

# Unraveling the Pressure Ulcer and Wound Care Sections of OASIS-C

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It's finally here! The long-awaited OASIS-C data collection tool for home care agencies was implemented January 1, 2010, leaving many home care nurses and agencies scrambling to understand the multitude of additions and revisions. These changes could significantly affect agency reimbursement and publicly reported quality measures while also providing essential guidance for surveyors.

With this in mind, home care agencies are faced with the daunting task of re-learning and understanding the new OASIS-C document. This article will help you make sense of the changes in the documentation of pressure ulcers and wound care that appear under the section of OASIS-C called "Integumentary Status."

## History and background

In 1999 the Centers for Medicare and Medicaid Services (CMS) began requiring all Medicare-certified home care agencies to begin collecting and submitting data related to all adult, non-maternity patients receiving skilled nursing services under Medicare and Medicaid. These requirements were documented in the Outcome and Assessment Information Set (OASIS). Over the years, OASIS has undergone changes to improve data collection requirements, refine items for payment algorithms and enhance outcome reporting.





Over the past decade CMS has focused on quality improvement and evidence-based practice recommendations from the Institutes of Medicine (IOM), the National Quality Forum (NQF) and the Medicare Payment Advisory Commission (MedPAC). Beginning in 2004, with the revision of long-term care's F-Tag 314 regarding pressure ulcers and the release of new guidelines to direct surveyors of long-term care facilities, CMS embarked on a journey to bring the providers of long-term care, acute care and home care into a synergistic relationship focused on improving outcomes and the quality of patient care.

Next, as a result of the federal Value Based Purchasing (VBP) Initiative, came the implementation of the present-on-admission (POA) indicators for acute care facilities on October 1, 2008. It includes a list of hospital-acquired conditions, including full thickness pressure ulcers (Stage III and IV), which are no longer reimbursable when they occur during a hospital stay.<sup>1</sup> In home care, the focus on quality and evidence-based practice has never been more evident than in the new OASIS-C data collection tool.

#### **Development of OASIS-C**

OASIS-C was developed for three reasons:

1. To address issues raised by home care providers
2. To expand home care quality measurement to include care processes

3. To align and “harmonize” OASIS measures with other care measurement instruments currently being developed across post-acute care settings (i.e., the nursing home Minimum Data Set [MDS] and the Continuity Assessment Record Evaluation [CARE]).

Regarding reason #3, pressure ulcer items on OASIS were revised to reflect current pressure ulcer assessment guidelines from the National Pressure Ulcer Advisory Panel (NPUAP) and the Wound, Ostomy and Continence Nurses Society (WOCN) and to collect additional information considered to be essential to care planning (i.e., wound length, width and depth).

Home care agencies also are being encouraged to use evidence-based practices, although the care processes included in OASIS-C are not currently mandated in the Home Health Agency (HHA) Conditions of Participation. Home care agencies may choose not to incorporate the care processes included in OASIS-C, but should be aware that since some of the process items will be utilized to support publicly reported measures, failure to incorporate the care processes may be reflected in their Home Health Compare scores. For example, one measure that will be publicly reported on Home Health Compare is: “Percentage of home health episodes of care in which the patient was assessed for risk of developing pressure ulcers at start of care/resumption of care.” The data for this care process will be obtained from a new question added

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to the OASIS-C, “**M1300** - Pressure Ulcer Assessment: Was the patient assessed for risk of developing pressure ulcers?”

The goal is clear; CMS expects home care agencies to take an active role in the prevention and treatment of pressure ulcers and expects patients’ wounds to improve. This will challenge agencies to take a closer look at their policies and procedures guiding delivery of care to ensure that they are in line with OASIS-C and the patient care practices being implemented. Staff training and education on wound healing and assessment will be essential in achieving the expertise necessary to accurately complete the questions included in the Integumentary Status section of OASIS-C. The inability to correctly assess, describe and measure wounds could not only result in serious financial implications for a home care agency, but also in poor outcome quality measures.

### **OASIS-C items related to pressure ulcers and other wounds**<sup>2,3,4,5</sup>

With that in mind, let’s take a look at OASIS-C. The first thing you will notice is that the items have been renumbered. The items for Integumentary Status are now numbered **M1300** through **M1350**. For a copy of the Integumentary Status section of OASIS-C, turn to page 86. It will be helpful to follow along with that document as you read this article.

