

MDS Alert

MDS 3.0: Tap These 3 Section M Assessment, Risk Management Advantages

Follow these instructions for differentiating a stage 2 pressure ulcer from suspected DTI.

The MDS 3.0 Section M isn't a whole new ballgame compared to the 2.0 version, but it does include numerous changes designed ultimately to improve care.

For starters: The MDS 3.0 Section M "provides more opportunity [than the MDS 2.0 does] to delineate the various types of wounds," says **Elizabeth A. Ayello, PhD, RN, ACNS-BC, CWON, MAPWCA, FAAN**, the nurse consultant who worked with CMS to develop the training materials for Section M: Skin Conditions for MDS 3.0.

For example, you can code diabetic foot ulcers on the MDS 3.0. "The MDS 3.0 includes a question in M1040 for foot problems where you identify a diabetic foot ulcer rather than coding it as an open lesion of the foot," as you would on the MDS 2.0, advises **Peggy Dotson, RN**, a consultant in Yardley, Pa. "Once you determine the etiology of the ulcer as a diabetic neuropathic ulcer, you code it as that [on the MDS 3.0]. You code only one area -- a diabetic ulcer or a pressure ulcer, not both," she adds.

Coding tip: "Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot)," states the RAI User's Manual for the MDS 3.0.

Flag Residents at Risk

The MDS 3.0 also helps you identify residents at risk for skin breakdown. "People are delighted to learn that Section M includes various ways to assess pressure ulcer risk at M0100 leading to a determination that the resident is at risk for pressure ulcers (M0150)," says Ayello.

At M0100 (Determination of Pressure Ulcer Risk), you check all that apply:

- A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device.
- B. Formal assessment instrument/tool (e.g., Braden, Norton, or other).
- C. Clinical assessment.
- Z. None of the above.

M0150 (risk of pressure ulcer) asks: Is this resident at risk of developing pressure ulcers? Code "0" for No, and "1" for Yes.

Chapter 3, Section M, of the RAI manual identifies examples of pressure ulcer risk factors as including:

immobility and decreased functional ability;

co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes;

drugs such as steroids;

impaired diffuse or localized blood flow;

resident refusal of care and treatment;
cognitive impairment;
exposure of skin to urinary and fecal incontinence;
under nutrition, malnutrition, and hydration deficits; and
a healed ulcer.

Identify Deep Tissue Injury

Chapter 3, Section M, also includes instructions that help you tell the difference between a stage 2 pressure ulcer and suspected DTI. "When a lesion that is related to pressure presents with an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury," the manual instructs.

Look for this: Tissue adjacent to, or surrounding, the blister that show signs of tissue damage, that is "color change, tenderness, boggy or firmness, warmth or coolness," suggests a suspected deep tissue injury rather than a stage 2 pressure ulcer, states the manual. (This assumes you've ruled out other conditions that could have caused the signs of tissue damage.)

Once you've determined a suspected DTI, don't code it as a stage 2 pressure ulcer, the manual directs. Rather, you'd capture it as suspected DTI, says **Rena Shephard, MHA, RN, RAC-MT, C**, founding chair and executive editor for the American Association of Nurse Assessment Coordinators, and president and CEO of RRS Healthcare Consulting Services in San Diego. You code suspected DTI at MO300G (see page 101 of this issue).

Also: An area of discolored intact skin caused by pressure may look like a stage 1. But if the area is "surrounded by tissue with symptoms such as pain, mushiness, temperature difference compared to the surrounding skin," it may be suspected DTI, says Shephard.

Clinical tip: Bruising from falls can look like suspected DTI, cautions Ayello. That's because "the intact skin may be discolored to a purple maroon hue. Knowing the resident history or whether the immediate cause was a [fall] event can be helpful," she says. To obtain this information, collaborate with the resident's caregivers, Ayello suggests.

"Feeling the temperature of the skin is one indicator that would help differentiate between a bruise, a hematoma related to a fall, and suspected DTI from pressure," Ayello adds.

Editor's note: Check out the pressure ulcer assessment and documentation tool on page 106 of this issue.

