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OASIS Alert

OASIS C :GET READY NOW FOR INCREASED PRESSURE ULCER SCRUTINY

Don't wait until fall to streamline your assessment and treatment processes.

CMS is including in the OASIS C assessment more information than just the number and stage of a patient's pressure ulcers.

The **Wound, Ostomy, and Continence Nurses Society** recommends that all patients in acute, long-term, and home care be assessed for risk of pressure ulcers at the time of admission. Now the **Centers for Medicare & Medicaid Services** is including this assessment in OASIS C.

Background: The new OASIS C assessment tool -- with an implementation date of January 2010 -- contains a number of new process items that home health agencies will need to address. These process items are meant to identify patients who are at high risk for problems, so many agencies already use them, according to **Angela Richard** of the **University of Colorado Health Science Center**, speaking at an industry conference inMarch.Agencies can implement these processes gradually, because at this point they are not required, she said.

Process items on the OASIS C ask questions about whether the agency has conducted certain kinds of assessments and whether there are any orders related to the results of the assessments, explains Chicago-based regulatory consultant **Rebecca Friedman Zuber**.

Focus On Pressure Ulcer Prevention Intensifies

For years CMS has focused intensely on pressure ulcers in skilled nursing facilities.

Soon HHAs will receive more scrutiny as well.

Early detection and prevention of pressure ulcers is crucial because pressure ulcers can be painful, expensive, and even fatal.

M1300 asks whether you assessed the patient for the risk of developing pressure ulcers.

If the answer is "yes," you are asked whether the assessment was based on an evaluation of clinical factors such as mobility, incontinence, and nutrition or using a standardized tool.

M1302 asks what you concluded about the patient's pressure ulcer risk.

Studies show that pressure ulcers in home care patients are almost as prevalent as they are in long term institutional care, according to the **Hartford Institute for Geriatric Nursing**.

Heads up: If you're not already using your own or a standardized tool to assess your patient's risk of developing pressure ulcers, now is the time to start.

Develop An Accurate Risk Picture Where to begin: Two popular pressure ulcer risk assessment tools are the Norton scale and the Braden scale. The Norton includes five categories: physical condition, mental state, activity, mobility, and incontinence.

The Braden includes six categories: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. The Braden is one of the most widely used tools for assessing pressure ulcer risk, according to **Elizabeth Ayello** of the **Excelsior College School of Nursing** in Albany, N.Y.

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Don't stop there: A risk score on a standardized risk assessment tool gives you a ballpark estimate of a patient's likelihood of developing a pressure ulcer. But don't count on it completely, because it can never capture all the risks, experts agree.

For example: After you use the Braden scale to assess a patient, ask yourself if the patient also has major risk factors such as fever, diastolic pressure below 60, hemodynamic instability or advanced age. If so, move them to the next highest level of risk, Ayello advises.

Remember to look at the entire patient, experts warn. Be on the lookout for comorbidities that contribute to pressure ulcer development or poor healing of existing ulcers. The list includes any condition that creates a strain on organ systems that makes it more likely the person's skin will break down with less pressure than usual such as chronic pulmonary disease, congestive heart failure, anemia, chronic or acute renal failure, thyroid disease, and delirium.

Medications can also increase the risk of pressure ulcers or impair their healing for example, by causing sedation, dry skin, urinary incontinence, diarrhea, etc.

Assessment Is Only The Beginning Of OASIS C Concerns

Once you determine a patient's risk for developing pressure ulcers, you need to focus on intervention. M2250 (Plan of Care Synopsis) asks if the physician-ordered plan of care includes interventions to prevent pressure ulcers (see related story on p. 57 and audioconference on p. 56).

Then in M2400 (Intervention Synopsis) section (e) asks whether you included an intervention to prevent pressure ulcers in the physician-ordered plan of care and if you implemented the intervention.

Besides answering "yes" or "no," you can answer "not applicable" because "formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment."

The interventions you choose are based on the specific reasons the patient is at risk. Among the possibilities are using a pressure redistribution support surface, teaching the caregiver to reposition the patient every two hours, using pillows or foam wedges to maintain the best body positions, using pillows or foam cups to keep heels off the bed, and using pillows to keep knees or ankles from pressing on each other, according to "The Nursing Process and Pressure Ulcer Prevention: Making the Connection" in the February 2009 issue of Advances in Skin & Wound Care.

If the patient has other risk factors such as poor nutrition or comorbidities, address these in your care planning also.

Note: For help using the Braden scale go to www.nursingcenter.com/library/JournalArticle.asp?Article_ID=839887. For more information on the Braden scale and additional resources, including a video for training staff on its use and competency tests, go to www.bradenscale.com. The Braden Scale is protected by copyright. Permission can be obtained, usually free of charge, for patient settings, at this web site.

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