



Welcome to the Centers for Medicare & Medicaid Services OASIS-C Online Training. This module will provide foundational education on 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.

This module continues the training provided in the module titled Integumentary Status: Pressure Ulcers (Part 1). It is recommended that you complete Part 1 before starting this module.

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

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



This program provides an introduction to OASIS-C items related to pressure ulcers found in the Integumentary Status domain. This module continues the training provided in the module titled Integumentary Status: Pressure Ulcers (Part 1). It is recommended that you complete Part 1 before starting this module. 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: 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

- 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



After completing this OASIS-C Online Training module, you will be able to 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.

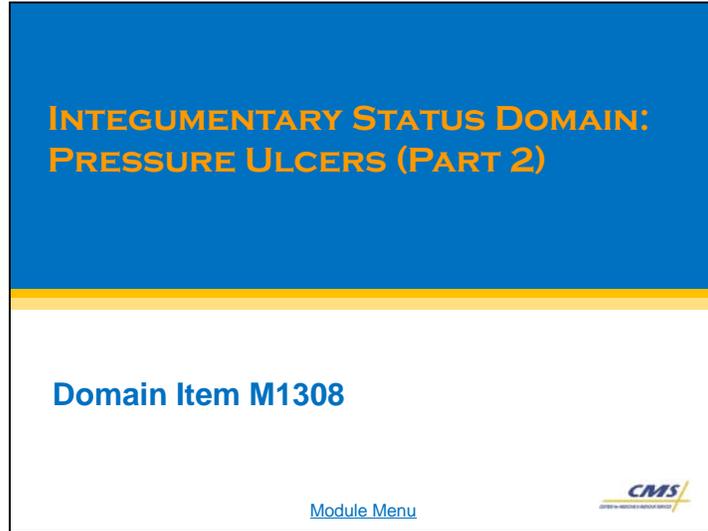
Module Menu

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In this topic, we will review Integumentary Status domain item M1308.

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



There are eleven OASIS items in the Integumentary Status domain related to pressure ulcers. This topic addresses one item: M1308 Number of Unhealed Pressure Ulcers.

M1308 Current Number of Unhealed Ulcers Item Intent		
(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage: <i>(Enter "0" if none; excludes Stage I pressure ulcers)</i>		
	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.		

Documents the number of Stage II or higher pressure ulcers at each stage present at the time of assessment.

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


Item M1308 Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage documents the number of Stage II or higher pressure ulcers at each stage present at the time of assessment. Notice that Stage I pressure ulcers are not reported in this item.

M1308 Current Number of Unhealed Ulcers Definitions

	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)
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.		

Note: NPUAP Pressure Ulcer Definitions (Stage II or higher and Unstageable)



As you can see, each stage is defined based upon the NPUAP definitions.

M1308 Current Number of Unhealed Ulcers Column 1 and Column 2		
(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage: <i>(Enter "0" if none; excludes Stage I pressure ulcers)</i>		
	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.		

Includes two columns with specific time points and types of data collected.

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



There are two columns in this grid, and each column has specific time points when the data is collected. Each column also has very specific guidance related to data collection. Let's review each column separately.

M1308 Current Number of Unhealed Ulcers Item Intent & Time Points (Column 1)	
	Column 1 Complete at SOC/ROC/FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>
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.	

Column 1 Intent:
Report the number of Stage II or higher pressure ulcers on the current day of the assessment.

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

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



Complete Column 1 at the Start of Care, Resumption of Care, Follow-up (Recertification and Other Follow-up), and Discharge from the agency not to an inpatient facility. The guidance directs you to report the number of Stage II or higher pressure ulcers on the current day of assessment.

M1308 Current Number of Unhealed Ulcers Response-Specific Instructions (Column 1)

	Column 1 Complete at SOC/ROC/FU & D/C
Stage description – unhealed pressure ulcers	Number Currently Present
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	1
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.	0
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.	0
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	0
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	0
d.3 Unstageable: Suspected deep tissue injury in evolution.	0

Column 1 Instructions:

- Mark a response for each row.
- Enter “0” if there are no pressure ulcers at a given stage.

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

Mark a response for each row of this item: a, b, c, d.1, d.2, and d.3. If there are NO ulcers at a given stage, enter “0” for those stages.

M1308 Column 1 Example

At Start of Care, your patient has a Stage II pressure ulcer to the coccyx and a Stage III pressure ulcer to the left heel.
How would you report these ulcers in Column 1 of item M1308?

	Column 1 Complete at SOC/ROC/FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>
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.	

Let’s review an example of how you would report pressure ulcer data in Column 1 of item M1308. Consider this scenario and review M1308. How would you report these ulcers in Column 1?

M1308 Column 1 Example Answer

At Start of Care, your patient has a Stage II pressure ulcer to the coccyx and a Stage III pressure ulcer to the left heel.

	Column 1 Complete at SOC/ROC/FU & D/C	
Stage description – unhealed pressure ulcers	Number Currently Present	Column 1 Scoring: Enter a “1” in row a. and row b. to report that the patient has a Stage II and a Stage III pressure ulcer on the day of assessment.
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.	1	
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.	1	



The scenario indicates that the patient has a current Stage II and Stage III pressure ulcer. Therefore, these pressure ulcers must be reported in Column 1 of item M1308. Based upon this scenario, you would enter a “1” in row a. and a “1” in row b. to indicate the patient has a Stage II and a Stage III pressure ulcer on the day of assessment.

M1308 Column 1 Example Answer, cont'd

At Start of Care, your patient has a Stage II pressure ulcer to the coccyx and a Stage III pressure ulcer to the left heel.

	Column 1 Complete at SOC/ROC/FU & D/C	
Stage description – unhealed pressure ulcers	Number Currently Present	Column 1 Scoring:
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.	0	Remember to enter a “0” in rows c, d.1, d.2, and d.3 to indicate that there are no pressure ulcers at those stages on the day of assessment.
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	0	
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	0	
d.3 Unstageable: Suspected deep tissue injury in evolution.	0	



Did you remember to enter a zero in the row if there are no pressure ulcers at that stage?
 Notice how we have entered 0's in row c, d.1, d.2, and d.3.

**M1308 Current Number of Unhealed Ulcers
Item Intent & Time Points (Column 2)**

Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C	Column 2 Intent: Report the number of Stage II or higher pressure ulcers listed in Column 1 that were present on the most recent SOC or ROC.
<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>	

Collected at Follow-up & DC Not to Inpatient

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

Now let's take a look at Column 2. For Column 2, report the number of Stage II or higher pressure ulcers listed in Column 1 that were present on the most recent Start of Care or Resumption of Care. Complete Column 2 only at Follow-up (Recertification and Other Follow-up) and at Discharge from the agency not to an inpatient facility.

M1308 Current Number of Unhealed Ulcers Response-Specific Instructions (Column 2)

Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
0	0

Column 2 Instructions:

- Enter a “0” in Column 2 if a “0” is listed in Column 1.
- Column 2 indicates if a pressure ulcer was already present at the Start of Care/ Resumption of Care **OR** developed since that time.

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

If you report a “0” in Column 1, meaning on the day of the assessment the patient did not have any pressure ulcers at that stage, then you will also enter a “0” in Column 2 of the same row. Pay attention to the fact that Column 2 indicates if a pressure ulcer was present at the time of the Start of Care or Resumption of Care **OR** developed since that time. When the number in Column 1 is greater than the number in Column 2, this indicates that the patient developed a pressure ulcer while under your agency’s care.

