



Welcome to the Centers for Medicare & Medicaid Services OASIS-C Online Training. This module will provide foundational education on stasis ulcers, surgical wounds, and skin lesions or open wounds requiring intervention in the Integumentary Status domain of the OASIS data set. Items M1330 through M1350 are addressed in this training.

Introduction

This program provides an introduction to OASIS-C items related to stasis ulcers, surgical wounds, and skin lesions 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



This program will provide an introduction to OASIS-C items related to stasis ulcers, surgical wounds, skin lesions, and open wounds 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.

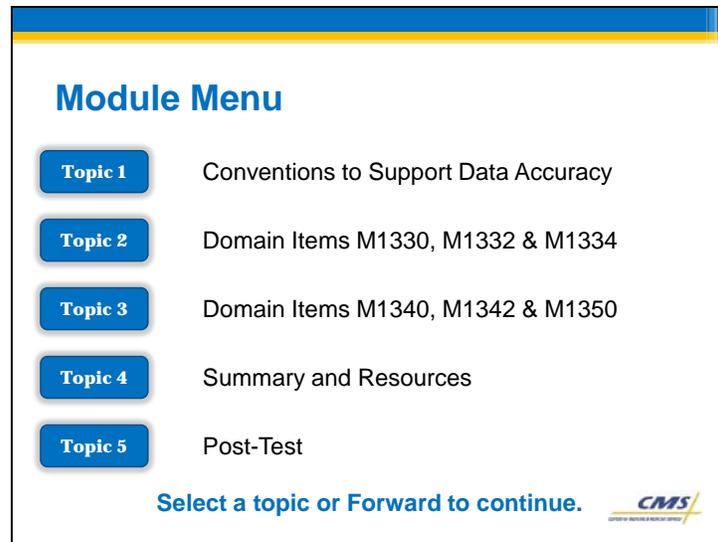
For the OASIS items contained in the Integumentary Status domain, the following information will be presented: specific OASIS conventions that apply to the Integumentary Status domain, item intent or clarification about what each specific item is intended to report, time points when each item should 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 stasis ulcer, surgical wound, and skin lesion items in the Integumentary Status domain.
- Identify appropriate healing status of stasis ulcers and surgical wounds based upon Wound Ostomy Continence Nurses Society Guidance.
- Apply item-specific guidance when selecting correct responses to items in the Integumentary Status domain.
- Identify sources of data collection for each item and supportive resources available as identified in Chapter 5 of the OASIS-C Guidance Manual (12/2011).



After completing this OASIS-C Online Training module, you will be able to identify specific OASIS conventions that apply to the stasis ulcer, surgical wound, and skin lesion items in the Integumentary Status domain, identify appropriate healing status of stasis ulcers and surgical wounds based upon Wound Ostomy Continence Nurses Society Guidance, apply item-specific guidance when selecting correct responses to items in the Integumentary Status domain, and identify sources of data collection for each item and supportive resources available as identified in Chapter 5 of the OASIS-C Guidance Manual (12/2011).

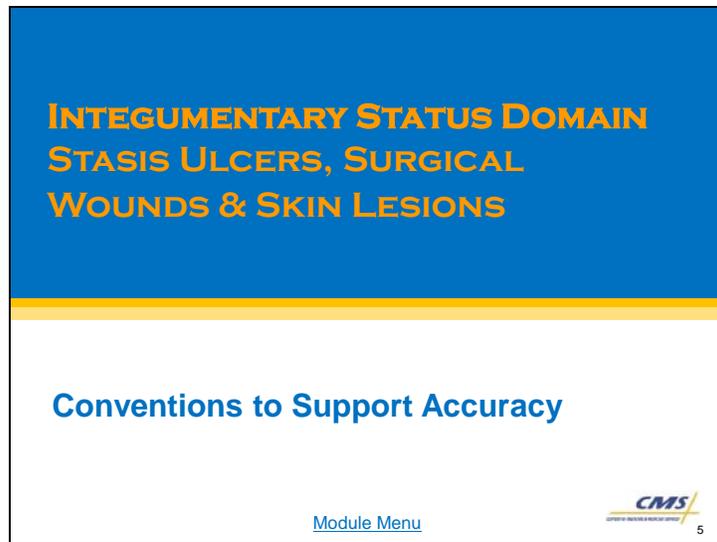


The screenshot shows a 'Module Menu' with five topics listed. Each topic is preceded by a blue button labeled 'Topic 1' through 'Topic 5'. The topics are: 'Conventions to Support Data Accuracy', 'Domain Items M1330, M1332 & M1334', 'Domain Items M1340, M1342 & M1350', 'Summary and Resources', and 'Post-Test'. At the bottom of the menu, 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 Data Accuracy
Topic 2	Domain Items M1330, M1332 & M1334
Topic 3	Domain Items M1340, M1342 & M1350
Topic 4	Summary and Resources
Topic 5	Post-Test

Select a topic or [Forward to continue.](#) 

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 us to report what is true on the day of the assessment.
 - Defined as the time spent in the home and the previous 24 hours.



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 stasis ulcer or surgical wound 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 to complete the assessment visit and the previous 24 hours.

Patient's Current Status

- Understand the time period under consideration for each item.
 - Majority of items direct us 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.



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 would indicate if stasis 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.



The next convention important to remember when collecting data for OASIS items in the Integumentary Status domain is to combine 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.



As we discuss the items in this domain, pay careful attention to the definition of terms. For example, consider the definition of a surgical wound 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 will provide direction for data collection accuracy.



In this topic, we will review Integumentary Status domain items M1330, M1332, and M1334.

Summary of M- Items

- **M1330 Does this patient have a Stasis Ulcer?**
- **M1332 Current Number of (Observable) Stasis Ulcer(s)**
- **M1334 Status of Most Problematic (Observable) Stasis Ulcer**
- **M1340 Does this patient have a Surgical Wound?**
- **M1342 Status of Most Problematic (Observable) Surgical Wound**
- **M1350 Does this patient have a Skin Lesion or Open Wound?**



There are six OASIS items in the Integumentary Status domain related to stasis ulcers, surgical wounds, and skin lesions or open wounds that will be discussed individually during this program. In this topic, we will focus on items addressing stasis ulcers: M1330 Does this patient have a Stasis Ulcer?, M1332 Current Number of Stasis Ulcers, and M1334 Status of Most Problematic Stasis Ulcer.

Stasis Ulcers

- Stasis ulcers ARE:
 - Ulcers caused by inadequate venous circulation in area affected.
 - Often associated with stasis dermatitis.
- Stasis ulcers ARE NOT arterial lesions or arterial ulcers.

A photograph showing a venous ulcer on the lower leg, characterized by a dark, irregular ulcer with surrounding skin discoloration and swelling.