Here is a detailed explanation of each item in the Integumentary Status section of OASIS-C:

#### **(M1300) Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?**

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

These are two new questions added to OASIS-C to capture home care agencies’ use of best practices in the assessment of pressure ulcer risk. Agencies are now required to screen patients for risk of developing pressure ulcers. They are not, however, required to use a standardized, validated risk assessment tool. CMS defines a standardized, validated tool as one that “1) has been scientifically tested and evaluated

with a population with characteristics similar to the patient who is being evaluated and shown to be effective in identifying people at risk for developing pressure ulcers; and 2) includes a standard response scale.” Examples of these types of tools include the Braden Scale and the Norton Scale. In place of the Braden or Norton Scale, agencies may choose to develop their own risk assessment tool or assess patients’ risk based on an evaluation of clinical factors. If an agency chooses this method, then they must also define what constitutes risk. These two questions are to be answered at Start of Care and Resumption of Care.

#### **(M1306) Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as “not stageable”?**

The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure ulcer as: “Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.”<sup>6</sup> It is important for the assessing clinician to make an accurate determination of the true causative factors/etiology of a wound to be sure that it truly is a pressure ulcer. If a patient’s wound is not a pressure-related injury, then the correct answer would be “0-No.”

If it is determined that the wound is a pressure-related injury, the clinician must have a thorough understanding of the NPUAP staging system, updated February 2007, as well as principles of wound healing. Stage I pressure ulcers involve intact skin, and thus no open wound, so they are not included

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in this question. Research regarding wound healing has revealed that partial thickness wounds such as Stage II pressure ulcers heal through regeneration of the dermis and epidermis. Once complete epithelialization occurs, the wound is considered healed and no longer counted as a pressure ulcer.

Under **M1306**, if the patient has a healed Stage II pressure ulcer and no other pressure ulcers, the correct answer would be “0-No.” On the other hand, full thickness wounds such as Stage III and Stage IV pressure ulcers heal differently than partial thickness wounds. Full thickness wounds heal through a process of granulation, contraction and epithelialization, which results in the formation of scar tissue. As a result, full thickness wounds never can be considered “healed.” However, they may be considered “closed” when they have fully granulated, and the wound has been resurfaced with new epithelium.

So, if a patient presents with a “closed” (or open) Stage III or IV pressure ulcer or if the patient has an Unstageable pressure ulcer or suspected deep tissue injury, the correct answer to this question would be “1-Yes.” The OASIS-C guidance also directs clinicians to select “1-Yes” if pressure ulcers are known

to exist or suspected to exist, but may not be observable due to the presence of dressings or devices (e.g., casts) that cannot be removed to assess the underlying skin. This question is to be answered at the following points in time: Start of care, Resumption of care, Follow-up and Discharge from agency – not to inpatient facility.

**(M1307) Date of Onset of Oldest Unhealed Stage II Pressure Ulcer identified since most recent Start of Care (SOC)/Resumption of Care (ROC) assessment**

This item is designed to identify the oldest Stage II pressure ulcer only and is collected upon discharge from the agency. An ulcer that is suspected of being a Stage II, but is Unstageable, should NOT be identified as the “oldest” Stage II pressure ulcer. With this question, CMS will be able to tell how long this ulcer remained unhealed while receiving services from the home care agency and identify patients who developed a pressure ulcer while under the care of the home care agency. Once again, as previously mentioned, CMS expects to see healing and not deterioration of patients or their wounds while receiving home care services.

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1. Shannon RJ, Coombs M, et al. Reducing hospital-acquired pressure ulcers with a silicone-based dermal nourishing emollient-associated skincare regimen. *Adv Skin Wound Care*, 2009;22:461-7.

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**(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage**

This chart of items requires the clinician to count the number of current open pressure ulcers and their stage. Completion of this item requires a sound understanding of the NPUAP Pressure Ulcer Classification System, available at [www.npuap.org/resources.htm](http://www.npuap.org/resources.htm).

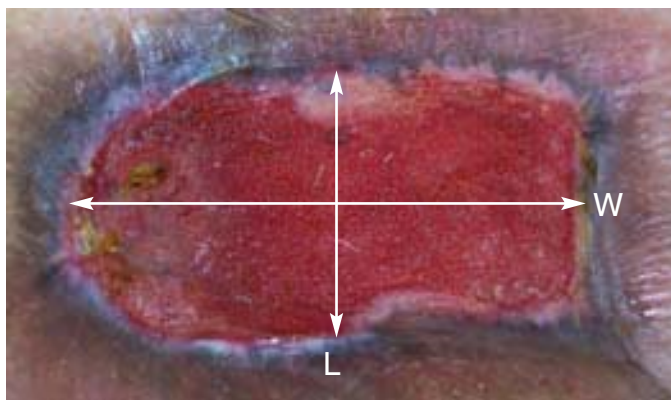
The clinician must be sure that each pressure ulcer meets the requirements of the definition of each stage. Stage I pressure ulcers and any healed (epithelialized) Stage II pressure ulcers are not counted. Likewise, pressure ulcers that are repaired surgically through procedures such as a muscle flap, skin advancement flap or rotational flap, are no longer considered to be pressure ulcers. Instead, the patient now has a surgical wound. Surgical debridement of a pressure ulcer, on the other hand, only removes necrotic tissue, so a surgically debrided wound would still be counted as a pressure ulcer.

