
- Submit Q & As to CMS.
 - [send email to CMSOASISquestions@oasisanswers.com](mailto:CMSOASISquestions@oasisanswers.com)



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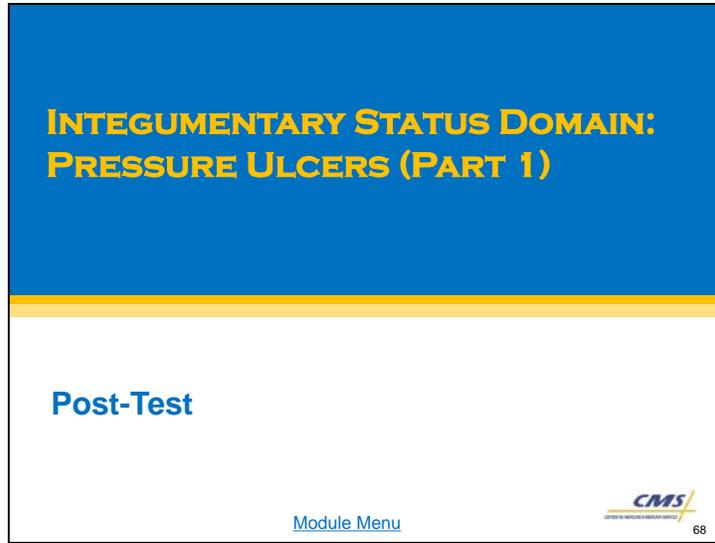
If you have comments related to this web module, please consider providing feedback to the OASIS training feedback mailbox at oasisctrainingfeedback@cms.hhs.gov.

Also, download and review additional guidance included in the CMS Q & As and the Quarterly Q&A updates, available at the links provided here.

If you should still have an unanswered data collection question after consulting the guidance contained in Chapter 3 of the OASIS-C Guidance Manual and the OASIS Q & As, contact your State OASIS Education Coordinator, who can provide free assistance in answering your OASIS data collection questions.

If your question cannot be resolved with the help of your OEC, consider submitting your inquiry to the CMS OASIS mailbox at CMSOASISquestions@oasisanswers.com

Thank you for your commitment to OASIS Accuracy.



This is the Integumentary Status Domain: Pressure Ulcers (Part 1) Module Post-Test. This test consists of five questions covering the material in this lesson.

Post-Test Question #1

All of the following tools would be appropriate to answer M1300 Pressure Ulcer Assessment as #2 Yes – Standardized Tool

EXCEPT:

- A. Braden Scale
- B. Norton Assessment
- C. An evidence-based tool that is appropriate in the community setting
- D. A tool that some of your clinicians think might capture patients at risk using just their clinical experience

The correct response is D. A tool that some of your clinicians think might capture patients at risk using just their clinical experience.



Post-Test Question #2

A resident has a pressure ulcer on the ankle that just has the first layer of skin opened. The wound bed is clean and red and shows no signs of infection. What stage is this pressure ulcer?

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable

The correct response is B. Stage II.



Post-Test Question #3

A reddened area is noted on the heel of a patient, but no open tissue and no deep purple tissue are noted. What stage is this pressure ulcer?

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable

The correct response is A. Stage I.



Post-Test Question #4

A coccyx pressure ulcer has slough and eschar covering most of the wound bed, but the muscle is visible. What stage is this pressure ulcer?

- A. Stage I
- B. Stage II
- C. Stage III
- D. Stage IV
- E. Unstageable

The correct response is D. Stage IV.



Post-Test Question #5

All of the following would be considered unstageable EXCEPT:

- A. Suspected deep tissue injury
- B. Fluid-filled blister that has not opened and wound bed not visible
- C. Pressure ulcer covered with non-removable dressing
- D. Pressure ulcer wound bed covered in slough and/or eschar

The correct response is B. Fluid-filled blister that has not opened and wound bed not visible.