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OASIS Alert

Education: AVOID TUNNEL VISION WHEN MEASURING ULCER DEPTH

But document everything you see -- and even what you can't.

If you get thrown for a loop when trying to measure and record pressure ulcers that contain a tunnel, we have good news. When answering item M1314 (Pressure Ulcer Depth) at start of care, resumption of care, and discharge, you don't have to measure how far the tunnel runs, according to a clarification by the **Centers for Medicare & Medicaid Services** published in July on the **OASIS Certificate and Competency Board** website.

Why? M1314 wants you to report the depth of the pressure ulcer from the visible surface to the deepest area. While a tunnel may be deep, it runs parallel to the skin -- which keeps it from being the deepest area, notes **Dorothy Doughty,** director of the Wound Ostomy Continence Nursing Education Center at **Emory University** in Atlanta.

Best: You should measure the tunnel's depth for your records, Doughty agrees. To do this, you'd measure the distance a cotton-tipped applicator or surgical probe can be inserted into the tunnel, she says.

But this information won't go into OASIS C. Clinicians "only document location and depth because you usually cannot visualize the base of the tunnel," Doughty explains. But don't think you're getting off too easily.

CMS encourages agencies to document additional details regarding the wound "within the comprehensive assessment," including "presence, location, and depth of sinus tracts or undermined areas," the clarification states. Any tunnels would fall into that category, Doughty says.

Important: When trying to document an ulcer's additional details, you should stick to the **Wound Ostomy and Continence Nurses Society's** (WOCN) guidance, which outlines all the information you should collect to thoroughly assess an ulcer.

WOCN offers these seven parameters for documentation:

1) Staging;

2) Dimensions and depth;

3) Presence, location, and depth of sinus tracts or undermined areas;

4) Status of the pressure ulcer bed (granulating or epithelializing versus clean but not granulating or avascular);

5) Volume, color, and odor of exudate;

6) Evidence of infection in surrounding tissue (e.g., erythema, induration, crepitance); and

7) Status of pressure ulcer edges (closed and nonproliferative versus open and proliferative).

Accurately recording this data conveys the true state of the pressure ulcer while allowing you to track the ulcer's progress over time, WOCN explains.

Resource: Download WOCN's complete guidelines at www.wocn.org/pdfs/WOCN_Library/Position_Statements/PressureUlcerStaging.pdf. You can read CMS' clarification at www.oasiscertificate.org.

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