When counting Stage III and IV pressure ulcers remember, “once a Stage III always a Stage III; once a Stage IV always a Stage IV.” Reverse staging of pressure ulcers is clinically incorrect and inappropriate because the stage only refers to the level of tissue damage. Stage III and IV pressure ulcers, as mentioned previously, heal through granulation, contraction and epithelialization and do not restore the previously damaged underlying layers.

So, if a Stage III pressure ulcer means a full thickness tissue loss down to the subcutaneous layer, then this amount of damage will always be present even when the wound has granulated to surface level and has been resurfaced with new epithelium. As a result, if a patient has a previously closed Stage III or IV that reopens, it is still a Stage III or IV (even if it only looks like a Stage II). When attempting to stage a granulating pressure ulcer, challenges arise if the clinician did not see the ulcer at its worst. In this case, the assessing clinician should make every reasonable attempt to determine the original stage of the ulcer at its worst by contacting previous providers (i.e., physician, hospital, nursing home).

**(M1310) Pressure Ulcer Length, (M1312) Pressure Ulcer Width, (M1314) Pressure Ulcer Depth**

These three questions are new to OASIS data collection and require the measurement of the largest unhealed Stage III or IV or Unstageable pressure ulcer only. To determine the largest ulcer, measure the length and width of each open Stage III, IV or Unstageable pressure ulcer to determine which has the largest surface area. The instructions direct the clinician how to obtain the measurements: length is measured as the longest length from “head to toe,” width is measured as the greatest width measured perpendicular to the length, and depth is measured from the visible surface to the deepest area of the wound. All measurements are to be recorded in centimeters.



**M1310, M1312 and M1314** require all home care agencies to measure wounds in the same manner to allow CMS to collect data that directly reflects a home care agency’s wound healing efforts as evidenced by either increasing or decreasing wound sizes. These items are completed at Start of Care, Resumption of Care and upon Discharge from agency – not to inpatient facility.

Measurements may be made using a variety of tools, including a cotton-tipped applicator, disposable measuring device, a camera or other device that calculates measurements. Measurements should always be taken following removal of the dressing and thorough wound cleansing.

## The “most problematic pressure ulcer” does not necessarily mean the largest.

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

For this question, the “most problematic pressure ulcer” does not necessarily mean the largest. The most problematic pressure ulcer could be the largest or the most advanced stage or the ulcer the clinician is having the most problem accessing because of location, difficulty with pressure relief or a variety of other factors.

Once the most problematic pressure ulcer is determined, the clinician must then make a determination of the healing status. The Wound, Ostomy and Continence Nurses Society (WOCN) recently issued a new guidance document to assist clinicians in making this determination. It’s available at [www.wocn.org/pdfs/GuidanceOASIS-C.pdf](http://www.wocn.org/pdfs/GuidanceOASIS-C.pdf). Here are a few items of note:

1. Since Stage II pressure ulcers do not granulate, as previously explained, the only appropriate answer for a Stage II pressure ulcer would be “3-Not healing.”
2. The response “NA-No observable pressure ulcer” only refers to pressure ulcers that cannot be observed due to the presence of a dressing or device that cannot be removed.
3. Unstageable pressure ulcers or ulcers with necrotic tissue (eschar/slough) would either be scored as “2-Early/partial granulation” or “3-Not healing,” depending on the amount of necrotic tissue present.
4. If a patient has only one pressure ulcer, then that ulcer is the most problematic. Stage I pressure ulcers are not considered for this item.

### **(M1322) Current Number of Stage I Pressure Ulcers**

A Stage I pressure ulcer is characterized by 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. This question identifies the presence of Stage I pressure ulcers at Start of Care, Resumption of Care, Follow-up and Discharge.

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

This item identifies the stage of the most problematic pressure ulcer that was previously determined in item M1320. Again, a thorough understanding of the NPUAP Pressure Ulcer Classification System is required to correctly answer this item. If the patient has no pressure ulcers or if the most problematic is Unstageable due to the presence of necrotic tissue or unobservable due to a non-removable dressing or device, then the correct answer would be “NA-No observable pressure ulcer.”

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

### **(M1332) Current Number of (Observable) Stasis Ulcer(s)**

These items pertain to stasis ulcers, which are caused by venous insufficiency in the lower leg. It is important for clinicians to differentiate stasis ulcers from other lower leg ulcers, such as arterial ulcers and other types of skin ulcers. This requires the clinician to utilize clinical assessment skills and knowledge of various etiologies of lower leg ulcers. These items are to be completed at Start of Care, Resumption of Care, Follow-up and Discharge from agency – not to inpatient facility. Hint: The WOCN produced a “Clinical Fact Sheet for Assessment of Leg Ulcers” that may be of value in helping with this process. For a copy, turn to page 93 or go to [www.wocn.org/pdfs/WOCN\\_Library/Fact\\_Sheets/C\\_QUICK\\_1.pdf](http://www.wocn.org/pdfs/WOCN_Library/Fact_Sheets/C_QUICK_1.pdf).

