Excellence in OASIS-C

COS-C Prep & OASIS Training

Webinar Series - Session 5
April 2, 2014
2:00 – 3:00PM EST

PRESENTER:
JOAN L. USHER, BS, RHIA, COS-C, ACE
JLU HEALTH RECORD SYSTEMS
TEL: (781) 829-9632 FAX: (781) 829-9636
Web Site: www.jluhealth.com Email: jluhealth@verizon.net

Session 4 Agenda

1. Integumentary Review M1300s
2. Explain completion of pressure ulcer, stasis ulcer and surgical wounds questions
3. Participants provided with Checklist of what is and what is NOT a surgical wound

Integumentary System

M1300s

3

Wound M Questions

Pressure Ulcers	M1300, M1302, M1306, M1307, M1308, M1310-M1314, M1320, M1322, M1324
Stasis Ulcers	M1330, M1332, M1334
Surgical Wounds	M1340, M1342
Skin Lesion/Open Wound	M1350

4

Determining the Origin of a Wound

Was the wound a result of a trauma/injury?	Answer in M1020-M1022 and M1350
Was the wound an outcome of surgery?	Answer in M1340
Were there post-operative issues with surgical wound?	Answer in M1020-M1022 and M1340
Is the wound an ulcer? Due to Pressure?	Answer in M1306
Is the wound an ulcer? Manifestation of diabetes	Answer in M1020-M1022 and M1350
Is the wound an ulcer? Non-pressure Lower extremity	Answer in M1020-M1022 and M1350
Is the ulcer due to venous insufficiency?	Answer in M1020-M1022 and M1330

5

M1300 Pressure Ulcer Assessment (QM)

- Was this patient assessed for **Risk of Developing Pressure Ulcers**?

☐ 0 - No assessment conducted [Go to M1306]

☐ 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool

☐ 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

6

Pressure Ulcer Terminology

- Pressure ulcer treatment is based on principles of moist wound healing
- Newly Epithelialized
  - When epithelial tissue has completely covered the wound surface regardless of how long the pressure ulcer has been re-epithelialized
- Unhealed means non-epithelialized
- Two PU with tunnel between are considered Two PU
- PU with necrotic tissue (eschar/slough) obscuring the wound bed cannot be staged, but its healing status is either “2” early/partial granulation if necrotic or avascular tissue covers <25% wound bed or “3” not healing if ≥25% necrotic or avascular tissue

Pressure Ulcer Terminology Stage I & II

- Stage II (partial thickness) pressure ulcers can heal through epithelialization (the process of regeneration of the epidermis across a wound surface)
  - An ulcer that is suspected of being Stage II but is unstageable should not be identified in M1307 Oldest Non-epithelialized Stage II PU
  - Stage II ulcers do not granulate, M1320 must be answered as “3” not healing
- Do not report fully epithelialized Stage I & Stage II pressure ulcers upon admission
- NEVER reverse stage an ulcer at any stage

Pressure Ulcer Terminology
Stage III-IV & DTI

- Stage III and IV (full thickness) pressure ulcers heal through a process of contraction, granulation, 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.
- DTI do not granulate
  - M1320 Status of Most Problematic PU is answered as “3” not healing

M1302 Risk Pressure Ulcer (QM)

- **(M1302)** Does this patient have a **Risk of Developing Pressure Ulcers**?

☐ 0 - No
☐ 1 – Yes

- *Tip: Be sure to answer M2250 (f) correctly*

M1306 Pressure Ulcer Stage II or Higher

- **(M1306)** Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?

☐ 0 - No [Go to M1322]
☐ 1 - Yes

M1306 Tips

- Select Response 0 – No
  - if the only pressure ulcer(s) is Stage 1
  - OR if a former Stage 2 pressure ulcer has healed AND the patient has no other pressure ulcers
- Select Response 1 – Yes
  - if the patient has an unhealed Stage II
  - OR a Stage III, or Stage IV pressure ulcer at any healing status level
  - OR if the patient has an unstageable ulcer(s)

Unstageable Ulcer

- Pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings :
  - unobservable due to dressings or devices (e.g., casts) that cannot be removed to assess the skin underneath.
  - 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.
- Suspected deep tissue injury (DTI) 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.
  - 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