Venous Ulcer

A photograph showing an arterial ulcer on the foot, characterized by a deep, well-defined ulcer with a pale, necrotic center and a sharp border.

Arterial Ulcer



As we begin our review of these items, let's first consider what is a stasis ulcer. Stasis ulcers are ulcers caused by inadequate venous circulation in the area affected, usually lower legs. This lesion is often associated with stasis dermatitis. Stasis ulcers DO NOT include arterial lesions or arterial ulcers.

M1330 Does Patient Have a Stasis Ulcer?
Item Intent & Time Points

(M1330) Does this patient have a Stasis Ulcer?

0 – No [*Go to M1340*]

1– Yes, patient has BOTH observable and unobservable stasis ulcers

2– Yes, patient has observable stasis ulcers ONLY

3– Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) [*Go to M1340*]

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

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



The intent of this item is for the assessing clinician to identify patients with this type of ulcer. If you are not sure the wound fits the definition of a stasis ulcer, contact the physician for clarification of wound etiology. This item is collected at the Start of Care assessment, Resumption of Care assessment, and Follow-up assessments and at Discharge from the agency not to an inpatient facility.

**M1330 Does Patient Have a Stasis Ulcer?
Response-Specific Instructions**

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

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

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

Response-specific instructions provide guidance to assist you in selecting the correct response for M1330. For this item, you must be sure to differentiate between ulcers caused by inadequate venous circulation and other types of skin lesions and ulcers.

**M1330 Does Patient Have a Stasis Ulcer?
Response-Specific Instructions, cont'd**

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

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

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



If the patient does not possess any ulcers caused by inadequate venous circulation, select Response 0 – No. This response should also be selected if a stasis ulcer has completely epithelialized. Once it has completely epithelialized, it is considered healed and should no longer be reported as a current stasis ulcer. Notice how the instructions direct you to skip to item M1340.

**M1330 Does Patient Have a Stasis Ulcer?
Response-Specific Instructions, cont'd**

(M1330) Does this patient have a Stasis Ulcer?

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

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



There are three “Yes” response options. Select Response 1 if the patient has both an observable stasis ulcer AND a reported stasis ulcer that cannot be observed because of a cast or dressing such as a compression dressing that cannot be removed. The patient, caregiver, or physician can provide information regarding the presence of a stasis ulcer underneath a cast or dressing.

**M1330 Does Patient Have a Stasis Ulcer?
Response-Specific Instructions, cont'd**

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

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

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



Select Response 2 if the patient has observable stasis ulcers ONLY. Select Response 3 only if the patient has a reported stasis ulcer but it cannot be observed because of a cast or dressing that cannot be removed AND has no observable stasis ulcers.

**M1330 Does Patient Have a Stasis Ulcer?
Data Sources / Resources**

- Gather information from the following sources:
 - Interview the patient and/or caregiver.
 - Interview the physician or review the physician orders.
 - Review referral information.
 - Review the patient's past health history.
 - Observe the patient directly during a physical assessment.
- Links to resources available [in Chapter 5 of the OASIS-C Guidance Manual \(12/11\)](#).
- Quick Assessment of Leg Ulcers
http://www.wocn.org/resource/resmgr/c_quick1.pdf

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

Gather data from several sources in order to select the correct response for this item. Interview the patient and/or caregiver during the comprehensive assessment, and interview the physician or review the physician orders. Review information collected at the time of referral, and review the patient's past medical history. Finally, observe the patient directly by conducting a physical assessment. Links for resources to support accurate data collection can be found in Chapter 5 of the OASIS-C Guidance Manual. Another resource, the Quick Assessment of Leg Ulcers, can be found on the Wound Ostomy and Continence Nurses Society (WOCN) Web site.

M1332 Number of Stasis Ulcers
Item Intent & Time Points

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

- 1 – One
- 2 – Two
- 3 – Three
- 4 – Four or more

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

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



Once you have determined that the patient has a stasis ulcer, item M1332 requires you to identify the current number of observable stasis ulcers. This item is collected at the Start of Care assessment, Resumption of Care assessment, and Follow up assessments and at Discharge not to an inpatient facility.

M1332 Number of Stasis Ulcers
Response-Specific Instructions

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

- 1 – One
- 2 – Two
- 3 – Three
- 4 – Four or more

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

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



When selecting the correct response for M1332 Current Number of (Observable) Stasis Ulcers, count all observable (visible) stasis ulcers. Keep in mind that all stasis ulcers are considered visible unless they are covered by a non-removable dressing or cast.

**M1332 Number of Stasis Ulcers
Data Sources / Resources**

- Gather information from the following sources:
 - Direct observation of the patient
 - Physical assessment findings
 - Review of health history
 - Query the physician
 - Referral information
- Refer to [Chapter 5 of the OASIS-C Guidance Manual](#).

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

To select the correct response to M1332 Current Number of (Observable) Stasis Ulcers, the information may be gathered from several sources. Observe the patient directly while conducting a physical assessment. You can review the patient’s health history, consult the physician, or review information received on referral.

**M1334 Stasis Ulcer Healing Status
Item Intent & Time Points**

**(M1334) Status of Most Problematic (Observable)
Stasis Ulcer:**

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

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

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



The final item addressing stasis ulcers is M1334 Status of Most Problematic (Observable) Stasis Ulcer. The intent of this item is for the assessing clinician to identify the degree of healing present in the most problematic, observable stasis ulcer. M1334 is collected at the Start of Care assessment, Resumption of Care assessment, and Follow-up assessments and at Discharge not to an inpatient facility.

M1334 Stasis Ulcer Healing Status Response-Specific Instructions

(M1334) Status of **Most Problematic** (Observable)
Stasis Ulcer:

0 – Newly epithelialized

1 – Fully granulating

2 – Early/partial granulation

3 – Not healing

- Only stasis ulcer
- Largest ulcer
- Most resistant to treatment
- Infected ulcer

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

To select the correct response, you must understand what is meant by the term “most problematic” for this item. If a patient has only one stasis ulcer, that ulcer is the most problematic. If a patient has multiple stasis ulcers, the “most problematic” ulcer may be the largest ulcer, the ulcer most resistant to treatment, or an ulcer that is infected. As the assessing clinician, you will use your clinical judgment to determine which stasis ulcer is the most problematic when more than one stasis ulcer is present.

**M1334 Stasis Ulcer Healing Status
Response-Specific Instructions, cont'd**

**(M1334) Status of Most Problematic (Observable)
Stasis Ulcer:**

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

All stasis ulcers are observable unless covered with a non-removable dressing or cast.

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



Remember, that all stasis ulcers are considered “observable” unless they are covered with a non-removable dressing or cast.

**M1334 Stasis Ulcer Healing Status
Response-Specific Instructions, cont'd**

**(M1334) Status of Most Problematic (Observable)
Stasis Ulcer:**

0 – Newly epithelialized

1 – Fully granulating

2 – Early/partial granulation

3 – Not healing

Definitions located at <http://www.wocn.org/?page=oasis>.

