OASIS Alert

Item Focus: M1320: Take 3 Steps to Identify the Status of Most Problematic Pressure Ulcer

Hint: You'll list NA in only one situation.

Accurately reporting the status of your patient's most challenging pressure ulcers can be complex. Make sure you have a thorough understanding of how to correctly represent your patient's condition by following this three-step process to answer M1320 -- Status of the most problematic (observable) pressure ulcer correctly.

Establish The Basics

OASIS item M1320 is one of the most confusing, and challenging questions on the OASIS-C data set, says **Tracie Jones, BSN, RN, CWOCN, WCC, COS-C** with **At Home Healthcare** in Tyler, Texas. This item asks you to indicate the degree of closure visible in the most problematic, observable Stage II or higher pressure ulcer.

Your response options for M1320 are:

- 0 -- Newly Epithelialized;
- 1 -- Fully Granulating;
- 2 -- Early/partial granulation;
- 3 -- Not healing; and
- NA -- No observable pressure ulcer.

Complete M1320 at start of care, resumption of care, and discharge from your agency.

But you need to know which pressure ulcers are observable, how to determine the most problematic pressure ulcer, and how to pick the right healing status before you can choose the correct response for this item.

Step 1: Identify observable pressure ulcers.

When answering M1320, you're looking for the patient's worst observable pressure ulcer. To determine the degree of healing, you'll need to be able to visualize the wound base. The **Centers for Medicare & Medicaid Services** lists only one circumstance that makes a pressure ulcer unobservable (NA) for this item:

- A non-removable dressing or device (such as a cast) prevents you from seeing the wound base.

So you'll need to consider all of your patient's pressure ulcers, except for those covered by a cast or other non-removable dressing or device, as you determine which to report in M1320.

If the patient's only pressure ulcer is unobservable, you might want to wait to answer this item, suggests Northampton, Mass.-based **Fazzi Associates** in the OASIS C Best Practice Manual. If the same clinician will remove the dressing/device so that the pressure ulcer can then be visualized within five days of SOC or two days of ROC, you would be able to report a more accurate answer to M1320.

Note: If you wait to answer this item, your M0090 -- Date assessment completed response would be the date you visualized the ulcer and completed the assessment.

Important: The presence of necrosis (slough/eschar) doesn't impact your ability to "observe" a pressure ulcer when determining the healing status for this item, Jones says. However, a wound that is covered with slough and/or eschar can't be staged, which is important for answering other OASIS pressure ulcer staging items such as M1324 -- Stage of

most problematic (unhealed) observable pressure ulcer.

The challenge lies in determining which wounds are observable for both M1320 (Status) and M1324 (Stage), Jones tells **Eli**. In a multiple wound situation where unobservable pressure ulcers occur, accurate data collection could require reporting of multiple wounds, she says.

For example: A patient's infected, unobservable pressure ulcer to the left ischium may be more problematic than her granulating Stage III pressure ulcer to the left trochanter, Jones points out. In this case, the most problematic wound for M1320 is the unobservable pressure ulcer and the "healing status" is captured as response 3 -- Not healing.

However, because you are unable to stage a wound that is obscured with tissue necrosis, this infected wound can't be an "observable wound" for M1324, Jones says. The patient also has a Stage III pressure ulcer, so that wound will serve as the most problematic for M1324. The correct response in M1324 for this patient is response 3 -- Stage III. If the patient did not have another pressure ulcer, then the correct response to M1324 would be NA -- No observable pressure ulcer or unhealed pressure ulcer.

Step 2: Determine which pressure ulcer is the most problematic.

The use of clinical judgment is necessary when determining the most problematic pressure ulcer for M1320, Jones says. The "most problematic" ulcer could be the largest pressure ulcer or one that is difficult to treat. Other factors that will influence pressure ulcer selection include the presence or absence of clinical infection or critical colonization, compliance with pressure relief and/or reduction, dressing selection, and wound location.

Ulcer selection should be patient-specific, Jones says. For example, a dry, stable eschar to the heel in a patient with adequate offloading may not be as problematic as a smaller Stage II pressure ulcer to the ischium of an incontinent patient.

Tip: If there is only one pressure ulcer, that one is automatically the most problematic. However, in multiple wound situations, it can become challenging to determine which wounds are observable and problematic, Jones says.

Step 3: Indicate healing status.

For CMS-approved instruction on reporting the healing status of pressure ulcers, look to the **Wound Ostomy Continence Nurses Society** (WOCN) guidance on OASIS-C integumentary items found here: www.wocn.org/resource/resmgr/docs/guidanceoasis-c.pdf. This document offers guidelines for completing all of the wound-related OASIS items based on WOCN and **National Pressure Ulcer Advisory Panel** (NPUAP) guidelines.

Whenever you're answering any of the OASIS-C pressure ulcer questions, you should refer to the WOCN/NPUAP guidelines. Using this tool will help keep all of the clinicians in your agency on the same page when it comes to ulcer staging. These guidelines spell out exactly what each stage of healing looks like.

Take note: All items must be met in order to classify a wound with a particular healing status. But if any of the non-healing wound descriptions apply, the pressure ulcer can be considered "Not healing."

WOCN Healing Status Definitions for M1320

0 -- Newly epithelialized

Wound bed completely covered with new epithelium.

No exudate.

No avascular tissue (eschar and/or slough).

No signs or symptoms of infection.

Closed Stage III and IV pressure ulcer.

1 -- Fully granulating

Wound bed filled with granulation tissue to the level of the surrounding skin.

No dead space.

No avascular tissue (eschar and/or slough).

No signs or symptoms of infection.

Wound edges are open.

Stage III or IV pressure ulcer with 100 percent of the wound bed covered with red granulation tissue.

2 " Early/partial granulation

≥25 percent of the wound bed is covered with granulation tissue.

< 25 percent of the wound bed is covered with avascular tissue (eschar and/or slough).

No signs or symptoms of infection.

Wound edges open.

Appropriate response for Stage III or IV pressure ulcer with less than 25 percent tissue necrosis in the wound bed.

3 - Not healing

Wound with ≥25 percent avascular tissue (eschar and/or slough) or

Signs/symptoms of infection or

Clean but non-granulating wound bed or

Closed/hyperkeratotic wound edges or

Persistent failure to improve despite appropriate comprehensive wound management.

Appropriate Response:

- Stage II pressure ulcer (blisters and open lesions).
- Suspected deep tissue injury.
- Stage III/IV pressure ulcer > 25 percent necrosis and/or signs and symptoms of infection.
- Unstageable pressure ulcer if > 25 percent of wound base is necrotic.

Choose '3' When ...

If your patient's most problematic pressure ulcer is a suspected deep tissue injury in evolution, you'll select response 3 -- Not healing, Fazzi says. You'll also choose "3" when the most problematic pressure ulcer is a Stage II, which includes an intact serum filled blister from pressure.

You can only report Stage II pressure ulcers in this item with response "3" because they do not granulate. And once a Stage II pressure ulcer is completely covered with epithelium it is healed according to OASIS guidelines and you would no longer report it.

Mind These Documentation Tips

Aside from answering M1320, you should also document complete wound description(s) in the clinical record, advises Fazzi. Use terms found in the WOCN descriptions of non-healing, early partial, fully granulating, and newly epithelialized wound status to describe the wound. Include location, size, depth, drainage, and appearance of wound bed and surrounding skin.

If your patient has multiple pressure ulcers that you can see, clearly document in the response section which wound you are identifying as most problematic and why you are designating it as such, Fazzi advises.