M1307 Pressure Ulcer Assessment

- **(M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge**

☐ 1 - Was present at the most recent SOC/ROC assessment
☐ 2 - Developed since the most recent SOC/ROC assessment:
record date pressure ulcer first identified: __ __ /__ __ /__ __ __ __
month / day / year
☐ NA - No non-epithelialized Stage II pressure ulcers are present at discharge

The intent of this item is to:
- a) identify the oldest Stage II pressure ulcer that is present at the time of discharge and is not fully epithelialized, and
- b) assess the length of time this ulcer remained unhealed while the patient received care from the home health agency and
- c) identify patients who develop Stage II pressure ulcers while under the care of the agency.

M1307 Tips

- DO NOT CONSIDER STAGE III OR IV ULCERS WHEN ANSWERING THIS ITEM.
- Select Response 1 if the oldest Stage II pressure ulcer that is not fully epithelialized was already present when the SOC/ROC assessment was completed.
- Select Response 2 if the oldest Stage II pressure ulcer that is not fully epithelialized was first identified since the most recent SOC/ROC visit (i.e., since the last time the patient was admitted to home care or had a resumption of care after an inpatient stay).
- Select Response "NA" if the patient has no Stage II pressure ulcers at the time of discharge, or all Stage II pressure ulcers have been fully epithelialized
- An ulcer that is suspected of being a Stage II, but is unstageable, should not be identified as the "oldest Stage II pressure ulcer."

M1308 Pressure Ulcer Assessment

- Identifies the number of Pressure Ulcers at each stage
- 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.**
- Enter "0" if none.
- Excludes Stage I pressure ulcers.
- Stage III & IV Pressure ulcers identified here require completion of measurements in M1310/1312/1314.

(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.		

17

Test Your Knowledge M1308

- 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.
- Timepoint Follow-up (Recertification)

18

(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.		

(M1308) Current Number of Unhealed (non epithelialized) Pressure Ulcers at Each Stage: (*Enter "0" if none; excludes Stage I pressure ulcers)* ***Example 1***

	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.	1	0
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.	0	0
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.	0	0
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	0	0
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	0	0
d.3 Unstageable: Suspected deep tissue injury in evolution.		

Test Your Knowledge M1308

- Example 2: Patient has a Stage III pressure ulcer on admission that is assessed to be a Stage IV at follow-up.
- Timepoint Follow-up (Recertification)

(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.		

(M1308) Current Number of Unhealed (non epithelialized) Pressure Ulcers at Each Stage: (*Enter "0" if none; excludes Stage I pressure ulcers*) *Example 2*

	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.	0	0
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.	0	0
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.	1	1
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	0	0
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	0	0
d.3 Unstageable: Suspected deep tissue injury in evolution.	0	0

M1310/1312/1314 Pressure Ulcer Measurement

- Directions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the Stage III or IV pressure ulcer with the largest surface dimension (length x width) and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.
  - (M1310) Pressure Ulcer Length: Longest length "head-to-toe" | ___ | ___ | . | ___ | (cm)
  - (M1312) Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length | ___ | ___ | . | ___ | (cm)
  - (M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area | ___ | ___ | . | ___ | (cm)

Pressure Ulcer Measurement Tips

- Identify the pressure ulcer reported in M1308, Column 1, rows b, c, or d.2, with the largest surface dimension (length x width)
  - record in centimeters.
- If all existing Stage III or IV pressure ulcers are closed (completely re-epithelialized) and the patient has no pressure ulcers that are unstageable due to coverage of the wound bed by slough and/or eschar
  - enter 00.0 for M1310, M1312, and M1314.
- Measure every existing non-epithelialized stage III or IV pressure ulcer or pressure ulcer that is unstageable due to the presence of slough or eschar) to determine which has the largest surface dimension (length x width).
  - Depth should not be considered in determining which pressure ulcer is largest.
- Once the largest pressure ulcer has been determined, report length (M1310), width (M1312), and depth (M1314) dimensions for that pressure ulcer.
  - Depth for a wound covered/filled with eschar can be entered as 00.0.

M1320 Most Problematic

- (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

M1320 Most Problematic

- "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.
- 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.