**0 - NEWLY
EPITHELIALIZED**

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

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



To further assist you in selecting the correct response, let's also define the terms found in the response options for M1334. These definitions can be found on the WOCN web site at the link for "Guidance on OASIS-C." According to the WOCN, "newly epithelialized" is defined as a wound bed that is completely covered with new epithelium. There is no exudate, no avascular tissue such as slough or eschar, and no signs or symptoms of infection. All of these requirements must apply in order to select "newly epithelialized" as a response.

**M1334 Stasis Ulcer Healing Status
Response-Specific Instructions, cont'd**

**(M1334) Status of Most Problematic (Observable)
Stasis Ulcer:**

0 – Newly epithelialized

1 – Fully granulating

2 – Early/partial granulation

3 – Not healing

Definitions located at <http://www.wocn.org/?page=oasis>.

1 - FULLY GRANULATING

- Wound bed filled with granulation tissue to the level of the surrounding skin
- No dead space
- No avascular tissue (slough and/or eschar)
- No signs or symptoms of infection
- Wound edges are open

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



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, and no signs or symptoms of infection, and the wound edges are open. All of these requirements must apply to the wound to select Response option 1.

**M1334 Stasis Ulcer Healing Status
Response-Specific Instructions, cont'd**

**(M1334) Status of Most Problematic (Observable)
Stasis Ulcer:**

0 – Newly epithelialized

1 – Fully granulating

2 – **Early/partial granulation**

3 – Not healing

Definitions located at <http://www.wocn.org/?page=oasis>.

2 - EARLY/PARTIAL GRANULATION

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

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

Early/partial granulation is defined as a wound bed with $\geq 25\%$ coverage of granulating tissue and $< 25\%$ coverage with avascular tissue (slough and/or eschar). The wound 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 Response option 2.

M1334 Stasis Ulcer Healing Status
Response-Specific Instructions, cont'd

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

0 – Newly epithelialized

1 – Fully granulating

2 – Early/partial granulation

3 – Not healing

Definitions located at <http://www.wocn.org/?page=oasis>.

3 - NOT HEALING

- **≥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

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

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 that only one of these requirements must apply to a wound to select Response option 3.

M1334 Stasis Ulcer Healing Status
Response-Specific Instructions, cont'd

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

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

Do not select Response option 0 to report healed (completely epithelialized) stasis ulcers.

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



Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer. The response option “newly epithelialized” should not be selected for a healed stasis ulcer, as a completely epithelialized (healed) stasis ulcer is not reported as a current stasis ulcer on OASIS.

**M1334 Stasis Ulcer Healing Status
Data Sources / Resources**

- Gather information from the following sources:
 - Direct observation of the patient
 - Physical assessment findings
 - Review of health history
- Resources
 - Wound Ostomy and Continence Nurses Society (WOCN)
<http://www.wocn.org/>
 - WOCN OASIS-C Guidance: <http://www.wocn.org/?page=oasis>
 - Quick Assessment of Leg Ulcers:
http://www.wocn.org/resource/resmgr/docs/c_quick1.pdf

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

To select the correct response to item M1334, gather information from several sources. Observe the patient directly while conducting a physical assessment. You can also review the patient’s health history to identify the number of stasis ulcers. Links to several resources can be found in Chapter 5 of the OASIS-C Guidance Manual. These resources include the Wound Ostomy and Continence Nurses Society web site, WOCN OASIS-C Guidance, and a Quick Assessment of Leg Ulcers. These resources may be helpful when selecting the correct response to stasis ulcer items.

M1330 Review Question

Neuropathic ulcers and ulcers caused by venous and arterial insufficiency are reported for M1330.

True

False

That is correct! This item reports only wounds caused by venous insufficiency, not wounds caused by arterial insufficiency.

Select an answer.



Let's review what we have learned about stasis ulcer items. Neuropathic ulcers and ulcers caused by venous and arterial insufficiency are reported for M1330. True or False?

M1334 Scenario Question

You remove your patient's compression dressing and notice that his stasis ulcer is covered with 40% slough (avascular tissue). Which response would you select for M1334 Status of Most Problematic (Observable) Stasis Ulcer?

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

Select the correct response for this scenario.



You remove your patient's compression dressing and notice that his stasis ulcer is covered with 40% slough (avascular tissue). Which response would you select for M1334 Status of Most Problematic (Observable) Stasis Ulcer?

M1334 Scenario Answer

You remove your patient's compression dressing and notice that his stasis ulcer is covered with 40% slough (avascular tissue). Which response would you select for M1334 Status of Most Problematic (Observable) Stasis Ulcer?

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

[Module Menu](#)

The correct response is 3 - Not healing. The description of the stasis ulcer meets the WOCN definition of "not healing" due to the fact that the wound is covered with greater than 25% avascular tissue. The wound in this scenario was covered with 40% avascular tissue. Remember, only one of the identifying characteristics in the WOCN definition of "not healing" need apply to report the healing status as not healing.

The correct response is 3 – Not healing. The description of the stasis ulcer meets the WOCN definition of "not healing" due to the fact that the wound is covered with greater than 25% avascular tissue. The wound in this scenario was covered with 40% avascular tissue. Remember, only one of the identifying characteristics in the WOCN definition of "not healing" need apply to report the healing status as not healing.



In this topic, we will review Integumentary Status domain items M1340, M1342, and M1350.

Summary of M- Items

- **M1330** Does this patient have a Stasis Ulcer?
- **M1332** Current Number of (Observable) Stasis Ulcer(s)
- **M1334** Status of Most Problematic (Observable) Stasis Ulcer
- **M1340** Does this patient have a Surgical Wound?
- **M1342** Status of Most Problematic (Observable) Surgical Wound
- **M1350** Does this patient have a Skin Lesion or Open Wound?



There are six OASIS items in the Integumentary Status domain related to stasis ulcers, surgical wounds, and skin lesions or open wounds that will be discussed individually during this program. In this topic, we will focus on items addressing surgical wounds and skin lesions or open wounds: M1340 Does this patient have a Surgical Wound?, M1342 Status of Most Problematic Surgical Wound, and M1350 Does this patient have a Skin Lesion or Open Wound?

M1340 Does Patient Have a Surgical Wound?
Item Intent and Time Points

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

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

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

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



The intent of item M1340 is for the assessing clinician to identify the presence of specific wounds resulting from a surgical procedure. M1340 Does this patient have a surgical wound? is collected at the Start of Care assessment, Resumption of Care assessment, and Follow-up assessments and at Discharge from the agency not to an inpatient facility.

