OASIS Alert

Item Focus: M1324: Take 3 Steps to Stage Most Problematic Pressure Ulcer

Hint: You'll list NA in only three circumstances.

Accurately staging your patient's most challenging pressure ulcers can be complex. Make sure you aren't leaving clinical points on the table by following this three-step process to answering M1324 correctly.

Establish The Basics

OASIS item M1324 seems simple up front. This item asks you to indicate the stage of your patient's most problematic, unhealed, observable pressure ulcer.

Your response options for M1324 are:

- 1 -- Stage I;
- 2 -- Stage II;
- 3 -- Stage III;
- 4 -- Stage IV; and

NA -- No observable pressure ulcer or unhealed pressure ulcer.

Complete M1324 at start of care, resumption of care, follow-up, and discharge from your agency (but not when the discharge is to an inpatient facility).

But you need to know which pressure ulcers areobservable, how to determine the most problematic pressure ulcer, and how to pick the right pressure ulcer stage before you can choose the correct response.

Step 1: Identify observable pressure ulcers.

When answering M1324, you're looking for the patient's worst observable pressure ulcer. In order to determine the degree of healing, you'll need to be able to visualize the wound base. The **Centers for Medicare & Medicaid Services** list only three circumstances that make a pressure ulcer unobservable:

- Necrotic tissue (including eschar or slough) makes it impossible for you to see the wound base,
- A non-removable dressing or device (such as a cast) prevents you from seeing the wound base, or
- A suspected deep tissue injury. If none of these conditions is met, the patient's pressure ulcer(s) are up for M1324 consideration.

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

You'll need to use your clinical judgment to establish the criteria you'll employ to select the patient's "most problematic" pressure ulcer. It could be the largest pressure ulcer, the one at the most advanced stage, the most difficult to access for treatment, or one in the area most difficult to relieve pressure.

Tip: If there is only one pressure ulcer, that one is automatically the most problematic.

Step 3: Indicate ulcer stage.

For CMS-approved instruction on staging pressure ulcers, look to the **Wound Ostomy Continence Nurses Society**

(WOCN) guidance on OASIS-C integumentary items found here: http://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, says **Marianne Rone, RN, BSN, HCS-D, COS-C** director of clinical services with **Healthcare Provider Solutions** in Nashville, Tenn. Using this tool helps keep all of the nurses in your agency on the same page when it comes to ulcer staging, she says.

When you use the WOCN/NPUAP tool as a guide, pressure ulcer staging becomes more factual, Rone says.

The WOCN includes the following descriptions of pressure ulcer stages:

Stage I. A Stage I pressure ulcer presents as intact skin with non-blanchable redness of a localized area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Stage II. A Stage II pressure ulcer is characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. It also may present as an intact or open/ruptured serumfilledblister.

Stage III. A Stage III pressure ulcer is characterized by full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. Stage III ulcers may include undermining and tunneling.

Stage IV. A Stage IV pressure ulcer presents with fullthickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. These ulcers often include undermining and tunneling.

Tip: If the patient has a blister or a ruptured blister with a dark red wound bed, you're more than likely looking at a deep tissue injury. And if the blister is bloodfilled, not serum filled, you're again more than likely looking at a deep tissue injury and not a Stage II ulcer, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C,** consultant and principal of **Selman-Holman & Associates** and **CoDR -- Coding Done Right** in\ Denton, Texas.

Take note: Stage 3 and 4 pressure ulcers may close, but they are never considered healed, so you should continue to report them at their worst stage.

M1324 example: Your patient has a wound that was previously documented as a Stage III pressure ulcer. It is covered in soft brown eschar on assessment. She has no other observable pressure ulcers. How would you answer M1324 for this patient?

You would select NA -- No observable pressure ulcer or unhealed pressure ulcer for this patient, says Selman- Holman. The patient's pressure ulcer cannot be staged because the wound bed is not visible.