OASIS Alert

Reader Question: Look to Guidance for Scabbed Pressure Ulcers

Question: Our patient had a Stage II pressure ulcer at start of care (SOC), but at resumption of care (ROC), we were unable to visualize the wound bed due to a scab. How should we answer M1308 – Current Number of Unhealed (Non Epithelialized) Pressure Ulcers at each stage and M1320 – Status of Most Problematic (Observable) Pressure Ulcer at ROC?

Answer: At the ROC assessment, if the scab obscures the wound bed so that the you can't visualize it, you're unable to determine the exact depth of damage, the Centers for Medicare & Medicaid Services in the October 2013 Quarterly OASIS Q&As. Because you can't see the wound bed, you won't be able to stage the pressure ulcer.

In M1308, you'll report this pressure ulcer in row "d.2 – Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar."

Tip: A scab is not slough or eschar, but for OASIS data collection purposes, this is the best way to report your patient's wound, CMS says. You can further describe the pressure ulcer in the patient's medical record.

Selecting your M1320 response will be a little more involved. When you report the healing status in this item, you must consider whether the pressure ulcer had partial or full thickness tissue loss, CMS says.

Choose response "3 – Not healing" when the wound has a scab over part of a partial thickness wound, without granulation. Remember, partial thickness ulcers do not heal by granulation and you cannot count a wound with a scab adhering to its wound base as newly epithelialized, CMS says.

But when you're gathering data about pressure ulcers with full thickness tissue loss that is partially obscured by scab, you should look to the to the Wound Ostomy and Continence Nurses Society's Guidance on OASIS-C Integumentary Items to select the correct healing status.

Response "0 – Newly epithelialized" is off limits when a scab obscures the wound bed, "because the wound bed is not completely covered by new epithelium," CMS says.

Report "1 – Fully granulating" if the scab is raised and appears to be covering a wound that has filled with granulation to the same level as the surrounding skin surface," CMS says. But be cautious. If the scab prevents you from visualizing whether the wound bed is filled with granulation tissue to the level of the surrounding skin, it may not be appropriate to report response "1."

When the wound bed is sunken below the level of the surrounding skin, then response options "0 – Newly epithelialized" and "1 – Fully granulating" are off the table for this pressure ulcer obscured by a scab.

Select response "2 – Early/partial granulation" if the wound shows no signs or symptoms of infection and you can see that granulation tissue covers at least 25 percent of the wound bed.

Select response "3 – Not Healing" if the scab-covered wound meets any of the WOCN criteria for response "3." This includes:

- Greater than or equal to 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.

What do you do when a scab completely covers a pressure ulcer to the point where you can't tell if there is any granulation tissue, or if the wound was partial or full thickness? Consider the scab similar to avascular tissue, and use your best judgment and the WOCN Guidance to determine whether the pressure ulcer is "1 Fully Granulating," "2 Early/Partial Granulation," or "3 Not Healing."

Note: Read all of the October 2013 Q&As here: www.oasisanswers.com/aboutoas_links.htm.