M1322 Number of Stage I

- (M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

M1324 Stage Problematic Unhealed

- (M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:
  - ☐ 1 - Stage I
  - ☐ 2 - Stage II
  - ☐ 3 - Stage III
  - ☐ 4 - Stage IV
  - ☐ NA - No observable pressure ulcer or unhealed pressure ulcer
- Refer to NPUAP and WOCN for guidance

Test Your Knowledge

- Patient admitted for aftercare post skin graft of a Stage III pressure ulcer of the hip. The autologous graft is noted to be sutured in place and the bed of the ulcer is not visible. The graft appears to be healthy, without signs or symptoms of infection, breakdown, or rejection and with complete re-epithelialization at the edges.
- At the SOC, what is the appropriate response for M1308, M1320, and M1324?

Test Your Knowledge Answer

- M1308 - Current Number = All Zero's except Row b (stage III) Column 1 = 1
- M1320 - Status = 0 - Newly epithelialized
- M1324 - Stage = 3 - Stage III

M1330 Stasis Ulcer Assessment

- (M1330) Does this patient have a Stasis Ulcer?

☐ 0 - No [Go to M1340]
☐ 1 - Yes, patient has BOTH observable and unobservable stasis ulcers
☐ 2 - Yes, patient has observable stasis ulcers ONLY
☐ 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) [Go to M1340]

- If mixed arterial & venous ulcers, review WOCN Quick Assessment Leg Ulcers:
  - Consider venous ulcers in M1330 – M1334
  - Consider arterial ulcers in M1350 if receiving intervention

M1332 M1334 Stasis Ulcer Assessment

- (M1332) Current Number of (Observable) Stasis Ulcer(s):
  - ☐ 1 - One
  - ☐ 2 - Two
  - ☐ 3 - Three
  - ☐ 4 - Four or more
- (M1334) Status of Most Problematic (Observable) Stasis Ulcer:
  - ☐ 0 - Newly epithelialized
  - ☐ 1 - Fully granulating
  - ☐ 2 - Early/partial granulation
  - ☐ 3 - Not healing

M1334 Stasis Ulcer Tips

- Once a stasis ulcer has completely epithelialized, it is considered healed
  - Do not report as a current stasis ulcer.
  - The response option “Newly epithelialized” should not be selected for a healed stasis ulcer, as a completely epithelialized (healed) stasis ulcer is not reported as a stasis ulcer on OASIS

M1340 M1342 Surgical Wound Assessment

- (M1340) Does this patient have a Surgical Wound?
  - ☐ 0 - No [Go to M1350]
  - ☐ 1 - Yes, patient has at least one (observable) surgical wound
  - ☐ 2 - Surgical wound known but not observable due to non-removable dressing [Go to M1350]
- (M1342) Status of Most Problematic (Observable) Surgical Wound:
  - ☐ 0 - Newly epithelialized
  - ☐ 1 - Fully granulating
  - ☐ 2 - Early/partial granulation
  - ☐ 3 - Not healing

.

M1340-M1342 Surgical Wound Assessment Tips

- A surgical site closed primarily with sutures, staples, bonding agent is a surgical wound until re-epithelization has been present for 30 days.
- Once a wound becomes a scar (after 30 days of complete epithelialization with no S/S of complication) it is no longer reported here unless it is an implanted venous access or infusion device.
- If the only surgical wound considered for this item is an implanted venous access or infusion device select response 0 when the implantation site has been completely epithelialized for longer than 30 days.
- Refer to Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at http://www.wocn.org.
- If patient has one observable wound & one unobservable wound – best response is 1.
- A muscle flap, skin advancement flap, or rotational flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer.
-

Healing Status

- The presence of a scab does not automatically equate to a "not healing" response. The clinician must first assess if the wound is healing entirely by primary intention (complete closure with no openings), or if there is a portion healing by secondary intention, due to dehiscence or interruption of the incision.
- Primary Intention: Surgical incisions healing by primary intention do not granulate, therefore the only appropriate responses would be 0-Newly epithelialized or 3-Not healing. If the wound is healing solely by primary intention, observe if the incision line has re-epithelialized. (If there is no interruption in the healing process, this generally takes within a matter of hours to three days.) If there is not full epithelial resurfacing such as in the case of a scab adhering to underlying tissue, the correct response would be "Not healing" for the wound healing by primary intention.
- Secondary Intention: If it is determined that there is incisional separation, healing will be by secondary intention, and the clinician will then have to determine the status of healing. Surgical incisions healing by secondary intention do granulate, therefore may be reported as "Not healing," "Early/partial granulation," "Fully granulating," and eventually "Newly epithelialized."