**M1308 Current Number of Unhealed Ulcers
Response-Specific Instructions (Column 2), cont'd**

Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>

Column 2 Instructions:

- Follow specific guidance if a patient comes out of the hospital during the 5-day recertification window.
- The ROC assessment will be completed to satisfy both ROC and Recertification assessment purposes.
- Leave Column 2 blank.

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

Column 2 is only collected at Follow-up (Recertification and Other Follow-up assessments) and Discharge assessments. There is specific guidance if your patient comes out of the hospital during the 5-day Recertification window, and a Resumption of Care assessment will be completed to satisfy the requirements for both a Resumption of Care assessment and a Recertification assessment. Follow the instructions for completing the Resumption of Care assessment when completing M1308. This means you will only complete Column 1 and leave Column 2 blank even though this assessment will also serve as the Recertification assessment.

M1308 Example

At Start of Care, your patient has a Stage II pressure ulcer to the coccyx and a Stage III pressure ulcer to the left heel.

At the Recertification assessment, your patient's left heel ulcer has progressed to a Stage IV pressure ulcer. The Stage II pressure ulcer that was on the coccyx at Start of Care has completely epithelialized.

How would you report these ulcers in Column 1 and Column 2 of M1308 at Recertification?



Let's revisit the scenario we viewed earlier but with additional information based on a Recertification assessment. At Start of Care, your patient has a Stage II pressure ulcer to the coccyx and a Stage III pressure ulcer to the left heel. At the Recertification assessment, the pressure ulcer on your patient's left heel has progressed to Stage IV. The Stage II pressure ulcer that was on the coccyx at the Start of Care has completely epithelialized. How would you report these ulcers in Column 1 and Column 2 of M1308 at the Recertification?

M1308 Example Answer: Row a. Column 1

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.		



[Review Scenario](#)

Let’s work through this row by row and column by column. Remember, Column 1 always reports the number of pressure ulcers at each stage on the day of assessment. On the day of the Recertification, did the patient have any Stage II pressure ulcers?

M1308 Example Answer: Row a.

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	0	0
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.		



[Review Scenario](#)

The answer is no. The Stage II pressure ulcer on the patient’s coccyx has completely epithelialized so is now considered healed. Item M1308 reports only unhealed pressure ulcers; therefore, you would place a “0” in Column 1 row a. Column 2 asks the number of pressure ulcers listed in Column 1 that were present at Start of Care or Resumption of Care. Since there were no Stage II pressure ulcers in Column 1, then there can’t be any in Column 2. Anytime you have a “0” in a row in Column 1, you will always have a “0” in the same row in Column 2.

M1308 Example Answer: Row b.

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	0	0
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.	0	0



[Review Scenario](#)

Now let’s look at row b. Stage III pressure ulcers. Did the patient have any Stage III pressure ulcers on the day of the Recertification assessment? The answer is no; therefore, place a “0” in both Column 1 and Column 2. As we just explained, anytime you have a “0” in a row in Column 1, you will also have a “0” in the same row in Column 2.

M1308 Example Answer: Row c. Column 1

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	1	



[Review Scenario](#)

Let’s look at row c. Stage IV pressure ulcers. Did the patient have any Stage IV pressure ulcers on the day of the Recertification assessment? The answer is yes, the patient had one Stage IV pressure ulcer on Recertification. Therefore, place a “1” in Column 1. To answer Column 2, ask how many of the pressure ulcers listed in Column 1 were present at the most recent Start of Care or Resumption of Care.

M1308 Example Answer: Row c. Column 2

	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)
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.	1	1



[Review Scenario](#)

In this case, there is only one pressure ulcer present, the current Stage IV pressure ulcer. This pressure ulcer was present at the Start of Care assessment and would, therefore, be reported as a “1” in Column 2. Note that Column 2 is not asking what stage the pressure ulcer was at the assessment. Column 2 just reports how many of the pressure ulcers at each stage in Column 1 were present at any stage at the most recent Start of Care or Resumption of Care assessment.

M1308 Scoring Guidance

- “Healed” vs. “Closed”
- Unstageable due to dressings or devices
- Surgical treatments



Scoring pressure ulcers accurately in item M1308 can be challenging due to a variety of factors including correct staging and treatments. Let’s stop at this point and review key guidance for reporting pressure ulcers based on factors such as healing at various stages, your ability to assess a pressure ulcer due to its dressings and devices, and how surgical treatment affects the reporting of a wound.

**M1308 Current Number of Unhealed Ulcers
Scoring Guidance: Stage I and Stage II**

Stage I and Stage II Guidance

Stage I pressure ulcers are not reported in this item.

Stage II pressure ulcers that have completely epithelialized and “healed” are not reported in this item.



We'll begin with “healed” or “closed” pressure ulcers. Stage I and Stage II pressure ulcers are described as “partial thickness” ulcers. As discussed in Part 1 of this training, it has been determined that partial thickness pressure ulcers can heal through a process of regeneration of the epidermis across a wound surface known as “epithelialization.” As we have seen for M1308, Stage I pressure ulcers are not reported in this item, and Stage II pressure ulcers that have healed are also not reported here.

**M1308 Current Number of Unhealed Ulcers
Scoring Guidance: Stage III and Stage IV**

Stage I and Stage II Guidance	Stage III and Stage IV Guidance
Stage I pressure ulcers are not reported in this item. Stage II pressure ulcers that have completely epithelialized and "healed" are not reported in this item.	Can never be considered "fully healed" but are "closed" when granulation tissue is covered with new epithelium. Reverse staging is not appropriate.



Remember, however, that Stage III and Stage IV pressure ulcers can never be considered "fully healed." They are 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. For example, if a pressure ulcer is Stage III at Start of Care and is granulating at the follow up visit, the ulcer remains a Stage III ulcer.

**M1308 Current Number of Unhealed Ulcers
Scoring Guidance: Stage III and Stage IV, cont'd**

Stage I and Stage II Guidance	Stage III and Stage IV Guidance
Stage I pressure ulcers are not reported in this item.	Can never be considered “fully healed” but can be considered “closed” when granulation tissue is covered with new epithelium.
Stage II pressure ulcers that have completely epithelialized and “healed” are not reported in this item.	Reverse staging is not appropriate.
	A closed Stage III or Stage IV pressure ulcer should be reported as a pressure ulcer at its worst stage even after it has re-epithelialized.
	A previously closed Stage III or Stage IV pressure ulcer that is currently open again should be reported at its worst stage.



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 a patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, making it challenging to know the stage of the wound at its worst. You should make every effort to contact previous providers, including the patient’s physician, to determine the stage of the wound at its worst. A pressure ulcer can also worsen and progress in staging. This item should be answered appropriately on subsequent assessments if this occurs.