**M1340 Does Patient Have a Surgical Wound?
Wound Reporting Guidelines**

- A surgical site closed by primary intention is considered a surgical wound.
 - Suture
 - Staples
 - Chemical bonding agent



To select the correct response for this item, you will need to understand the guidance related to how long a surgical wound is reported and what surgical wounds are included and excluded for this item. Let's begin with how surgical wounds are reported. For the purpose of this OASIS item, a surgical site closed by primary intention is considered a surgical wound. "Closed by primary intention" means the wound has been closed by suture, staples, or a chemical bonding agent.

**M1340 Does Patient Have a Surgical Wound?
Wound Reporting Guidelines, cont'd**

- A surgical site closed by primary intention is considered a surgical wound.
 - Suture
 - Staples
 - Chemical bonding agent
- Described as a surgical wound until re-epithelialization has been present for approximately 30 days.
- After re-epithelialization is present for 30 days, the wound is described as a scar and no longer reported.
 - Does not dehiscence
 - No signs of infection



This type of wound is generally described as a surgical wound until re-epithelialization is present for approximately 30 days. If the wound does not dehiscence or present signs of infection, it is generally described as a scar after re-epithelialization has been present for 30 days and should no longer be reported in this item.

**M1340 Does Patient Have a Surgical Wound?
Included as Surgical Wounds**

Includes

- Muscle flap, skin advancement flap, or rotational flap performed to surgically replace a pressure ulcer
- “Take-down” procedure of a previous bowel ostomy



The OASIS-C Guidance Manual indicates what is considered a surgical wound for item M1340. If a pressure ulcer is surgically replaced with a muscle flap, skin advancement flap, or rotational flap, it is no longer considered a pressure ulcer but is now identified as a surgical wound. A bowel ostomy is not considered a surgical wound unless a “take down” procedure of a previous bowel ostomy is performed. In this case, the surgical take-down procedure produces a surgical wound. Otherwise, a bowel ostomy being allowed to close on its own is excluded as a surgical wound.

M1340 Does Patient Have a Surgical Wound? Included as Surgical Wounds, cont'd

Includes	
<ul style="list-style-type: none">• Muscle flap, skin advancement flap, or rotational flap performed to surgically replace a pressure ulcer	<p>Surgical Staples</p>
<ul style="list-style-type: none">• "Take-down" procedure of a previous bowel ostomy	
<ul style="list-style-type: none">• Orthopedic pin sites	<p>Sutures</p>
<ul style="list-style-type: none">• Stapled or sutured incisions	
<ul style="list-style-type: none">• Wounds with drains	
<ul style="list-style-type: none">• Central line sites	
<ul style="list-style-type: none">• Medi-port sites and other implanted infusion devices	
<ul style="list-style-type: none">• Venous access devices	

Orthopedic pin sites, stapled or sutured incisions, and wounds with drains are all considered surgical wounds. Central line sites, Medi-port sites, and other implanted infusion devices or venous access devices are considered surgical wounds as long as they are implanted in the patient's body.

M1340 Does Patient Have a Surgical Wound? Excluded as Surgical Wounds

Excludes

- Pressure ulcer that has been surgically debrided
- Debridement or placement of a skin graft



Pressure ulcer before & after debridement



Skin Graft



The OASIS-C Guidance Manual also defines what is not to be considered a surgical wound for the purposes of item M1340. Debridement or the placement of a skin graft does not result in a surgical wound as these are treatments performed to an existing wound. The wound continues to be defined as the type of wound previously identified. For example, a pressure ulcer that is surgically debrided does not become a surgical wound but remains a pressure ulcer.

M1340 Does Patient Have a Surgical Wound? Excluded as Surgical Wounds, cont'd

Excludes	
<ul style="list-style-type: none">• Pressure ulcer that has been surgically debrided• Debridement or placement of a skin graft	
<ul style="list-style-type: none">• All Ostomies: colostomy, cystostomy, urostomy, thoracostomy, tracheostomy, gastrostomy, etc.	

Pressure ulcer before & after debridement

Skin Graft Colostomy



All ostomies are excluded from consideration under this item and should not be counted as surgical wounds. There are many types of “ostomies,” all of which involve a surgically-formed opening from outside the body to an internal organ or cavity. Examples include a cystostomy, urostomy, thoracostomy (chest tubes), tracheostomy, and gastrostomy. Ostomies other than bowel ostomies for elimination may be reported in M1350 Skin Lesion or Open Wound if the home health agency is providing intervention specific to the ostomy. They would not be considered as a surgical wound for item M1340.

M1340 Does Patient Have a Surgical Wound? Excluded as Surgical Wounds, cont'd

Excludes		
<ul style="list-style-type: none"> Pressure ulcer that has been surgically debrided Debridement or placement of a skin graft 		<p style="text-align: center; font-size: small;">Pressure ulcer before & after debridement</p>
<ul style="list-style-type: none"> All Ostomies: colostomy, cystostomy, urostomy, thoracostomy, tracheostomy, gastrostomy, etc. 		
<ul style="list-style-type: none"> Cataract surgery of the eye Surgery to mucosal membranes Gynecological surgical procedure via vaginal approach 	<p style="text-align: center; font-size: small;">Skin Graft</p>	<p style="text-align: center; font-size: small;">Colostomy</p>
<ul style="list-style-type: none"> PICC line Peripherally inserted vascular devices 		
<ul style="list-style-type: none"> Old surgical wounds that have resulted in scar or keloid formation 	<p style="text-align: center; font-size: small;">Eye Surgery</p>	<p style="text-align: center; font-size: small;">PICC Line</p>

Cataract surgery of the eye, surgery to the mucosal membranes, or a gynecological surgical procedure via a vaginal approach do not create a surgical wound for the purposes of M1340. PICC lines and other peripherally inserted venous access devices are also not considered as surgical wounds for this item. Finally, old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds and should not be included in this item.

**M1340 Does Patient Have a Surgical Wound?
Response-Specific Instructions**

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

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

Select Response 1 if patient has both an observable and an unobservable wound.

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

If the patient does not have any surgical wounds as defined in the OASIS-C guidance, then select Response 0 – No and skip to M1350 Skin Lesion or Open Wound. Select Response 1 – Yes if the patient has at least one observable surgical wound. If the patient has both an observable and an unobservable wound, the best response is 1 – Yes, patient has at least one (observable) surgical wound.

**M1340 Does Patient Have a Surgical Wound?
Response-Specific Instructions, cont'd**

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

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

Not observable due to a dressing or cast that is ordered not to be removed.

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

Select Response 2 – Surgical wound known but not observable due to a non-removable dressing if a wound is not observable. A wound is considered "not observable" if it is covered by a dressing or cast which is not to be removed per physician orders.

