OASIS Alert

Assessment: Prevent Financial Losses By Understanding Ulcer Definitions

Use these resources to improve your OASIS assessment accuracy.

How accurate is your staff in distinguishing between different kinds of ulcers? You may be surprised by what staff don't know about assessing wounds -- and by what that knowledge gap is costing your agency.

"OASIS accuracy will determine clinical and financial performance and outcomes," says consultant **Lynda Laff** with Hilton Head, SC-based **Laff Associates**.

But clinicians don't always have concentrated training in wound assessment, especially new clinicians. And OASIS accuracy -- and reimbursement -- requires them to know the difference between pressure ulcers, stasis ulcers, diabetic ulcers and arterial ulcers.

Know Your Ulcer Types

Check out these ulcer identity pointers to answer the OASIS items M0445 through M0476 correctly:

1. Pressure ulcer. OASIS item M0445 defines a pressure ulcer as any lesion caused by unrelieved pressure resulting in tissue hypoxia and damage of the underlying tissue. Skin breakdown caused by shearing force or friction -- such as sliding in bed or transferring to a chair -- is also considered a pressure ulcer. The **National Pressure Ulcer Advisory Panel** considers all bed-bound and chair-bound patients, as well as patients who have difficulty repositioning themselves, as at risk for pressure ulcers.

How to identify it: Look for skin breakdown over bony prominences. Don't forget to check the back of the head and the ear lobes on patients who are bedridden or who had lengthy surgical procedures. Look for skin redness, especially if the area doesn't turn white when you press on it. For a patient with darker skin, look for areas that look darker or lighter than surrounding skin. After reddening, the skin may blister or form an open sore. Later it deepens to damage underlying tissue.

Don't forget: A debrided pressure ulcer is still a pressure ulcer, but if the ulcer is repaired with a muscle flap it becomes a surgical wound.

2. Stasis (venous) ulcer. M0468 defines a stasis ulcer as one caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis.

How to identify it: The ulcer may have a moist, granulating wound bed, be superficial and have minimal to copious serous drainage unless infected. If the patient has highly pigmented skin, look for a darker area around the wound. It may be painful if the leg is in a dependent position.

3. Arterial ulcer. An arterial ulcer or arterial wound is an ulceration that results from arterial occlusive disease. The area of tissue necrosis results from non-pressure related disruption of the arterial blood flow to an area.

How to identify it: An arterial ulcer occurs in the distal portion of the lower extremity. It may be over the ankle or bony

areas of the foot (e.g., top of the foot or toe, or outside edge of the foot). Look for a dry, pale wound bed with minimal or no exudate, experts say. Suspect an arterial ulcer if the patient has poor pedal pulses and the skin looks white and pale and lacks hair. Arterial ulcers are also painful, especially at night or when the leg is elevated.

4. Diabetic ulcer. Diabetic ulcers are not classified as pressure, stasis or arterial ulcers when answering M0 items. They are usually found on any part of the leg, especially below the ankle and on the foot. The ulcer may not be painful if the patient suffers from neuropathy or paresthesia.

How to identify it: To have a diabetic ulcer, the patient must have a documented diagnosis of both diabetes and peripheral neuropathy. Ask the physician to clarify whether the ulcer is caused by pressure or by the diabetes. Then document that discussion in the record, experts advise.

3 Sources Of Further Training

If you find you need a complete review for your staff, consider consulting with a certified Wound Care Nurse. To locate someone near you, go to www.wocn.org and click on "WOC Nurse Referral." The **Wound, Ostomy and Continence Nurses Society** also has a chart to help you identify different types of ulcers at http://www.wocn.org/pdfs/WOCN_Library/Fact_Sheets/C_QUICK1.pdf.

You may also find someone from a nearby wound care supply company who will give a presentation to your staff on this topic. Or you can watch the Webcast of a comprehensive wound care program the **Centers for Medicare & Medicaid Services** presented in April 2004. Go to http:// cms.internetstreaming.com, register, click on "Ar-chived Webcasts" and then on "Wound Care."

Note: The NPUAP information on pressure ulcer staging, prevention and care is at http://www.npuap.org.