**M1308 Current Number of Unhealed Ulcers
Scoring Guidance: Unstageable**

Stage I and Stage II Guidance Stage I pressure ulcers are not reported in this item. Stage II pressure ulcers that have completely epithelialized and "healed" are not reported in this item.	Stage III and Stage IV Guidance Can never be considered "fully healed" but can be considered "closed" when granulation tissue is covered with new epithelium. Reverse staging is not appropriate. A closed Stage III or Stage IV pressure ulcer should be reported as a pressure ulcer at its worst stage even after it has re-epithelialized. A previously closed Stage III or Stage IV pressure ulcer that is currently open again should be reported at its worst stage.
Unstageable Guidance Presence of a pressure ulcer may be known or suspected but cannot be assessed due to a non-removable dressing or device. Always report a pressure ulcer that cannot be assessed due to a non-removable dressing or device as unstageable.	



Remember that some pressure ulcers may be known to exist but cannot be staged due to a non-removable dressing or device. A care provider may also suspect that a pressure ulcer is present based on clinical assessment findings such as patient report of discomfort or past history of skin breakdown in the same area. Any known or suspected pressure ulcer that is unstageable due to a device or dressing (like a cast) that cannot be removed to assess the skin underneath should be reported as unstageable in row d.1.

**M1308 Current Number of Unhealed Ulcers
Scoring Guidance: Surgical Wound**

Surgical Wound
A **muscle flap, skin advancement flap, or rotational flap** performed on a pressure ulcer = **surgical wound**



Additional guidance in scoring M1308 is provided for a flap that is performed to surgically replace a pressure ulcer. This includes a muscle flap, skin advancement flap, or rotational flap, which is 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. In this case, the wound becomes a surgical wound. This wound should now be reported as a surgical wound for item M1342 and should no longer be reported as a pressure ulcer for item M1308.

**M1308 Current Number of Unhealed Ulcers
Scoring Guidance: Surgical Wound, cont'd**

Surgical Wound vs. Pressure Ulcer	
A muscle flap, skin advancement flap, or rotational flap performed on a pressure ulcer = surgical wound	A pressure ulcer that has been surgically debrided = pressure ulcer



A pressure ulcer that has been surgically debrided, however, remains a pressure ulcer. Debridement is a procedure that is performed to the wound, but it does not change the classification of the type of wound. It should not be reported as a surgical wound for item M1342.

**M1308 Current Number of Unhealed Ulcers
Scoring Guidance: Surgical Wound, cont'd**

Surgical Wound vs. Pressure Ulcer	
A muscle flap, skin advancement flap, or rotational flap performed on a pressure ulcer = surgical wound	A pressure ulcer that has been surgically debrided = pressure ulcer Pressure ulcer treated with skin graft = pressure ulcer



Finally, a pressure ulcer that is treated with a skin graft remains a pressure ulcer. A skin graft is defined as transplantation of skin to another site, but a pressure ulcer treated with a skin graft should not be reported as a surgical wound for item M1342. Until the graft edges completely heal, the grafted pressure ulcer should be reported on item M1308 as an unstageable pressure ulcer.

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. For example, your patient has a Stage IV pressure ulcer that the physician covers with a skin graft. While the graft is healing, the wound bed cannot be visualized to determine the stage. Therefore, it is reported as unstageable in row d.1. Once the edges heal, the pressure ulcer would continue to be reported in M1308 as a Stage IV since, at its worst stage, it was reported as a Stage IV.

M1308 Current Number of Unhealed Ulcers
Data Sources / Resources

- Use information from several sources:
 - Interview the patient and caregiver during the assessment.
 - Observe the patient directly.
 - Conduct a physical assessment of the patient.
 - Review the patient’s clinical record and previous health information.
- Consult NPUAP published guidelines.
- Refer to [Chapter 5 of the OASIS-C Guidance Manual](#).

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


When assessing your patient’s number of unhealed ulcers, use information from several sources to help you select an appropriate response. You can interview the patient and caregiver during the assessment, observe the patient directly, and conduct a physical assessment of the patient. Also review the clinical record and previous health information. You can obtain this information from the referral and the intake process and query the physician for wound information.

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.

M1308 Scenario #1

A patient has one Stage II pressure ulcer on admission, and still has the Stage II pressure ulcer at the Follow-up assessment.



Now let's practice applying this guidance for scoring item M1308 by completing some scenarios. For the first scenario, a patient has one Stage II pressure ulcer on admission and still has the Stage II pressure ulcer at the Follow-up assessment.

M1308 Scenario #1 Column 1

How would you complete row a. Column 1?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.		

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row a. Column 1.

[Review Scenario](#) 

How would you complete row a. Column 1?

M1308 Scenario #1 Column 2

How would you complete row a. Column 2?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	1	

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row a. Column 2.

[Review Scenario](#)

Now, how would you complete row a. Column 2?

M1308 Scenario #1 Completed Scoring

	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.	1	1
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	0	0
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.	0	0
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	0	0
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	0	0
d.3 Unstageable: Suspected deep tissue injury in evolution.	0	0

This table illustrates the full scoring of item M1308 for this scenario. Remember to enter a "0" for pressure ulcer types that do not apply to the patient.



[Review Scenario](#)

This table illustrates the scoring of item M1308 for this scenario. Remember to enter a zero for pressure ulcer types that do not apply to the patient.

M1308 Scenario #2

A patient has no Stage II pressure ulcers on admission, but develops one during the first episode that is present at the Recertification (Follow-up) assessment.



For this scenario, a patient has no Stage II pressure ulcers on admission but develops one during the first episode that is present at the Recertification assessment.

M1308 Scenario #2 Column 1

How would you complete row a. Column 1 at Recertification?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.		

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row a. Column 1.

[Review Scenario](#)

How would you complete row a. Column 1?

M1308 Scenario #2 Column 2

How would you complete row a. Column 2?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	1	

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row a. Column 2.

[Review Scenario](#)

Now, how would you complete row a. Column 2?

M1308 Scenario #2 Completed Scoring

	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.	1	0
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.	0	0
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.	0	0
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	0	0
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	0	0
d.3 Unstageable: Suspected deep tissue injury in evolution.	0	0

This table illustrates the full scoring of item M1308 for this scenario. Remember to enter a "0" for pressure ulcer types that do not apply to the patient.

[Review Scenario](#)


This table illustrates the scoring of item M1308 for this scenario. Remember to enter a zero for pressure ulcer types that do not apply to the patient.

M1308 Scenario #3

Your patient has one Stage II pressure ulcer and two Stage III pressure ulcers.

How would you complete M1308 for a Start of Care assessment?



Your patient has one Stage II pressure ulcer and two Stage III pressure ulcers. How would you complete M1308 at the Start of Care?

M1308 Scenario #3 Row a. Column 1

How would you complete row a. Column 1 at SOC?

	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.		

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row a. Column 1.

[Review Scenario](#) 

Let’s begin with row a. and the patient’s Stage II pressure ulcers. How would you complete Column 1 for row a. at the Start of Care? Remember, Column 1 directs us to report the number of pressure ulcers currently present on the day of the assessment.

M1308 Scenario #3 Row a. Column 2

How would you complete row a. Column 2 at SOC?

	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.	1	

A. 0 B. 1 C. Leave Blank D. Date of this pressure ulcer

Select the correct value for row a. Column 2.

[Review Scenario](#) 

Now, how would you complete Column 2 at the Start of Care?

M1308 Scenario #3 Row b. Column 1

How would you complete row b. Column 1 at SOC?

	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)
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.		

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row b. Column 1.

[Review Scenario](#)

Now, how would you complete Column 1 for row b. at the Start of Care?