Types of Surgical Wounds

- Abscess surgically excised
- Arthrocentesis Site (arthroscopy)
- A-V Shunt/Fistula/grafts*
- Central Venous Sites*
- Drain Site
- Excisional Biopsy Site
- Implanted Infusion Device*
- I & D excision necrotic mass
- I & D mesh
- I & D appliances or structures
- Incisions
- Incision for Mammmosite
- Kyphoplasty – open approach
- LVAD cannula exit site
- Mediport sites*
- Muscle Flap
- Ostomy Takedown/Reversal Wound
- Paracentesis Site (w/drain) (A-V shunt)
- Peritoneal dialysis catheter (exit site)
- Pin Sites
- Port-a-cath*
- Punch biopsy Site (skin CA lesion)
- Shave biopsy site (skin CA lesion)
- Skin graft donor site
- Thoracentesis Site (arthroscopy)
- Trauma resulting in surgical repair of organs, ligaments etc.
- Venous Access Device*
- Wounds w/drains

**Even if not presently functional*

Not a Surgical Wound

- Bowel Ostomy (exception takedown – then Yes)
- Bowel Ostomy allowed to heal on its own
- Callus removed
- Cardiac cath performed via puncture
- Cataract surgery of eye
- Chest tube site (thoracotomy)
- Debridement of skin graft
- Fistula (complication of surgery)
- Gynecological surgical procedure via vaginal approach
- I&D of an abscess
- Ileal conduit (ileostomy)
- Kyphoplasty – percutaneous approach
- Needle aspiration
- Pacemakers (after original incision is healed)
- PICC Line (peripherally inserted)
- PICC, tunneled
- Retention sutures that utilizes buttons
- Surgery to mucosal membranes
- Suprapubic tube site (cystostomy)
- Suturing of traumatic wound
- Thoracostomy (chest tube)
- VP shunt for hydrocephalus (after initial incision healed)

Test Your Knowledge

- A patient had a “PICC” catheter inserted centrally into the internal jugular. Is this considered a central line when scoring M1340, Surgical Wounds?

- Central venous catheters or central lines are those with the catheter tip located in the superior vena cava. Central lines can be peripherally inserted (i.e., basilic or cephalic vein in upper arm, or femoral vein in the groin) or centrally inserted (i.e., internal jugular vein in the neck, or subclavian or axillary vein in the chest). Central lines that are centrally inserted (as in the internal jugular example) ARE considered surgical wounds for M1340 because of the central insertion, even if the type of catheter inserted into the central vein was intended to be inserted peripherally. Central lines that are peripherally inserted are not considered surgical wounds.

Test Your Knowledge

- If the patient had a pressure ulcer and the post-op surgical report states it was surgically excised and closed without placement of a muscle flap, do we still have a Stage 4 pressure ulcer-the original etiology or did this become a surgical incision?

- If all the tissue damaged by pressure is removed surgically, e.g. amputation or surgical excision, there is no longer a pressure ulcer. It becomes a surgical wound until healed.

M1350 Skin Lesion or Open Wound Assessment

- (M1350) Does this patient have a Skin Lesion or Open Wound, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?

☐ 0 - No
☐ 1 – Yes

M1350 Skin Lesion or Open Wound Assessment Tips

- Skin lesions or open wounds that are **not** receiving clinical intervention from the home health agency should not be considered when responding to this question.
- Sores, skin tears, burns, ulcers, rashes, edema cysts etc., are all considered lesions.
- Persistent redness without a break in the skin is also considered a lesion.
- PICC line and peripheral IV sites are considered skin lesions / open wounds.
- Ostomies, other than bowel ostomies, (e.g., tracheostomy, thoracostomy, urostomy) ARE considered to be skin lesions or open wounds if clinical interventions (e.g., cleansing, dressing changes) are being provided by the home health agency during the home health care episode.

Next Session:

April 9, 2014
2:00 – 3:00PM EST

Some Highlights:
Functional Questions
M1800-M1900
ADL& IADLs