M1340 Does Patient Have a Surgical Wound?
Data Sources / Resources

- Gather information from the following sources:
 - Interview with the patient and/or caregiver
 - Direct observation of the patient
 - Physical assessment findings
 - Review of health history and/or referral information
 - Query the physician
- Resources
 - Wound Ostomy and Continence Nurses Society (WOCN)
<http://www.wocn.org/>
 - WOCN OASIS-C Guidance: <http://www.wocn.org/?page=oasis>

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



To select the correct response to M1340 Does this patient have a surgical wound, the information may be gathered from several sources. You can obtain this information by interviewing the patient and/or caregiver, or through direct observation of the patient during your physical assessment. You could also review the patient’s health history to identify if the patient has a surgical wound. The information may be obtained from the physician or from information received on the referral.

Resources to support accurate data collection of this item can be found in Chapter 5 of the OASIS guidance manual and at the WOCN websites noted on this slide.

M1340 Review Question

A patient had surgery to repair abdominal adhesions 45 days ago. Report revealed there were no complications with the healing process.

You assess the patient today and find the wound is intact and approximated. The incision line is pink and completely re-epithelialized without signs and symptoms of infection.

Would this surgical wound be reported for M1340 at Start of Care?

Yes

No

That is correct! Per the OASIS-C response-specific instructions, a surgical site closed primarily (with sutures, staples or chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days. If the wound does not dehisce or present signs of infection, it is generally described as a scar after re-epithelialization has been present for 30 days and should not be included in this item.

Let's practice applying these guidelines. A patient had surgery to repair abdominal adhesions 45 days ago. Report revealed there were no complications with the healing process. You assess the patient today and find the wound is intact and approximated, and the incision line is pink and completely re-epithelialized, and without signs and symptoms of infection. Would this surgical wound be reported for M1340 at Start of Care?

**M1342 Surgical Wound Healing Status
Item Intent & Time Points**

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

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

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

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



The intent of M1342 Status of the Most Problematic (Observable) Surgical Wound is for the assessing clinician to identify the degree of healing present in the most problematic, observable surgical wound. This item is collected at the Start of Care assessment, Resumption of Care assessment, and Follow-up assessments and at Discharge from the agency not to an inpatient facility.

**M1342 Surgical Wound Healing Status
Response-Specific Instructions**

- “Problematic” and “Observable”
- Definitions of response options
- Type of healing
 - Primary intention
 - Secondary intention

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

In order to score this item correctly, you must apply response-specific instructions addressing how to determine the healing status of surgical wounds. This item is similar to pressure ulcers and stasis ulcers in applying the terms “problematic” and “observable” to determine which wound to report. This item also uses the same response options as defined by the Wound Ostomy and Continence Nurses Society, so an understanding of these definitions will help you select the correct response for the most problematic wound. For surgical wounds, you must also be able to determine if the wound is healing by primary intention or secondary intention. Let’s review response-specific instructions for each of these requirements to help you complete this item.

**M1342 Surgical Wound Healing Status
Response-Specific Instructions, cont'd**

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

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

- Largest wound
- Most resistant to treatment
- Infected wound

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



Let's begin with a review of the terms "problematic" and "observable." As with pressure ulcers and stasis ulcer, to select the correct response, you must understand what is meant by the term "most problematic" for this item. If a patient has only one surgical wound, that wound is the most problematic. If a patient has multiple surgical wounds, the "most problematic" wound may be the largest wound, the wound most resistant to treatment, or a wound that is infected. As the assessing clinician, you will use your clinical judgment to determine which surgical wound is the most problematic when more than one wound is present.

**M1342 Surgical Wound Healing Status
Response-Specific Instructions, cont'd**

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

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

All surgical wounds are observable unless covered with a non-removable dressing or cast.



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

All surgical wounds are considered “observable” unless they are covered with a non-removable dressing or cast that the physician has ordered not to be removed. Let’s now review the definitions for the four response options for this item.

**M1342 Surgical Wound Healing Status
Response-Specific Instructions, cont'd**

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

- 0 – [Newly epithelialized](#)
- 1 – [Fully granulating](#)
- 2 – [Early/partial granulation](#)
- 3 – [Not healing](#)

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

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



Once you have identified the most problematic observable surgical wound, report the healing status of this wound by selecting one of the response options available for this item. This item uses the same WOCN definitions as for the most problematic pressure ulcer and stasis ulcer. Select each response option to review the definition.

M1342 Surgical Wound Healing Status Response-Specific Instructions, cont'd

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

- 0 – [Newly epithelialized](#)
- 1 – [Fully granulating](#)
- 2 – [Early/partial granulation](#)
- 3 – [Not healing](#)

Definitions located at <http://www.wocn.org/?page=oasis>.

0 - NEWLY EPITHELIALIZED

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

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

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

According to the WOCN, “newly epithelialized” is defined as a wound bed that is completely covered with new epithelium. There is no exudate, no avascular tissue such as slough or eschar, and no signs or symptoms of infection. All of these requirements must apply in order to select “newly epithelialized” as a response.

M1342 Surgical Wound Healing Status Response-Specific Instructions, cont'd

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

- 0 – [Newly epithelialized](#)
- 1 – [Fully granulating](#)
- 2 – [Early/partial granulation](#)
- 3 – [Not healing](#)

Definitions located at <http://www.wocn.org/?page=oasis>.

1 - FULLY GRANULATING

- 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

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

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



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, and no signs or symptoms of infection, and the wound edges are open. All of these requirements must apply to the wound to select Response option 1.

**M1342 Surgical Wound Healing Status
Response-Specific Instructions, cont'd**

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

- 0 – [Newly epithelialized](#)
- 1 – [Fully granulating](#)
- 2 – [Early/partial granulation](#)
- 3 – [Not healing](#)

Definitions located at <http://www.wocn.org/?page=oasis>.

2 - EARLY/PARTIAL GRANULATION

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

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

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



Early/partial granulation is defined as a wound bed with $\geq 25\%$ coverage of granulating tissue and $< 25\%$ coverage with avascular tissue (slough and/or eschar). The wound 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 Response option 2.

**M1342 Surgical Wound Healing Status
Response-Specific Instructions, cont'd**

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

- 0 – [Newly epithelialized](#)
- 1 – [Fully granulating](#)
- 2 – [Early/partial granulation](#)
- 3 – [Not healing](#)

Definitions located at <http://www.wocn.org/?page=oasis>.

3 - NOT HEALING

- 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

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

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



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 that only one of these requirements must apply to a wound to select Response option 3.