M1308 Scenario #3 Completed Scoring

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	1	
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.	2	
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.	0	
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device.	0	
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	0	
d.3 Unstageable: Suspected deep tissue injury in evolution.	0	

This table illustrates the scoring of item M1308 for this scenario. Remember to enter a "0" for pressure ulcer types that do not apply to the patient. Leave Column 2 blank for a Start of Care assessment.



[Review Scenario](#)

This table illustrates the scoring of item M1308 for this scenario. Remember to enter a zero for pressure ulcer types that do not apply to the patient. Leave Column 2 blank for a Start of Care assessment.

M1308 Scenario #4

You are conducting an Other Follow-up assessment.

Your patient had one Stage II and one Stage III pressure ulcer at Start of Care.

During the episode, the Stage III pressure ulcer completely epithelialized and closed. The Stage II pressure ulcer remained unchanged in staging, and the patient developed one new Stage II pressure ulcer.



In this scenario, you are conducting an Other Follow-up assessment. Your patient had one Stage II and one Stage III pressure ulcer at Start of Care. During the episode, the Stage III pressure ulcer completely epithelialized and closed. The Stage II pressure ulcer remained unchanged in staging, and the patient developed one new Stage II pressure ulcer.

M1308 Scenario #4 Row a. Column 1

How would you complete row a. Column 1 at Follow-up?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.		

A. 0 B. 1 C. 2 D. 3 E. Leave Blank

Select the correct value for row a. Column 1.

[Review Scenario](#)

Let's begin with row a. How would you complete Column 1 for row a. for the Other Follow-up assessment?

M1308 Scenario #4 Row a. Column 2

How would you complete row a. Column 2?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	2	

A. 0 B. 1 C. 2 D. 3 E. Leave Blank

Select the correct value for row a. Column 2.

[Review Scenario](#)

Now, how would you complete Column 2?

M1308 Scenario #4 Row b. Column 1

How would you complete row b. Column 1?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.		

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row b. Column 1.

[Review Scenario](#)

How would you complete Column 1 for row b. for this assessment?

M1308 Scenario #4 Row b. Column 2

How would you complete row b. Column 2?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	1	

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row b. Column 2.

[Review Scenario](#) 

How would you complete Column 2 for row b. for this assessment?

M1308 Scenario #4 Completed Scoring

	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.	2	1
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.	1	1
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.	0	0
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	0	0
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	0	0
d.3 Unstageable: Suspected deep tissue injury in evolution.	0	0

This table illustrates the scoring of item M1308 for this scenario. Remember to enter a "0" for pressure ulcer types that do not apply to the patient.

[Review Scenario](#)


This table illustrates the scoring of item M1308 for this scenario. Remember to enter a zero for pressure ulcer types that do not apply to the patient.

M1308 Scenario #5

You are completing this scenario for a Follow-up assessment.

Your patient had one Stage III pressure ulcer at Start of Care.

This ulcer worsened during the episode and is now classified as a Stage IV pressure ulcer.



You are completing this scenario for a Follow-up assessment. Your patient had one Stage III pressure ulcer at Start of Care. This ulcer worsened during the episode and is now classified as a Stage IV pressure ulcer.

M1308 Scenario #5 Row b. Column 1

How would you complete row b. Column 1?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.		

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row b. Column 1.

[Review Scenario](#)

Let's start with row b. Stage III pressure ulcers. How would you complete Column 1 for this assessment?

M1308 Scenario #5 Row b. Column 2

How would you complete row b. Column 2?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	0	

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row b. Column 2.

[Review Scenario](#)

Then how would you complete Column 2 for row b. for this assessment?

M1308 Scenario #5 Row c. Column 1

How would you complete row c. Column 1?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.		

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row c. Column 1.

[Review Scenario](#)

Now let's complete row c. Stage IV pressure ulcers. How would you complete Column 1?

M1308 Scenario #5 Row c. Column 2

How would you complete row c. Column 2?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	1	

A. 0 B. 1 C. 2 D. Leave blank

Select the correct value for row c. Column 2.

[Review Scenario](#)

Finally, how would you complete Column 2?

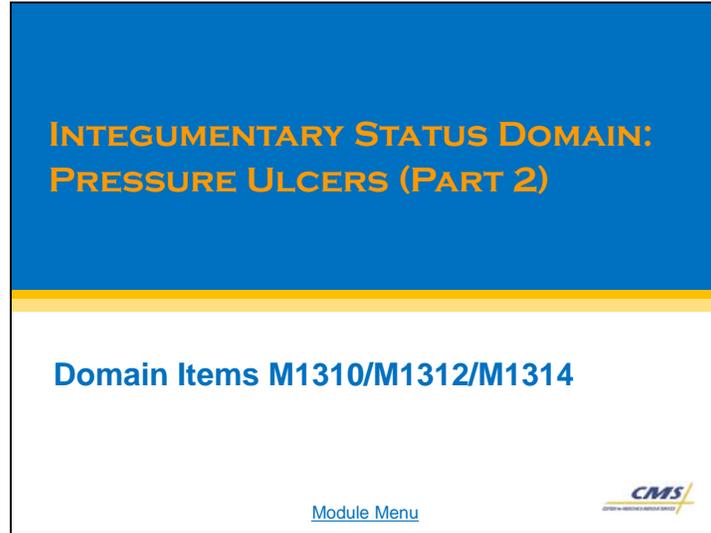
M1308 Scenario #5 Completed Scoring

Stage description – unhealed pressure ulcers	Column 1	Column 2
	Complete at SOC/ROC/FU & D/C	Complete at FU & D/C
	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.	0	0
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.	0	0
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.	1	1
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device.	0	0
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	0	0
d.3 Unstageable: Suspected deep tissue injury in evolution.	0	0

This table illustrates the scoring of item M1308 for this scenario. Remember to enter a "0" for pressure ulcer types that do not apply to the patient.

[Review Scenario](#)
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This table illustrates the scoring of item M1308 for this scenario. Remember to enter a zero for pressure ulcer types that do not apply to the patient.



In this topic, we will review Integumentary Status domain items M1310, M1312, and M1314.

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



There are eleven OASIS items in the Integumentary Status Domain related to pressure ulcers. Items M1310, M1312, and M1314 document the measurements of the largest Stage III or Stage IV pressure ulcer or a pressure ulcer that is unstageable due to slough or eschar.

M1310/M1312/M1314 Pressure Ulcer Measurement Item Intent & Time Points

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)

Collected at SOC, ROC & DC Not to Inpatient

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



There are three items that address pressure ulcer measurement. The intent of these items is to identify the length, width, and depth of the pressure ulcer with the largest surface area (length x width). This applies only to an unhealed Stage III or Stage IV pressure ulcer or a pressure ulcer that is unstageable due to slough or eschar. Notice how the item intent includes pressure ulcers that are unstageable due to the presence of slough or eschar. Note that this information is not included in the directions, but must be included based upon the item intent and response-specific instructions. The time points for data collection of these items include at Start of Care, Resumption of Care, and Discharge from agency not to an inpatient facility.

Before we discuss each item, let’s review the instructions found in Chapter 3 of the OASIS-C Guidance Manual related to pressure ulcer measurement.

