MDS Alert

Pressure Ulcers: New Staging Guidelines Increase Pressure To Juggle Standard Of Care And MDS Coding

Navigate the growing gap between the NPUAP guidelines and MDS.

The updated **National Pressure Ulcer Advisory Panel's** (NPUAP) guidelines for staging pressure ulcers offer a new challenge for meeting the standard of care and MDS coding requirements. But the right know- how can help you bridge the two.

A new coding dilemma: The NPUAP guidelines designate suspected deep tissue injury or DTI as a separate pressure ulcer stage. The guidelines define DTI as a "purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear."

The updated guidelines don't affect how you code pressure ulcers on the MDS, however. For example, you would code suspected DTI as a stage 1 on the MDS if the overlying skin is intact--even though you clearly identify signs indicating underlying tissue injury, such as skin discoloration.

But that doesn't mean you can't keep your assessment, documentation and care plan in line with the standard of care.

Clinical best practices: Look for suspected DTI as part of your skin assessments, especially at admission or when a resident returns from the emergency department or outpatient surgery. Suspected DTI is usually "very apparent in someone with light skin where you see the purple or maroon discoloration under intact skin," says **Janet Cuddigan, RN, PhD, CWCN, CCCN**, nursing professor at the **University of Nebraska** and an NPUAP board member.

But to detect DTI in someone with dark skin, compare the area to surrounding normal tissue, Cuddigan advises. For example, the area may appear darker. You may also note induration and heat if the underlying tissue is in a stage where it's highly inflamed, Cuddigan notes. The area will feel cooler, however, once the underlying tissue is dead, she says. It may also feel either boggy or soft or harder, depending on the status of the underlying tissue, Cuddigan adds.

Three smart ideas: Supporting skin assessment forms need to include "a precise description" of areas of suspected DTI, including "color, consistency, temperature, and diagnoses such as arterial or venous insufficiency and diabetic neuropathy, etc.," advises **Lynn Gerard, RN**, director of nursing for **Guardian Angels Care Center** in Elk River, MN. Also document your assessment promptly and implement interventions immediately to provide pressure reduction and relief, Gerard emphasizes.

Facilities need to have pressure-relieving products on hand to apply as soon as staff note the deep-tissue injury, she adds.

You may be able to turn things around: "If suspected DTI is in a very early stage," says Cuddigan, "sometimes you can reverse the damage. You can compare that concept to the cardiac ischemia model where if you re-perfuse an area of cardiac ischemia, sometimes you can limit the damage or the area will recover."

Evaluate Skin Tears Carefully

The updated NPUAP guidelines caution against counting all types of skin lesions as stage 2 pressure ulcers. "This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation," according to the NPUAP.

The MDS coding requirements: "Skin tears/shears are coded in item M4 unless pressure was a contributing factor," instructs the RAI user's manual. Your best bet for deciding whether a skin tear had a pressure-related cause: Analyze how it occurred. The definition of a pressure ulcer has more to do with skin breakdown caused by some level of unrelieved pressure--and not a traumatic injury, observes **Rena Shephard, RN, MHA, FACDONA**, president of **RRS Healthcare Consulting** in San Diego, and founding chair and executive editor for the **American Association of Nurse Assessment Coordinators**.

Example: If a resident is completely mobile and doesn't have undue pressure on her hip bone, and she bumped into a corner of a wall and has a skin tear, Shephard wouldn't advise calling that pressure-related.

"You'd code a skin tear not caused by pressure as a skin tear in Section M4," advises **Joan Brundick, RN, BSN,** RAI state coordinator for Missouri. But if you determine the skin tear was caused by pressure (shearing, friction), then stage and code it as a pressure ulcer--for example, a stage 2 if it meets that criteria in the RAI manual, she advises.

An example of a skin tear caused by friction and shearing that you'd count as pressure-related, says Brundick: "A skin tear on the resident's hip caused by dragging the person up in bed."

New Unstageable Category

The NPUAP has also added an unstageable category for a pressure ulcer that needs to be debrided before you can stage it. But the "MDS says you stage/code an unstageable wound where you can't see the wound bed as a stage 4," notes **Dorothy Doughty, RN, MSN, COWN, FAAN**, director of the **Wound Ostomy Continence Nursing Education Center** at **Emory University**. Doughty notes that "almost always, a wound bed covered by necrotic tissue is a stage 4." Even so, "you cannot technically stage the wound until you can visualize the wound bed."

Follow the standard of care in clinical practice: The fact that the NPUAP guidelines differ from MDS instructions is nothing new, of course. The NPUAP has long said you don't back stage pressure ulcers as they heal, which the MDS--for payment purposes--requires a nursing facility to do.

Shephard recommends nurses on the floor use the standard of care when caring for, staging and monitoring pressure ulcers. So you'd "call an ulcer that was at its worst, a stage 3, a healing stage 3 as it healed," she says. "Based on the nurse's description of the ulcer as it healed, the MDS nurse would then translate that into MDS language for staging the ulcer for the MDS."

Shephard doesn't think anyone would be able to fault facilities that switch from the staging definitions currently found for F314 in the State Operations Manual to the current standard of practice according to NPUAP. "I don't think surveyors will write up facilities for updating their practice, which is what facilities are supposed to do."