**M1342 Surgical Wound Healing Status
Wound Reporting: Primary Intention**

- A surgical site closed by primary intention is considered a surgical wound.
 - Staples
 - Sutures
 - Chemical bonding agent
- Described as a wound during “epidermal resurfacing” as the wound is covered by epithelial cells.
- After re-epithelialization is present for 30 days, the incision is described as a scar and no longer reported as a surgical wound.
 - Does not dehisce
 - No signs of infection



Finally, let’s review the distinction between healing by primary intention and by secondary intention and how this affects the scoring of item M1342. As you recall from earlier in this topic, a surgical incision closed by primary intention such as staples, sutures, or chemical bonding is described as a surgical wound as it re-epithelializes. The term “epidermal resurfacing” is used in the OASIS-C guidance and means the opening created during the surgery is covered by epithelial cells. If there is no disruption to the healing process, this generally takes within a matter of hours to three days. After re-epithelialization is present for 30 days, the incision is generally described as a scar and is no longer reported as a surgical wound for this item unless it dehisces or presents signs of infection.

M1342 Surgical Wound Healing Status Response-Specific Instructions, cont'd

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

0 – Newly epithelialized

1 – Fully granulating

2 – Early/partial granulation

3 – Not healing

- Observe the incision line.
- Select Response option 0 if epidermal resurfacing has occurred.
- Select this option until 30 days have passed without complication.
- Select Response 3 if there is not full epithelial resurfacing.

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

To determine the correct scoring for a surgical incision healing by primary intention, observe the incision line for re-epithelialization. If epidermal resurfacing has occurred completely, the correct response for this item would be “newly epithelialized” until 30 days have passed without complication. After the 30 days, it is no longer a reportable surgical wound. If there is not full epithelial resurfacing for a surgical incision healing by primary intention, the correct response would be not healing.

**M1342 Surgical Wound Healing Status
Wound Reporting: Secondary Intention**

- Occurs if there is incisional separation.
- Incisions healing by secondary intention do granulate.
- Presence of a scab does not automatically equate to Response 3 – Not healing.
- Determine if the wound is healing by primary intention or a portion healing by secondary intention.
 - Primary intention is complete closure with no openings.
 - Secondary intention occurs due to dehiscence or interruption of the incision.



If there is incisional separation, healing will be by secondary intention, and you will determine the status of healing. Surgical incisions healing by secondary intention DO granulate and may be reported as not healing, early/partial granulation, fully granulating, and eventually newly epithelialized. The presence of a scab does not automatically equate to a “not healing” response. You must first assess if the wound is healing entirely by primary intention, which is complete closure with no openings, or if there is a portion healing by secondary intention due to dehiscence or interruption of the incision.

**M1342 Surgical Wound Healing Status
Response-Specific Instructions, cont'd**

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

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

- Select response option that reflects the healing status of an incision healing by secondary intention.
- Select Response 0 for a healed insertion site for implanted venous access devices and infusion devices.

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



If the incision is healing by secondary intention, select the response option that best reflects the healing status of the wound. Select Response 0 – Newly epithelialized when the insertion site for implanted venous access devices and infusion devices is healed. For example, select this option for a Port-a-Cath that is not currently accessed.

M1342 Surgical Wound Healing Status
Data Sources / Resources

- Gather information from the following sources:
 - Interview with the patient and/or caregiver
 - Direct observation of the patient
 - Physical assessment findings
 - Review of health history and/or referral information
 - Query the physician
- Resources
 - Wound Ostomy and Continence Nurses Society (WOCN)
<http://www.wocn.org/>
 - WOCN OASIS Guidance
<http://www.wocn.org/resource/resmgr/docs/guidanceoasis-c.pdf>

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

To select the correct response to M1342 Status of the Most Problematic (Observable) Surgical Wound, the information may be gathered from several sources. You can obtain this information by interviewing the patient and/or caregiver, direct observation of the patient, and from physical assessment findings. You can also review the patient’s health history or information received on the referral to identify the date of surgery and course of healing of the surgical wounds. The information may also be obtained from the patient’s physician. Resources to support accurate data collection of this item can be found in Chapter 5 of the OASIS Guidance Manual and at the WOCN website.

M1342 Scenario

Upon admission to your agency, you identify that your new patient had a right total hip replacement 15 days ago. You assess the incision is 15 cm in length, intact, and approximated.

The incision is pink, and there are no openings, no drainage, and no avascular tissue or signs and symptoms of infection present.



Now let's try a scenario and determine the healing status of this surgical wound. Upon admission to your agency, you identify that your new patient had a right total hip replacement 15 days ago. You assess the incision is 15 cm in length, intact, and approximated. The incision is pink, and there are no openings, no drainage, and no avascular tissue or signs and symptoms of infection present.

M1342 Scenario Question

Based upon this information, what is the correct response for M1342 Status of Most Problematic (Observable) Surgical Wound?

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

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

Select the correct response for this scenario.



Based upon this information, what is the correct response for M1342 Status of Most Problematic (Observable) Surgical Wound?

M1342 Scenario Answer

Based upon this information, what is the correct response for M1342 Status of Most Problematic (Observable) Surgical Wound?

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

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

The correct response is 0 –Newly epithelialized. Our assessment reveals that the healing status meets all the indicators from the WOCN definition of “newly epithelialized.” This is defined as a wound bed that is completely covered with new epithelium and no exudate, avascular tissue, or signs or symptoms of infection.

The correct response is 0 – Newly epithelialized. Our assessment reveals that the healing status meets all the indicators from the WOCN definition of newly epithelialized. This is defined as a wound bed that is completely covered with new epithelium and no exudate, avascular tissue, or signs or symptoms of infection.

**M1350 Skin Lesion or Open Wound
Item Intent & Time Points**

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

0 – No
 1 – Yes

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

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



The intent of this item is for the assessing clinician to identify the presence or absence of a skin lesion or open wound that has not already been addressed in previous items such as pressure ulcers, stasis ulcers, and surgical wounds and that is receiving clinical assessment or intervention from the home health agency. This item is collected at the Start of Care assessment, Resumption of Care assessment, and Follow-up assessments and at Discharge from the agency not to an inpatient facility.

M1350 Skin Lesion or Open Wound Included

Included	
Skin lesions or open wounds receiving clinical intervention (sores, skin tears, burns, rashes)	
PICC lines and Peripheral IV	Rash
Any skin condition that is clinically assessed (such as persistent redness, edema)	
Ostomies receiving intervention (other than bowel ostomies for elimination)	Burn



A lesion is a broad term used to describe an area of pathologically altered tissue. Sores, skin tears, burns, ulcers, and rashes are all considered lesions. All alterations in skin integrity are considered to be lesions except for bowel ostomies, which are reported in OASIS item M1630. Persistent redness without a break in the skin is also considered a lesion. Items that would be considered for this item if receiving intervention include PICC lines and peripheral IV's, ostomies other than bowel ostomies for elimination such as tracheostomies, thoracostomies, urostomies, jejunostomies, and gastrostomies if receiving clinical intervention such as cleansing, dressing changes, or assessment from the home health agency.