M1310/M1312/M1314 Pressure Ulcer Measurement Guidelines

- Record measurements for the largest of the following:
 - Any unhealed Stage III and Stage IV pressure ulcers
 - Any unstageable pressure ulcer due to slough or eschar
- Remove all dressings.
- Clean the wounds to remove all exudate.
- Use one of the following to measure the wound:
 - Disposable measuring device
 - Cotton-tipped applicator
 - Camera
 - Other wound technology



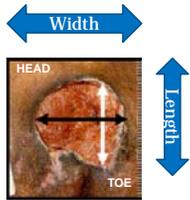


Items M1310, M1312, and M1314 record measurements for a patient’s largest unhealed (non-epithelialized) Stage III or Stage IV pressure ulcer or unstageable pressure ulcer due to the presence of slough or eschar. These pressure ulcers would be identified in item M1308 Column 1 rows b, c, or d.2.

When measuring each pressure ulcer, first remove all dressings and clean the wounds to remove all exudate. Use a disposable measuring device, a cotton-tipped applicator, a camera, or other wound technology to measure the wound. If you are using a cotton-applicator, mark the distance between healthy skin tissue at each margin on the applicator, and lay the applicator next to a centimeter ruler or measuring device to determine measurements. Round measurements to the nearest tenth of a centimeter.

M1310/M1312/M1314 Pressure Ulcer Measurement Guidelines, cont'd

- Measure all Stage III, Stage IV, and unstageable (due to slough or eschar) pressure ulcers.
- Measure diagonal or slanted pressure ulcers from head to toe for length.
- Measure width perpendicular to the length.
- Measure depth from the visible surface to the deepest area in the base of the wound.
- Do not include depth of tunneling.



Measure all Stage III or IV pressure ulcers and any unstageable pressure ulcers that are covered with any amount of slough or eschar. Measure length and width in centimeters. Measure the length from head to toe even for pressure ulcers that lie diagonally or slanted. Width is measured perpendicular to the length. Depth is measured from the visible surface to the deepest area at the base of the wound. Do not include the depth of any tunneling present.

M1310/M1312/M1314 Pressure Ulcer Measurement Response-Specific Instructions

- Complete these items only if M1308 Column 1 Rows b, c, or d.2 are greater than zero.
- Determine which pressure ulcer has the largest surface dimension (length x width).
- Record the length, width, and depth of the pressure ulcer with the largest surface dimension in centimeters.

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

OASIS-C guidance directs you to complete these items only if item M1308 Column 1 rows b, c, or d.2 are greater than zero. If more than one of these pressure ulcers is present, measure all existing non-epithelialized Stage III and Stage IV pressure ulcers and pressure ulcers that are unstageable due to slough and eschar. Determine which pressure ulcer has the largest surface dimension. Surface dimension is defined as length x width. Report the length, width, and depth of the pressure ulcer with the largest surface dimension in items M1310, M1312, and M1314. Record all dimensions in centimeters.

M1310/M1312/M1314 Pressure Ulcer Measurement Response-Specific Instructions, cont'd

- Leave these items blank if no pressure ulcers exist.
- Enter 00.0 if all existing Stage III or Stage IV ulcers are closed (completely epithelialized) and there are no unstageable ulcers.
- Enter 00.0 for the depth of a pressure ulcer covered/filled with eschar (see example below).

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

| 0 | 0 | . | 0 | (cm)

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



If the patient does not have any of these pressure ulcers, leave these items blank. If all existing Stage III or IV pressure ulcers are closed (completely epithelialized) and there are no unstageable pressure ulcers due to slough or eschar, enter 00.0 for these items. If a pressure ulcer is covered/filled with eschar, enter the depth as 00.0.

M1310/M1312/M1314 Pressure Ulcer Measurement Data Sources / Resources

- Use information from the following sources:
 - Physical assessment of the patient
 - Direct observation of the patient
- Refer to [Chapter 5 of the OASIS-C Guidance Manual](#).



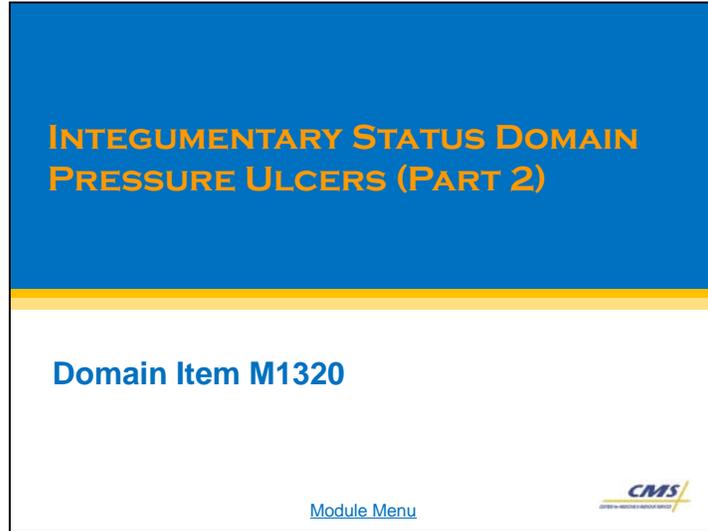
[Module Menu](#)

Item IntentTime PointsResponse-Specific Instructions**Data Sources/
Resources**



When assessing and reporting the length, width, and depth of your patient’s pressure ulcers, collect data from your physical assessment and direct observation of the patient during this assessment.

Refer to Chapter 5 of the OASIS-C Guidance Manual as needed.



In this topic, we will review Integumentary Status domain item M1320.

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



There are eleven OASIS items in the Integumentary Status domain related to pressure ulcers. M1320 documents the healing status of the most problematic observable pressure ulcer.

**M1320 Pressure Ulcer Healing Status
Item Intent & Time Points**

**(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

Collected at SOC, ROC & DC Not to Inpatient

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



M1320 identifies the healing status of the most problematic observable pressure ulcer at Stage II or higher. This item is collected at the Start of Care, Resumption of Care, and Discharge not to an inpatient facility time points. Keep in mind that Stage I pressure ulcers are NOT included in this OASIS-C item. Stage II pressure ulcers that have completely epithelialized and healed are also not included in this item.

M1320 Pressure Ulcer Healing Status Definitions

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

PROBLEMATIC

- Largest
- Most advanced stage
- Most difficult to access for treatment
- Most difficult to relieve pressure



In order to select the response that most accurately describes the healing process you see occurring in the most problematic observable pressure ulcer, you must understand how these terms are defined in the OASIS-C assessment. The most problematic pressure ulcer may be the one that is the largest or the one with the most advanced stage. It might be the one that is the most difficult to access for treatment or the one that is the most difficult to relieve pressure. It is up to the assessing clinician to determine which is the most problematic pressure ulcer if more than one pressure ulcer is present.

M1320 Pressure Ulcer Healing Status Definitions, cont'd

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

PROBLEMATIC	NOT OBSERVABLE
<ul style="list-style-type: none"> • Largest • Most advanced stage • Most difficult to access for treatment • Most difficult to relieve pressure 	<ul style="list-style-type: none"> • Cannot be observed due to a dressing or device that cannot be removed • Does not include wound covered with necrotic tissue



The other term that must be understood is the use of the term “observable.” When determining the healing status of a pressure ulcer, you must be able to visualize the wound. The only reason you should not be able to visualize a wound is if it is covered with a dressing or device that cannot be removed, such as a cast. If a wound is covered with necrotic tissue, you can see the evidence that the wound is not healing. Therefore, a wound covered with necrotic tissue is considered observable for the purposes of determining the healing status. The necrotic tissue itself provides information to you about the healing status of that wound, specifically that it is not healing.

