MDS Alert

Resident Assessment: Don't Make Pressure Ulcers Appear Better - Or Worse - Than They Really Are

Get clinicians, surveyors, payers on the same page with wound severity.

With tougher F314 guidance in play, the pressure is on for coding pressure ulcers on the MDS correctly while also providing the "rest of the story" about a wound's true condition.

To achieve that feat, use this winning combination of assessment and documentation to keep your survey record in the clear - and your RUGs on the up and up.

1. Carefully document descriptions of stage 1 wounds, especially those that the facility inherits at admission. "Convey exactly how the person's skin, wound or other condition appears to the nurse's eye and other senses," advises **Rena Shephard, RN, MHA, FACDONA,** president of **RRS Healthcare Consulting** in San Diego. And don't rely on labels to convey this information in a clear and complete manner, Shephard says.

Example: A deeply discolored "stage 1," with the overlying skin still intact, will require more aggressive treatment than a little reddened place that's also a stage 1, says **Nathan Lake, RN, BSN, MSHA**, an MDS expert and software developer in Seattle.

And if you simply document such a wound as a stage 1, a surveyor or clinician might assume the nurse was referring to a red place on the skin that didn't go away in a couple of minutes after relief of pressure. "Yet as the **Centers for Medicare & Medicaid Services** describes in the guidance at F314, a wound coded as stage 1 (because the skin is still intact) can include deeply discolored and ischemic tissue underneath that probably heralds development of a stage 3 or even stage 4 ulcer," says Shephard.

The **National Pressure Ulcer Advisory Panel** is discussing reclassifying stage 1 wounds in the light of the issue of underlying tissue damage that's visible to the eye when the skin is still intact, says **Courtney Lyder, ND**, a member of the panel and professor of internal medicine and geriatrics at **University of Virginia** in Charlottesville.

Also assess and document "mushy" heels, which could herald impending skin breakdown. If the resident has boggy heels, immediately provide pressure relief. For example, keep the heels off the bed at all times by positioning the legs with pillows, advises **Lois Hottle, RN**, wound-care nurse at **Green Acres Nursing & Rehabilitation Center** in Gettysburg, PA.

Tip: New ultrasound technology allows providers to differentiate between a soft heel due to aging and one caused by pressure-induced damage, says **Connie Phillips-Jones RN, MSN.** Phillips-Jones is director of clinical support for **Longport Inc.** in Glen Mills, PA, which holds the patent on ultrasound technology that can detect the difference using portable scanners (for more information, see "In the Spotlight," later is this issue).

2. Don't be fooled by counterintuitive pressure ulcer staging directions. For example, a blister with blood or dark drainage inside may seem more serious than a stage 2 ulcer, Shephard notes. "But the RAI manual says a stage 2 ulcer includes a blister. And it's important not to overthink that sort of thing so that you end up over-staging pressure ulcers."

On the other hand, the RAI manual still requires facilities to "backstage" pressure ulcers, which runs contrary to established clinical standards of practice. That is, clinically speaking, a stage 4 decubitus remains a stage 4 throughout

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the healing process - but not on the MDS, which drives payment.

The way out of that potential discrepancy between established clinical standards and MDS coding requirements: "Take the wound assessment and documentation and translate it into MDS language for coding," suggests Shephard.

Coding tip: The RAI manual requires facilities to code a wound covered by necrotic tissue or eschar as a stage 4. But you can describe and document the wound in the medical record as being unstageable due to being covered by the eschar, says Hottle.

3. Carefully assess whether wound infection really exists before coding it on the MDS. Remember: Bacterial colonization isn't the same as an infection. "Current literature reports that all stage 2, 3 and 4 pressure ulcers are colonized with bacteria but may not be infected," cautions the revised survey guidance at F314. "Infection occurs when the bacteria invade the tissue surrounding or within the pressure ulcer," the guidance further states.

"Expect to see an inflammatory response as part of the normal healing process or about the first three to five days after the wound develops," advises **Kathleen Thimsen, RN, ET, MSN,** president of **RARE Consulting Group** in Bella Vista, AR.

By contrast, an infected wound may be reddened and have purulent drainage with an odor to it, hyperemic edges or margins and involvement of the peri-wound area, Thimsen adds. "The patient would be considered infected if he had an elevated systemic temperature, lethargy, elevated WBC - in addition to the wound signs."

The new survey guidance says to classify a wound as infected based on signs and symptoms and/or a wound culture (obtained using accepted standards such as sterile tissue aspirate, a "quantitative surface swab" using the Levine Technique or semi-quantitative swab) containing 100,000 or greater microorganisms per gram of tissue.

4. Ask physicians and physician extenders to document prognostic statements about wounds. Examples where such documentation might help include a healing stage 3 versus a progressing stage 3 - or a stage 1 with skin intact but deeply discolored underlying tissue signaling more extensive pressure-induced damage, says Lake. "Also document the conditions that make a decline unavoidable," he emphasizes.

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