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

This item utilizes the same thought process as item **M1320** to determine the most problematic stasis ulcer and describes the healing status of the ulcer dependent on the amount of necrotic tissue and granulation tissue based on the WOCN guidance.



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

**(M1342) Status of Most Problematic (Observable)**

**Surgical Wound**

This item identifies the presence of any wound caused by a surgical procedure. Scars and keloids are NOT considered surgical wounds. Bowel ostomies and all other ostomies are not considered surgical wounds, either; however, the wound that results after an ostomy reversal procedure is considered to be a surgical wound. As mentioned previously, surgical repair of a pressure ulcer with flap surgery is NOT considered a pressure ulcer and would instead be included under this item. Debridement or skin grafting does NOT create a surgical wound, and these wounds would continue to be considered the same type of wound as previously identified prior to the procedure.

The CMS guidance states “For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples or a chemical bonding agent) is generally described in documentation as a surgical wound until epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection.” Surgical sites that have been epithelialized for 30 days should be described as a scar, and should not be included in this item.

Surgical wounds also include: Orthopedic pin sites, central line sites, wounds with drains, medi-port sites and other types of implanted infusion devices or venous access devices. A PICC line is NOT considered a surgical wound since it is peripherally inserted. Also EXCLUDED are procedures such as cataract surgery, surgery to mucosal membranes or vaginal gynecological procedures.

Item **M1342** identifies the most problematic surgical wound and the status of the healing surgical wound based on the WOCN Guidance Document. CMS encourages clinicians to follow the guidance suggested in the WOCN Guidance Document on "OASIS Skin and Wound Status M0 Items" (revised July 2006) in the assessment of surgical wounds. The document is available at [www.wocn.org/pdfs/WOCN\\_Library/OASIS\\_Guidance\\_rev\\_07\\_24\\_2006.pdf](http://www.wocn.org/pdfs/WOCN_Library/OASIS_Guidance_rev_07_24_2006.pdf).

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

This final item identifies all other types of wounds or skin lesions other than pressure ulcers, stasis ulcers and surgical wounds that are CURRENTLY receiving intervention. On previous versions of OASIS, clinicians identified the presence of all skin lesions, including moles, scars, etc. With OASIS-C, however, this item now pertains only to lesions that are receiving intervention by the home care agency. PICC lines and IV sites qualify as skin lesions/open wounds under this item. Tracheotomies, urostomies and nephrostomies are also included here if interventions such as cleansing and dressing changes are being provided by the home care agency.

Two new care process items, **M2250** and **M2400**, also include items that directly pertain to the use of best practices in the prevention and treatment of diabetic foot ulcers and pressure ulcers. As mentioned earlier, CMS is encouraging home care agencies to use best practice patient care processes, and OASIS-C includes data items to measure the use of these best practices. Clinicians are asked if the plan of care ordered by the physician includes the following:

- Diabetic foot care, including monitoring for the presence of skin lesions on the lower extremities
- Patient/caregiver education on proper foot care
- Intervention(s) to prevent pressure ulcers
- Pressure ulcer treatment based on principles of moist wound healing: When determining if the wound care is based on the principles of moist wound healing, the clinician might consider the definition of a moist wound dressing as published in the “AHCPR Treatment of Pressure Ulcers: Clinical Guideline Number 15,” December 1994.<sup>7</sup> According to this guideline:
  - A moist dressing keeps the ulcer bed continuously moist. **Wet-to-dry dressings should be used only for debridement and are not considered continuously moist saline dressings.**
  - The dressing needs to keep the surrounding intact (perilucer) skin dry while keeping the ulcer bed moist.
  - Pressure ulcers require dressings to maintain their physiologic integrity. An ideal dressing should protect the wound, be biocompatible, and provide ideal hydration. The condition of the ulcer bed and the desired dressing function determine the type of dressing needed.

Item **M2250** (plan of care synopsis) asks whether the physician-ordered plan of care includes interventions to address seven process measures: vital signs and other clinical findings, diabetic foot care, falls prevention, depression, pain and pressure ulcer prevention and treatment.

### Conclusion

As you can see, the new OASIS-C incorporates many new ideas and concepts intended to improve patient care. As overwhelming as it may seem, this should be viewed as a great opportunity to improve not only your clinical assessment skills with wounds, but also to improve the care you provide to your patients. With a little time, education and experience, you will feel more confident in assessing your patients, and your patients will feel more confident with you. I encourage you to seek out opportunities to further your knowledge base and never stop learning.

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