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MDS Alert

Resident-Centered Care: Understand the Language Changes in Section M

Besides adjusting the language so it's standard across different levels of care, CMS's changes emphasize staff's need to bolster their assessment and documentation skills for skin conditions.

If you've paged through the 2018 version of the RAI Manual, you know that the language in Section M (Skin Conditions) surrounding pressure ulcers is a little different. The Centers for Medicare and Medicaid Services (CMS) adjusted the language, updating the terminology so it's consistent with the standard usage by the National Pressure Ulcer Advisory Panel (NUPAP).

This foundational change should make it easier to navigate the somewhat confusing and high-stakes situation of categorizing and coding pressure ulcers. Another important change in the language - and therefore how staff and the long-term care industry talk about and even think about pressure ulcers - is CMS's addition of "/injury," an acknowledgement that there may be more going on in an ulcer site than initially meets the eye.

Prioritize Assessment

If you take any single thing away from the changes to Section M, let it be CMS's emphasis on staff bolstering their skin and wound assessment skills.

"You cannot pick the correct treatment for wound management if you do not know what caused that wound. What was the cause? What was the etiology? Was it from pressure? Was it from some other type of injury? That's very important to keep reminding ourselves," says

Jane Belt, MS, RN, RAC-MT, QCP, curriculum development specialist at the **American Association of Nurse Assessment Coordination (AANAC)** in Denver, Colorado, in a September 2018 AANAC webinar.

Though several items were removed from Section M on the MDS, like the requirement for listing certain dates or dimensions of wounds, you shouldn't let those items' absence affect how you document and care plan for pressure ulcer care - or the care of any skin condition that could devolve into a more serious issue.

"In the definition of the pressure ulcer or injury risk factor, that whole thing is entirely the same as it's been for several years but there's one addition: the term 'microclimate,'" Belt says.

Basically, microclimate refers to the environment surrounding a resident's body and skin - especially the points on the body that are touching the support surface. This includes the air temperature, the humidity, and airflow at these points of contact, Belt says.

"Microclimate has a role in pressure injuries, considering the effects of perspiration, drainage, or incontinence. Microclimate is an important consideration for assessing pressure ulcer/injury risk factors. Moisture increases friction and sheer. Elders often have a reduced ability to dissipate heat with changes in blood vessels, temperature, and skin moisture. Moisture increases tissue deformation and maceration, which increases risk for pressure ulcer/injury formation," says **Sally Fecto**, senior vice president of field operations at **Harmony Healthcare International** in Topsfield, Massachusetts.

"NUPAP is on a mission to really study these support surfaces, and that's why that's there," Belt says.

Beware: Nurse assessment coordinators (NACs) will be responsible to collect accurate information to report new quality

measures (QMs), which will reflect a facility's performance in the Skilled Nursing Facility Quality Reporting Program (SNF QRP). NACs and other staff's comfort and confidence in assessing, documenting, and coding skin integrity will play into those QMs - and the reporting thereof.

Look Beyond Pressure Ulcers, Too

Though pressure ulcers/injuries may keep you and other team members up at night (not to mention the affected residents!), don't leave the documentation of other skin conditions by the wayside. Although some skin conditions, like lacerations and rashes, aren't typically coded on the MDS, don't forget to document their existence and condition and include the delivery of care in your care plan. Document the details, like the measuring the size of a laceration or describing the appearance and location of a rash.

Take careful note of any skin problems observed during the seven-day observation period, especially if they were also present during the previous MDS assessment, Belt says. "If they didn't go away, make sure you're coding them."

Focus on Details - And The Big Picture

CMS's adjustments to the RAI Manual should help facility staff deliver more comprehensive care to individual residents, lessening the chance of anyone slipping through the cracks. But the changes to such foundational elements as the language surrounding pressure ulcers/injuries are also an acknowledgement about the ways the long-term care industry culture of care needs to evolve, as well.

If a resident develops a pressure ulcer/injury under your watch, turn your care plan into a sort of micro necropsy. Though some residents' situations may make certain individuals more prone to pressure ulcers/injuries, some part of your facility's delivery of care system may have failed, too. In learning to better assess skin integrity, look back to the how and why, too.

Ask the hard questions. "Reevaluate when something is worsening or developing: What happened to our system? Why did that occur? We need to figure it out, so we can prevent it from happening again," Belt suggests.

Remember: Make accurate, comprehensive assessment and documentation your goal. If the resident had a pressure ulcer/injury or other skin condition that healed during the lookback period, don't code it, Belt says.