**M1320 Pressure Ulcer Healing Status
Response-Specific Instructions**

**(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

- Identify which pressure ulcers are observable.
- Consider the one that is the most problematic based on clinical judgment.
- Report the status of this ulcer.
- If only one ulcer exists, report the status of that ulcer.

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



You will report on the most problematic observable pressure ulcer for M1320. If there is more than one pressure ulcer, first identify which pressure ulcers are observable. Then consider the one that is the most problematic based upon your clinical judgment. Report the healing status of this pressure ulcer. If only one observable pressure ulcer is present, report the healing status of that pressure ulcer.

Healing Status of Pressure Ulcers

O - NEWLY EPITHELIALIZED

- Wound bed completely covered with new epithelium
- No exudate
- No avascular tissue (slough and/or eschar)
- No signs or symptoms of infection



To help you select the correct response, let’s define the terms found in the response options for M1320. These definitions can be found on the Wound Ostomy Continence Nurses Society (WOCN) web site: www.wocn.org under the link for Guidance on OASIS-C. Newly epithelialized is defined as a wound bed that is completely covered with new epithelium. There is no exudate, no avascular tissue (slough and/or eschar), and no signs or symptoms of infection. All of these requirements must apply to the wound in order to select Newly epithelialized as a response.

Healing Status of Pressure Ulcers, cont'd	
0 - NEWLY EPITHELIALIZED	1 - FULLY GRANULATING
<ul style="list-style-type: none">• Wound bed completely covered with new epithelium• No exudate• No avascular tissue (slough and/or eschar)• No signs or symptoms of infection	<ul style="list-style-type: none">• Wound bed filled with granulation tissue to the level of the surrounding skin• No dead space• No avascular tissue• No signs or symptoms of infection• Wound edges are open

Fully granulating is defined as a wound bed that is filled with granulation tissue to the level of the surrounding skin. There is no dead space, no avascular tissue, no signs or symptoms of infection, and the wound edges are open. All of these requirements must apply to the wound to select this response.

Healing Status of Pressure Ulcers, cont'd

2 - EARLY/PARTIAL GRANULATION

- ≥25 % of the wound bed covered with granulation tissue
- < 25% of the wound bed covered with avascular tissue (slough and/or eschar)
- May have dead space
- No signs or symptoms of infection
- Wound edges are open



Early/partial granulation is defined as a wound bed with ≥25% coverage of granulation tissue and <25% coverage with avascular tissue (slough and/or eschar). The ulcer may have dead space. There are no signs or symptoms of infection, and the wound edges are open. All of these requirements must apply to select the response Early/partial granulation.

Healing Status of Pressure Ulcers, cont'd	
2 - Early/Partial Granulation	3 - Not Healing
<ul style="list-style-type: none">• $\geq 25\%$ of the wound bed covered with granulation tissue• $< 25\%$ of the wound bed covered with avascular tissue (slough and/or eschar)• May have dead space• No signs or symptoms of infection• Wound edges are open	<ul style="list-style-type: none">• $\geq 25\%$ avascular tissue (eschar and/or slough) OR <ul style="list-style-type: none">• Signs or symptoms of infection OR <ul style="list-style-type: none">• Clean but not granulating wound bed OR <ul style="list-style-type: none">• Closed/hyperkeratotic wound edges OR <ul style="list-style-type: none">• Persistent failure to improve despite appropriate care

Not healing is defined as a wound with at least one of these characteristics. The wound contains $\geq 25\%$ avascular tissue (eschar and/or slough) OR signs or symptoms of infection OR a clean but not granulating wound bed OR closed/hyperkeratotic wound edges OR a persistent failure to improve despite appropriate care. Notice how only one of these requirements needs to apply to a wound to select the response of Not healing.

**M1320 Pressure Ulcer Healing Status
Response-Specific Instructions, cont'd**

(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

You must be able to visualize the wound in order to identify the degree of healing evident in the most problematic observable ulcer.

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



When determining the correct response to select, you should remember that you must be able to visualize the wound in order to identify the degree of healing evident in the ulcer determined to be the most problematic observable ulcer. Use the WOCN guidance and response-specific instructions to assist you.

M1320 Pressure Ulcer Healing Status Response-Specific Instructions, cont'd

(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

- Select Response 0 when epithelial tissue has completely covered the surface of the pressure ulcer.
- Use this option no matter how long the pressure ulcer has been re-epithelialized.
- Select response 1 if the pressure ulcer is fully granulated, but epithelial tissue has not completely covered the wound surface.

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



You would mark response 0 Newly epithelialized for a Stage III or Stage IV pressure ulcer when epithelial tissue has completely covered the wound surface of the pressure ulcer. Use this option regardless of how long the pressure ulcer has been re-epithelialized. Response 1 Fully granulating would be an appropriate response for a Stage III or Stage IV pressure ulcer that is fully granulated, but epithelial tissue has not completely covered the wound surface.

M1320 Pressure Ulcer Healing Status Response-Specific Instructions, cont'd

(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

- Do not select Response 0 or Response 1 for Stage II pressure ulcers.
- Fully epithelialized Stage II ulcers are not reported.
- Stage II pressure ulcers do not granulate.
- Response 3 is the only appropriate response for Stage II pressure ulcers.

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



Response 0 – Newly epithelialized is an appropriate response for Stage III and Stage IV pressure ulcers only. Do not use this option for Stage II ulcers as fully epithelialized Stage II ulcers would not be reported. 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 Response 3 – Not healing.

M1320 Pressure Ulcer Healing Status Response-Specific Instructions, cont'd

(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

- Cannot stage a pressure ulcer with necrotic tissue obscuring the wound base.
- Select Response 2 if necrotic or avascular tissue covers <25% of the wound bed.
- Select Response 3 if ≥25% of necrotic tissue is present or signs and symptoms of infection.
- Select Response 3 for suspected deep tissue injury (DTI).

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



A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged. Its healing status is Response 2 – Early/partial granulation if necrotic or avascular tissue covers <25% of the wound bed. Otherwise, its healing status is Response 3 – Not healing if the wound has ≥25% necrotic or avascular tissue or any signs and symptoms of infection. Response 3 – Not healing is also an appropriate response for suspected deep tissue injury (DTI). Deep tissue injury does not granulate and would not be covered with new epithelial tissue, which means that Response 3 – Not healing is the only appropriate response.

**M1320 Pressure Ulcer Healing Status
Response-Specific Instructions, cont'd**

(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**

- Response NA includes only those pressure ulcers that cannot be observed due to the presence of a dressing or device that cannot be removed.
- The presence of necrotic tissue does NOT make the pressure ulcer non-observable.

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



To select NA – No observable pressure ulcer, remember that this response includes only those pressure ulcers that cannot be observed due to the presence of a dressing or device that cannot be removed. Also remember that the presence of necrotic tissue does NOT make the pressure ulcer non-observable.