M1350 Skin Lesion or Open Wound Excluded

Excluded	
<ul style="list-style-type: none">• Skin lesions or open wounds that are NOT receiving intervention from the home health agency	
<ul style="list-style-type: none">• Bowel ostomies	
<ul style="list-style-type: none">• Cataract surgery of the eye• Surgery to mucosal membranes• Gynecological surgical procedures via vaginal approach	
<ul style="list-style-type: none">• Tattoos or piercings unless receiving intervention	

If not receiving intervention from agency



This item excludes skin lesions not receiving clinical intervention from the home health agency, bowel ostomies, cataract surgeries of the eye, surgery to mucosal membranes, or gynecological surgical procedures by a vaginal approach. Tattoos and piercings not receiving clinical intervention are also excluded.

M1350 Skin Lesion or Open Wound Response-Specific Instructions

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

0 – No

1 – Yes

- Report any skin condition that is being clinically assessed on an ongoing basis.

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



Skin lesions or open wounds that are not receiving clinical intervention from the home health agency should not be considered when responding to this question. If however, the patient has any skin condition that is being clinically assessed on an ongoing basis as indicated on the home health agency’s Plan of Care, such as wound measurements, then the lesion or wound is receiving clinical intervention, and this item should be answered “Yes”.

**M1350 Skin Lesion or Open Wound
Data Sources / Resources**

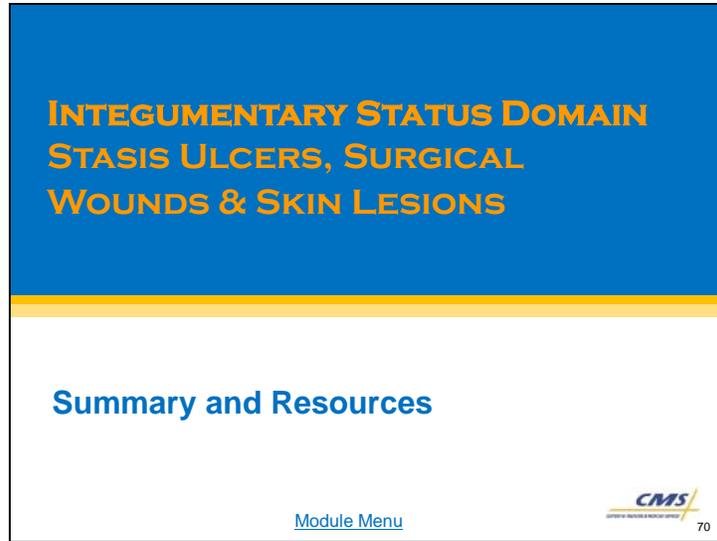
- Gather information from the following sources:
 - Interview with the patient and/or caregiver
 - Direct observation of the patient
 - Physical assessment findings
 - Review of health history and/or referral information
 - Query the physician

[Module Menu](#)

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



To select the correct response to M1350 Does this patient have a Skin Lesion or Open Wound, excluding bowel ostomy, other than those described previously, that is receiving intervention by the home health agency? The information may be gathered from several sources. You can obtain this information by interviewing the patient and/or caregiver, through direct observation of the patient, and from physical assessment findings. You could also review the patient’s health history to identify skin lesions or open wounds. The information may be obtained from the physician or from information received on referral.



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. Let's recap some highlights of what we learned in this module.

Summary: M1330 Does Patient Have a Stasis Ulcer?

M1330

- Report stasis ulcers only (caused by venous insufficiency).
- Indicate whether patient has observable or unobservable stasis ulcers.



Item M1330 reports whether the patient has any observable or unobservable stasis ulcers. Remember that stasis ulcers are caused by venous insufficiency. This item does not include arterial ulcers or other types of wounds.

Summary: M1332 Number of Stasis Ulcers

M1330

- Report stasis ulcers only (caused by venous insufficiency).
- Indicate whether patient has observable or unobservable stasis ulcers.

M1332

- Report the number of observable stasis ulcers.
- All stasis ulcers are considered visible unless they are covered by a non-removable dressing or cast.



Item M1332 reports the number of observable stasis ulcers. All stasis ulcers are considered visible unless they are covered by a non-removable dressing or cast.

Summary: M1334 Stasis Ulcer Healing Status

- M1330**
 - Report stasis ulcers only (caused by venous insufficiency).
 - Indicate whether patient has observable or unobservable stasis ulcers.
- M1332**
 - Report the number of observable stasis ulcers.
 - All stasis ulcers are considered visible unless they are covered by a non-removable dressing or cast.
- M1334**
 - Report the healing status of the most problematic observable stasis ulcer.
 - Use your clinical judgment to determine the most problematic if more than one ulcer is present.
 - Response options based on WOCN definitions to determine healing status.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Item M1334 reports the healing status of the most problematic observable stasis ulcer. The most problematic ulcer may be the only stasis ulcer, the largest ulcer, the ulcer most resistant to treatment, or an ulcer that is infected. Use your clinical judgment to determine which stasis ulcer is the most problematic when more than one stasis ulcer is present. Select a response based on the WOCN definitions for healing status.

Summary: M1340 Does Patient Have a Surgical Wound?

M1340

- Identify the presence of specific wounds resulting from a surgical procedure.
- Indicate whether patient has observable or unobservable surgical wounds.
- Refer to OASIS-C guidance for the types of wounds that are reported for this item.



Item M1340 identifies whether the patient has any observable or unobservable wounds as result of a surgical procedure. Report whether the patient has any observable or unobservable surgical wounds as defined by the OASIS-C guidance.

Summary: M1342 Surgical Wound Healing Status

M1340

- Identify the presence of specific wounds resulting from a surgical procedure.
- Indicate whether patient has observable or unobservable surgical wounds.
- Refer to OASIS-C guidance for the types of wounds that are reported for this item.

M1342

- Identify the degree of healing present in the most problematic, observable surgical wound.
- Determine if wound is healing by primary or secondary intention.
- Response options based on WOCN definitions to determine healing status.



Item M1342 identifies the degree of healing present in the most problematic, observable surgical wound. You must determine if the wound is healing by primary intention or secondary intention and select a response based on the WOCN definitions for healing status.

Summary: M1350 Skin Lesion or Open Wound

M1340

- Identify the presence of specific wounds resulting from a surgical procedure.
- Indicate whether patient has observable or unobservable surgical wounds.
- Refer to OASIS-C guidance for the types of wounds that are reported for this item.

M1342

- Identify the degree of healing present in the most problematic, observable surgical wound.
- Determine if wound is healing by primary or secondary intention.
- Response options based on WOCN definitions to determine healing status.

M1350

- Identify the presence or absence of a skin lesion or open wound that has not already been addressed.
- Report only skin lesions or open wounds that are receiving clinical intervention.

