OASIS ITEM

(M1320) Status of Most Problematic (Observable) Pressure Ulcer:

- ☐ 0 - Newly epithelialized
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable pressure ulcer

ITEM INTENT

Identifies the degree of closure visible in the most problematic observable pressure ulcer, stage II or higher. Please note, Stage I pressure ulcers are not considered for this item.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Determine the most problematic pressure ulcer. Visualization of the wound is necessary to identify the degree of healing evident in the ulcer identified in M1320.
- "Most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.
- If the patient has only one observable pressure ulcer, then that ulcer is the most problematic.
- Mark the response that most accurately describes the healing process you see occurring in the most problematic pressure ulcer.
- Stage III and IV pressure ulcers close by contraction, granulation, and epithelialization. Epithelialization is regeneration of the epidermis across a wound surface.
- Mark response 0 – Newly epithelialized – when epithelial tissue has completely covered the wound surface of the pressure ulcer, regardless of how long the pressure ulcer has been re-epithelialized. This is an appropriate response for Stage III and IV pressure ulcers, but not for Stage II ulcers as fully epithelialized Stage II ulcers should not be reported.
- Response 1 – Fully Granulating – is the appropriate response for a Stage III or IV pressure ulcer that is fully granulated, but epithelial tissue has not completely covered the wound surface.
- Because Stage II ulcers do not granulate and newly epithelialized Stage II ulcers are not counted, the only appropriate response for Stage II ulcers is 3 – Not healing.
- Since suspected deep tissue injury (DTI) does not granulate and would not be covered with new epithelial tissue, the status of "Not healing" is the most appropriate response.
- "No observable pressure ulcer" includes only those that cannot be observed due to the presence of a dressing or device that cannot be removed (including casts). (When determining the healing status of a pressure ulcer for answering M1320, the presence of necrotic tissue does NOT make the pressure ulcer NA – No observable pressure ulcer.)
- A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is either Response 2 – Early/partial granulation if necrotic or avascular tissue covers <25% of the wound bed, or Response 3 - Not healing, if the wound has ≥25% necrotic or avascular tissue.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M1320)

- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- Additional resources for the WOCN, the NPUAP, and the NQF can be found in Chapter 5 of this manual.