**M1320 Pressure Ulcer Healing Status
Data Sources / Resources**

- Use information from several sources:
 - Direct observation of the pressure ulcers
 - Physical assessment findings
- [Chapter 5 of the OASIS-C Guidance Manual](#) includes resources for WOCN, NPUAP, and the National Quality Forum (NQF).

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

When determining the healing status of the most problematic observable pressure ulcer, information may be gathered by direct observation of the pressure ulcers and physical assessment findings. Additional resources for the WOCN, the NPUAP, and the NQF can be found in Chapter 5 of the OASIS-C Guidance Manual.

M1320 Scenario

Your patient has one Stage III pressure ulcer on the left heel that is 100% covered in eschar.



Let's practice completing item M1320. In this scenario, your patient has one Stage III pressure ulcer on the left heel that is 100% covered in eschar. How would you score M1320 Status of the Most Problematic (Observable) Pressure Ulcer?

M1320 Scenario Question

How would you score 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

Select the correct response for this scenario.

[Review Scenario](#) 

How would you score M1320 Status of the Most Problematic (Observable) Pressure Ulcer?

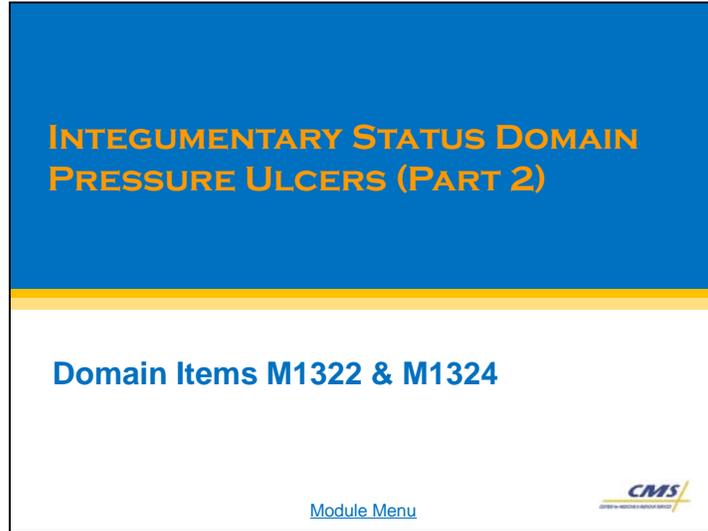
M1320 Scenario Answer

How would you score 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

The correct response is 3 - Not healing. Remember that the amount of necrotic tissue can tell us about the healing status of this pressure ulcer. Refer back to the definition of non-healing per the WOCN Guidance: a wound with $\geq 25\%$ avascular tissue (eschar and/or slough) OR signs or symptoms of infection OR clean but not granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate care. Remember that only one of these items needs to apply to a wound to select the response Not Healing

The correct response is 3 – Not healing. Remember that the amount of necrotic tissue can tell us about the healing status of this pressure ulcer. Refer back to the definition of non-healing per the WOCN guidance: a wound with $\geq 25\%$ avascular tissue (eschar and/or slough) OR signs or symptoms of infection OR clean but not granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate care. Remember that only one of these items needs to apply to a wound to select the response Not healing.



In this topic, we will review Integumentary Status domain items M1322 and M1324.

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



There are eleven OASIS items in the Integumentary Status domain related to pressure ulcers. Item M1322 documents the number of Stage I pressure ulcers. Item M1324 documents the stage of the most problematic unhealed, observable pressure ulcer, including Stage I pressure ulcers.

M1322 Stage I Pressure Ulcers
Item Intent & Time Points

(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

Collected at SOC, ROC, Follow Up & DC Not to Inpatient

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



M1322 Stage I pressure ulcers identifies the presence of Stage I pressure ulcers only. Notice that the definition of Stage I pressure ulcers is included in the stem of this item. The time points for data collection for this item include the Start of Care, Resumption of Care, Follow-up, and Discharge from the agency not to an inpatient facility.

M1322 Stage I Pressure Ulcers
Data Sources / Resources

- Use information from the following sources:
 - Direct observation of the patient
 - Physical assessment of the patient
 - Patient and caregiver interview

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

Data for this item may be gathered by direct observation or while performing your physical assessment, and supplemented with information from patient or caregiver interview.

M1324 Pressure Ulcer Stage
Item Intent and Time Points

(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

Select a response option to review a definition or Forward to continue.

Collected at SOC, ROC, Follow Up & DC Not to Inpatient

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



M1324 identifies the stage of the most problematic unhealed, observable pressure ulcer, including Stage I pressure ulcers. The definitions of the pressure ulcer stages are derived from the National Pressure Ulcer Advisory Panel as presented earlier in this module. The time points that this item are collected include at the Start of Care, Resumption of Care, the Follow-up assessment time points, and at Discharge from the agency not to an inpatient facility. Select each response option to review the definition.

M1324 Pressure Ulcer Stage Definitions
(M1324) Stage of Most **Problematic** Unhealed (Observable) Pressure Ulcer:

PROBLEMATIC

- Largest
- Most advanced stage
- Most difficult to access for treatment
- Most difficult to relieve pressure



Just as with identifying the healing status in item M1320, we see the terminology of “problematic” and “observable” used, which we must pay special attention to. Notice that the definition of problematic remains the same. It may be the largest pressure ulcer or the one with the most advanced stage. It could be the one that is the most difficult to access for treatment or the one that is the most difficult to relieve the pressure. Your clinical judgment will make the determination.

M1324 Pressure Ulcer Stage Definitions, cont'd
(M1324) Stage of Most Problematic Unhealed **(Observable)** Pressure Ulcer:

PROBLEMATIC	NOT OBSERVABLE
<ul style="list-style-type: none">• Largest• Most advanced stage• Most difficult to access for treatment• Most difficult to relieve pressure	<ul style="list-style-type: none">• Cannot be observed due to a dressing or device that cannot be removed OR <ul style="list-style-type: none">• Cannot be observed due to the presence of necrotic tissue that obscures the wound bed



Do you see there is a difference in what makes a pressure not observable for staging? When attempting to stage a pressure ulcer, you must be able to visualize the base of the wound bed to identify the depth of tissue involvement evident in the ulcer. If the wound is covered with a dressing or device that cannot be removed or necrotic tissue obscures the wound bed, then it is not considered observable. You cannot stage the wound if you are unable to visualize the wound bed.

M1324 Pressure Ulcer Stage Response-Specific Instructions

(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

- No reverse staging
- A closed Stage III or IV pressure ulcer continues to be reported at its worst stage.
- A previously closed Stage III or IV pressure ulcer that breaks down again should be staged at its worst stage.

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

When selecting a response for this item, remember that reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the NPUAP. If a pressure ulcer is a Stage III at Start of Care but has granulated and begun epithelialization at the Follow-up assessment, it does not become a Stage II pressure ulcer. It remains a Stage III. A closed Stage III or Stage IV pressure ulcer continues to be reported at its worst stage. For example, a closed Stage IV pressure ulcer will continue to be reported at its worst stage (Stage IV) even after it has completely epithelialized. A previously closed Stage III or Stage IV pressure ulcer that breaks down again should be staged at its worst stage even if the current damage to tissue appears to be less than what is currently visualized.

**M1324 Pressure Ulcer Stage
Data Sources / Resources**

- Use information from several sources:
 - Direct observation of the pressure ulcers
 - Physical assessment findings
 - Information obtained on referral
- May need to review past health history and/or query the physician regarding staging of closed pressure ulcers.
- [Chapter 5 of the OASIS-C Guidance Manual](#) includes resources for WOCN and NPUAP.