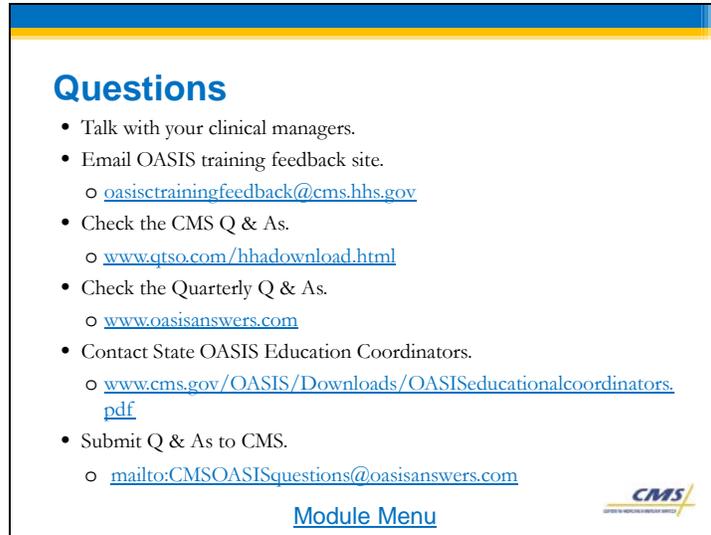
Item M1350 identifies the presence or absence of a skin lesion or open wound that has not already been addressed in previous items. Indicate whether the patient has any skin condition that is being clinically assessed on an ongoing basis as indicated on the home health agency's Plan of Care.

Resources / References

- OASIS-C Guidance Manual
 - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html>
 - Chapter 3 provides guidance on OASIS-C questions.
- Wound Ostomy and Continence Nurses Society (WOCN)
 - <http://www.wocn.org/resource/resmgr/docs/guidanceoasis-c.pdf>
 - Guidance on OASIS-C Integumentary Status items
- OASIS Answers, Inc.
 - <http://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.
 - oasisctrainingfeedback@cms.hhs.gov
- Check the CMS Q & As.
 - www.qtso.com/hhadownload.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.
 - <mailto:CMSOASISquestions@oasisanswers.com>

[Module Menu](#)



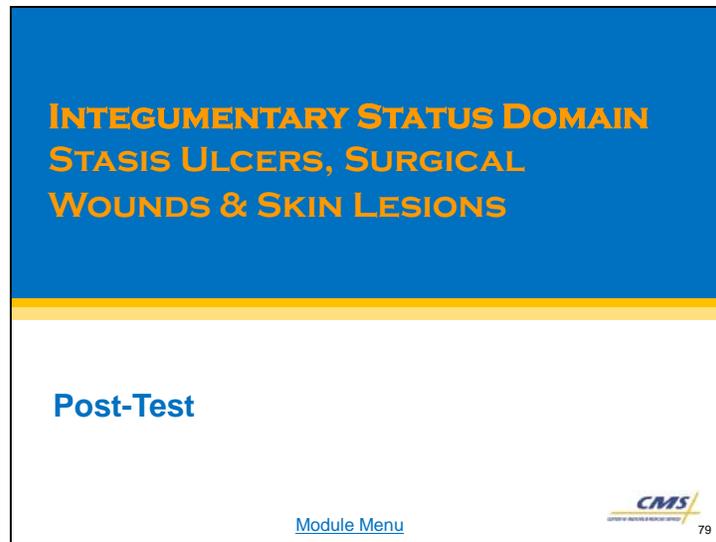
If you have comments related to this web module, please consider providing feedback to the OASIS training feedback mailbox at oasisctrainingfeedback@cms.hhs.gov.

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: Stasis Ulcers, Surgical Wounds & Skin Lesions Module Post-Test. This test consists of five questions covering the material covered in this lesson.

Post-Test Question #1

You receive a referral for wound care for a patient with a stasis ulcer to the medial aspect of the lower extremity. Upon reading the history and physical provided by the hospital, you note that the wound is caused by arterial insufficiency. How would you respond to M1330 Does this patient have a Stasis Ulcer?

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

That is correct! The item intent for M1330 provides specific instruction to not include arterial lesions or arterial ulcers. This item identifies patients with ulcers caused by inadequate venous circulation. Therefore, the correct response is 0 – No.



Post-Test Question #2

Your patient has a stasis ulcer to the anterior aspect of the right lower extremity. When you remove the dressing you assess that the ulcer is completely epithelialized. How would you report the healing status for M1334?

- A. Newly epithelialized
- B. Fully granulating
- C. Early/partial granulation
- D. Not reported

That is correct! The response-specific guidance for M1334 states, "Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer." The response "newly epithelialized" should not be selected for a healed stasis ulcer as a completely epithelialized (healed) stasis ulcer is not reported as a stasis ulcer on OASIS.



Post-Test Question #3

You are performing a Start of Care assessment and during your assessment identify that the patient has a chest tube, a new ostomy, and an old Port-a-Cath that is not accessed or maintained. Which of these would be reported for M1340 Does this patient have a Surgical Wound?

- A. Chest tube
- B. New ostomy
- C. Port-A-Cath
- D. None of the these wounds would be reported.

That is correct! Implanted infusion devices are included as current surgical wounds per the response-specific instructions for M1340. Therefore, a Port-a-Cath would be reported for item M1340. A chest tube is a thoracostomy and is excluded along with all types of ostomies.



Post-Test Questions #4 and #5 Scenario

A patient had a total hip replacement on November 1 and was admitted to home care on November 7 for skilled nursing for wound care and physical therapy for continued gait training and muscle strengthening.

The Admission assessment revealed the surgical wound was intact and approximated with staples, but there was a 1cm x 1cm x 2cm opening that was angry red with a large amount of foul-smelling purulent drainage at the distal end of the incision.

At the time of the Recertification assessment, the incision was intact and approximated without staples. The incision line was pink with no drainage or signs and symptoms of infection. Wound care had been discontinued two weeks ago when the surgical wound completely re-epithelialized.



Post-Test Question #4

What would be the correct response for M1342 Status of the Most Problematic (Observable) Surgical Wound at the Start of Care assessment?

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

That is correct! To arrive at the correct response we must first identify if the wound is healing by primary or secondary intention. In this scenario, even though the wound was closed with staples, there was obvious incisional separation. This would indicate that the open portion of the wound was healing by secondary intention.

We then need to refer to the WOCN definitions of healing status to determine the correct response. In our scenario, this wound meets the definition of “not healing” due to the signs and symptoms of infection that were present.

Post-Test Question #5

What would be the correct response for M1342 Status of the Most Problematic (Observable) Surgical Wound at the Recertification assessment?

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

That is correct! To answer this item correctly, we need to understand how long a surgical incision continues to be reported. Per the response-specific instructions, a surgical wound continues to be reported until re-epithelialization has been present for approximately 30 days. In this scenario, since the incision has only been completely re-epithelialized for two weeks, it is still reported. The current healing status meets the WOCN definition of “newly epithelialized.”
