OASIS ITEM

(M1308) Current Number of Unhealed (non epithelialized) Pressure Ulcers at Each Stage:
(*Enter "0" if none; excludes Stage I pressure ulcers)*

	COLUMN 1 Complete at **SOC/ROC/FU & D/C**	**COLUMN 2** Complete at **FU & D/C**
Stage description – unhealed pressure ulcers	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
a. **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.		
b. **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.		
c. **Stage IV:** Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.		
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device		
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.		
d.3 Unstageable: Suspected deep tissue injury in evolution.		

ITEM INTENT

Identifies the number of Stage II or higher pressure ulcers at each stage present at the time of assessment. Stage I pressure ulcers are not reported in this item.

TIME POINTS ITEM(S) COMPLETED

Start of care – Column 1

Resumption of care – Column 1

Follow-up – Columns 1 and 2

Discharge from agency – not to inpatient facility – Columns 1 and 2

Guidance for this item updated 12/2012

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1308)

- For Column 1, report the number of Stage II or higher pressure ulcers on the current day of assessment. This column must be completed at Start of Care, Resumption of Care, Follow-up, and Discharge.
- For Column 2, report the number of Stage II or higher pressure ulcers that were identified in Column 1 and were present on the most recent SOC/ROC, **even if it was at a different stage.**.
  - Example 1: Patient has no Stage II pressure ulcers on admission, but develops one during the first episode that is present at the time of follow-up. In this case, row a, column 1 would be "0" at SOC. At follow-up, row a, column 1 would be "1" and row a column 2 would be "0," indicating the pressure ulcer was not present on admission.
  - Example 2: Patient has a Stage III pressure ulcer on admission that is assessed to be a Stage IV at follow-up. In this case, row b, column 1 would be "1" at SOC. At follow-up, row b, columns 1 and 2 would both be "0," as the patient no longer has a Stage III ulcer. Row c, column 1 would be "1" and column 2 would be "1" indicating the ulcer was present on admission, **even though it was at a different stage**.
  - Example 3: Patient has a Stage II pressure ulcer on admission that heals within the first 2 weeks, but then develops another Stage II pressure ulcer prior to discharge at week 4. In this case, row a, column 1 would be "1" at SOC. At Follow-up, row a, column 1 would be "1" and row a, column 2 would be "0", indicating the pressure ulcer that is present at follow up or discharge was not present on admission.
- Column 2 is left blank when the ROC assessment is completed during the 5-day recertification window.

For both Columns 1 and 2:

- Mark a response for each row of this item: a, b, c, d1, d2, and d3. If there are NO ulcers at a given stage, enter "0" for that stage.
- **Stage I and II ulcers**
  - Stage I and II pressure ulcers are described as "partial thickness" ulcers. Based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it has been determined that Stage I and Stage II (partial thickness) pressure ulcers can heal through the process of regeneration of the epidermis across a wound surface known as "epithelialization."
  - Stage I ulcers are not reported in this item.
  - Stage II ulcers that have healed are not reported in this item.
- **Stage III and IV ulcers**
  - Stage III and IV ulcers are described as "full thickness" ulcers. Stage IV ulcers involve full thickness skin loss with extensive destruction accompanied by tissue necrosis with damage to muscle, bone, tendon, or joint capsule. Stage III and IV (full thickness) pressure ulcers close through a process of granulation, contraction, and epithelialization. They can never be considered "fully healed" but they can be considered closed when they are fully granulated and the wound surface is covered with new epithelial tissue.
  - Reverse staging of granulating Stage III and Stage IV pressure ulcers is NOT an appropriate clinical practice according to the NPUAP. If a pressure ulcer is Stage III at SOC and is granulating at the follow-up visit, the ulcer remains a Stage III ulcer.
  - Although the wording in M1308 includes the term "non epithelialized," for this item, a closed Stage III or Stage IV pressure ulcer should be reported as a pressure ulcer at its worst stage, even if it has re-epithelialized.
  - A previously closed Stage III or Stage IV pressure ulcer **that is currently open again** should also be reported at its worst stage.
  - If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst. An ulcer's stage can worsen, and this item should be answered appropriately if this occurs.

Guidance for this item updated 12/2012

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1308)

- A muscle flap, skin advancement flap, or rotational flap (defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply) performed to surgically replace a pressure ulcer is a surgical wound. It should not be reported as a pressure ulcer on M1308.
- A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) remains a pressure ulcer and should not be reported as a surgical wound on M1342. Until the graft edges completely heal, the grafted pressure ulcer should be reported on M1308 as d.1 (unstageable) pressure ulcer. The number of pressure ulcers meeting these definitions should be counted to determine the response to d.1. Once the graft edges heal, the closed Stage III or Stage IV pressure ulcer would continue to be regarded as a pressure ulcer at its worst stage.
- A pressure ulcer that has been surgically debrided, remains a pressure ulcer and should not be reported as a surgical wound on M1342.
- Pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings (e.g., patient report of discomfort, past history of skin breakdown in the same area), but that are unstageable due to dressings or devices (e.g., casts) that cannot be removed to assess the skin underneath should be reported as d.1 (unstageable).
- Response d.2 refers to pressure ulcers that the care provider suspects may be present based on clinical assessment findings (e.g., patient report of discomfort, past history of skin breakdown in the same area), but cannot be staged due to full thickness tissue loss in which the true wound depth is obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. The number of pressure ulcers meeting this definition should be counted to determine the response to d.2.
- Response d.3 refers to a suspected deep tissue injury in evolution, which is defined by the NPUAP as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. The number of pressure ulcers meeting this definition should be counted to determine the response to d.3. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Clinical record
- Referral documentation
- Physician
- Consult published guidelines of NPUAP for additional clarification and/or resources for training. Resources and links can be found in Chapter 5 of this manual.
- See Chapter 5 of this manual for NPUAP staging illustrations.