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

When determining the stage of the most problematic, observable pressure ulcer, data may be gathered from the following sources. This information may be gathered by direct observation of the pressure ulcers, physical assessment findings, and from information obtained on referral. It might be necessary to review past health history and/or query the physician regarding the stage of pressure ulcers that might be closed at the time of your assessment. Additional resources for the WOCN and NPUAP can be found in Chapter 5 of the OASIS C Guidance Manual.

M1324 Scenario

Your patient has one Stage III pressure ulcer on the left heel that is 100% covered in eschar.



Now let's try to score item M1324. In this scenario, your patient has one Stage III pressure ulcer on the left heel that is 100% covered in eschar.

M1324 Scenario Question

How would you score 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

Select the correct response for this scenario.

[Review Scenario](#)



How would you score M1324 Stage of the Most Problematic Unhealed (Observable) Pressure Ulcer?

M1324 Scenario Answer

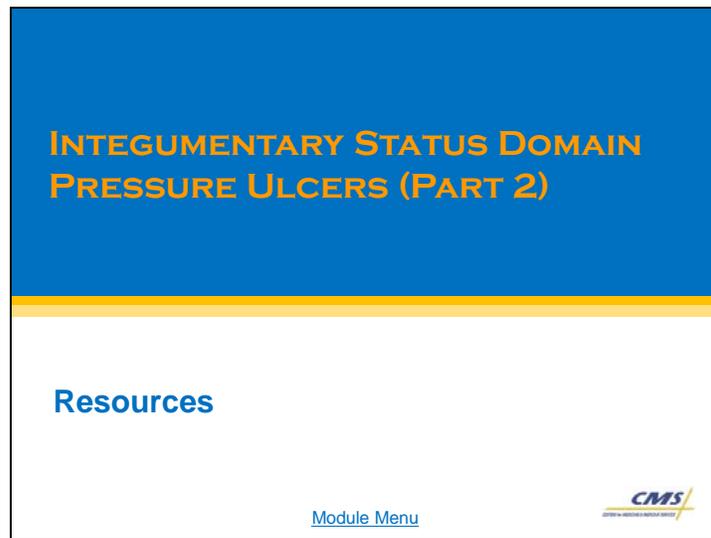
How would you score M1324 Stage of Most Problematic Unhealed (Observable) Pressure Ulcer?

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

The correct response is NA. If a wound bed is covered in eschar so that you cannot visualize it, then it is considered not observable. In this case, we would not be able to stage this wound until enough eschar has been removed. This scenario illustrates how the definition of "observable" changes between healing status and stage of the pressure ulcer.



The correct response is NA. Did you remember if a wound bed is covered in eschar so that you cannot visualize it, then it is considered not observable? In this case, we would not be able to stage this wound until enough eschar has been removed. This scenario illustrates how the definition of “observable” changes between healing status and stage of the pressure ulcer.



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 Q & As.

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 published guidelines of National Pressure Ulcer Advisory Panel (NPUAP) including illustrations.
- Wound Ostomy and Continence Nurses Society (WOCN)
 - www.wocn.org/?page=osis
 - Guidance on OASIS-C Integumentary Items
- OASIS Answers, Inc.
 - www.oasisanswers.com



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.
 - oisistrainingfeedback@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)


[Module Menu](#)

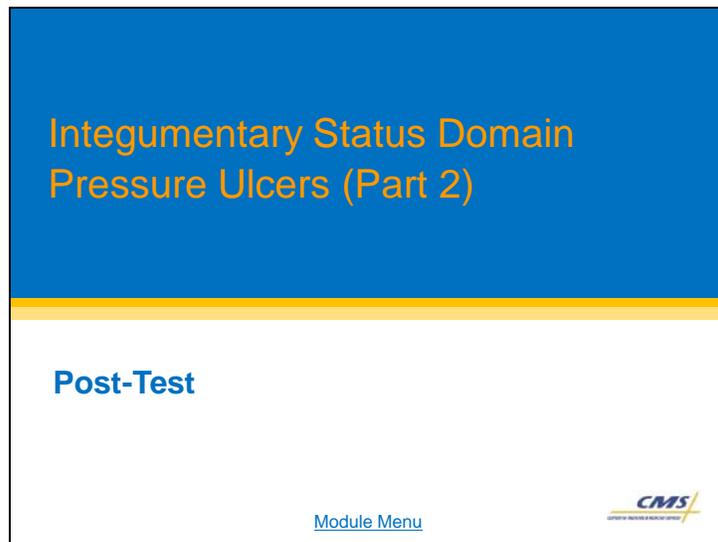
If you have comments related to this web module, please consider providing feedback to the OASIS training feedback mailbox at oisistrainingfeedback@cms.hhs.gov.

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 2) Module Post-Test. This test consists of five questions covering the material covered in this lesson.

Post-Test Question #1

A patient is admitted to homecare with Stage II pressure ulcers on each heel and one Stage III pressure ulcer on the coccyx. How would you answer M1308 Column 1 rows a – c?

	Column 1 Complete at SO / ROC / FU & D/C
Stage description – unhealed pressure ulcers	Number Currently Present
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle 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.	

- Row a. 1, Row b. 1, Row c. 1
- Row a. 2, Row b. 1, Row c. 0
- Row a. 0, Row b. 1, Row c. 0

Row a. Column 1 should be scored as 2. Row b. Column 1 should be scored as 1. Row c. Column 1 should be scored as 0.



Post-Test Question #2

A patient was admitted with a Stage III pressure ulcer on the coccyx and a Stage II pressure ulcer on the left heel. Now on Discharge, the coccyx ulcer has closed completely, the left heel ulcer has completely healed, and the right heel has a Stage II pressure ulcer that developed a few weeks ago, but it is clean and without signs or symptoms of infection. How would you answer M1308 Columns 1 & 2 rows a – c ?

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
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.	1	0
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling	1	1
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.	0	0

Column 1: Row a. 1, Row b. 0, Row c. 0
Column 2: Row a. 0, Row b. 0, Row c. 0

Column 1: Row a. 1, Row b. 1, Row c. 0
Column 2: Row a. 1, Row b. 1, Row c. 0

Column 1: Row a. 1, Row b. 1, Row c. 0
Column 2: Row a. 0, Row b. 1, Row c. 0

Column 1 should be scored as Row a. 1, Row b. 1, and Row c. 0.
Column 2 should be scored as Row a. 0, Row b. 1, and Row c. 0.

Post-Test Question #3

A patient has one Stage III pressure ulcer on the hip with yellow slough covering half the wound bed, and a Stage I pressure ulcer on the heel. How would you answer 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

The correct response is 3 - Not healing.



Post-Test Question #4

A patient has a Stage III coccyx pressure ulcer that has recently closed over and a Stage II pressure ulcer that remains open, has a red wound base, and still requires dressing changes. How would you answer 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

The correct response is 3 - Not healing.



Post-Test Question #5

A patient has a closed Stage III left heel pressure ulcer and a Stage II right heel pressure ulcer that is reddened around the edges with a small amount of purulent drainage. How would you answer 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

The correct response is 2 – Stage II.