

Clinical Update: MDS 3.0 Section M Skin Conditions



Elizabeth A. Ayello

PhD, RN, ACNS-BC, CWON, MAPWCA, FAAN

- Faculty Excelsior College of Nursing, Albany, NY
- Senior Advisor, The John A. Hartford Institute for Geriatric Nursing, New York, NY
- President Ayello, Harris & Associates, New York, NY
- Clinical Associate Editor, Advances in Skin & Wound Care, Ambler, PA
- Executive Editor, World Council of Enterostomal Therapists Journal, Australia
- Co-Director, International Interprofessional Wound Care Course, (IIWCC) University of Toronto
- Co-Secretary WUWHS 2008-2012
- 1999 NPUAP President

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elizabeth@ayello.com



Disclaimer and Disclosures

- Dr Ayello is not an employee of CMS nor do her opinions or this presentation represent official CMS statements. Consult official CMS documents for compliance with regulations.
- Dr. Ayello was a consultant to CMS on F TAG 314 and is currently working with CMS in the development of CMS Train the Trainer educational materials for MDS 3.0 Section M.
- Dr Ayello has disclosed to NPUAP her other financial relationships including those with industry partners.

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Participants will:

- Describe the **major changes** in MDS 3.0 section M Skin Conditions.
- Review the **skill set** that clinicians need as a result of the changes in section M.

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Where have all the pressure ulcers gone?



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Long Term Care


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Section M

Skin Conditions

V1.01

Section M -MDS 3.0 is greatly expanded



 Minimum Data Set (MDS) 3.0 Section M August 2010
 

M0100 Determination of Pressure Ulcer Risk

- Reflects multiple approaches for determining a resident's risk for developing a pressure ulcer.
 - Presence or indicators of pressure ulcers
 - Assessment using a formal tool
 - Physical examination of skin and/ or medical record

M0100. Determination of Pressure Ulcer Risk



↓ Check all that apply

A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device


B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)



C. Clinical assessment

Z. None of the above

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M0100A Risk Factors



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M0100B Formal Assessment/ Tools

- Braden Scale®
 - www.bradenscale.org
 - www.hartfordign.org
- Norton Scale
 - <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hsahcpr&part=A4521>
- Other
 - Institution scales

M0100. Determination of Pressure Ulcer Risk



↓ Check all that apply

A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device

B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)



C. Clinical assessment

B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)

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M0100C Clinical Assessment

- Observe the resident's skin.
- Review the medical record.
- Imperative to determine etiology of all wounds and lesions.
- Consider using mnemonics that capture key risk factors.
 - o HALT® is one example.
 - © Ayello

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M0150 Risk of Pressure Ulcers



- Determine if resident is at risk for pressure ulcers.
- Recognize/ evaluate each resident's risk factors.
- Identify/ evaluate all areas at risk of constant pressure.
- Determine if resident is at risk.

M0150. Risk of Pressure Ulcers

Enter Code **Is this resident at risk of developing pressure ulcers?**

0. No

1. Yes

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M0300 Guidelines₁

1. Determine deepest anatomical stage of each pressure ulcer.
2. Identify unstageable pressure ulcers.
3. Determine "present on admission."



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M0300 Guidelines

- **No** more reverse staging
- Do **not** code lesions not primarily related to pressure here.
- **Initial** numerical staging of ulcers **after debridement** or **sDTI** that declares itself should be **coded in terms of what is assessed** (seen and palpated, i.e. visible tissue, palpable bone) during the look-back period.



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New Staging Definitions

- Resources:
 - www.npuap.org
 - Free diagrams of ulcer stages can be downloaded for educational use.
- CMS has **adapted** these definitions.



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Category/ Stage 1 Pressure Ulcer

- Intact skin with **non-blanchable redness** of a localized area usually over a bony prominence.
- **Darkly pigmented skin** may not have visible blanching.
- Color may differ from the surrounding area.



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M0300B Stage 2 Pressure Ulcers Coding Instructions

1. **Number** of Stage 2 pressure ulcers
2. Number of Stage 2 pressure ulcers **present upon admission/ reentry**
 - Number of pressure ulcers first noted at time of admission
 - Number of pressure ulcers acquired during a hospital stay if being readmitted
3. **Date** of **oldest** Stage 2 pressure ulcer
 - Code suspected deep tissue injury at M0300G.



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Category/ Stage 2 Pressure Ulcer₁

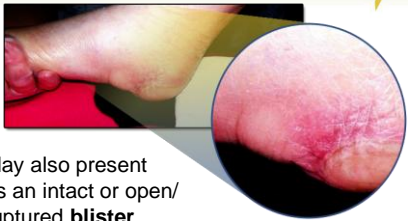
- **Partial thickness** loss of dermis presenting as:
 - **Shallow open** ulcer
 - Red or pink wound bed
 - **Without slough**



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Category/ Stage 2 Pressure Ulcer₂



- May also present as an intact or open/ruptured **blister**.

M0300B Assessment Guidelines₂

- Stage 2 ulcers will **generally** lack the surrounding characteristics found with a deep tissue injury.
- Blood-filled blisters related primarily to pressure are more likely than serous filled blisters to be associated with a suspected deep tissue injury.
- Ensure, again, a complete, and comprehensive, assessment of the resident and the site of injury.
- Do **not** code skin tears, tape burns, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury in M0300B.

Category/ Stage 3 Pressure Ulcer

- **Full thickness** tissue loss.
- Subcutaneous **fat may be visible** but bone, tendon or muscle are **not** exposed.
- **Slough may be present** but does not obscure the depth of tissue loss.
- **May** include undermining and tunneling.



Category/ Stage 4 Pressure Ulcer

- **Full thickness** tissue loss with **exposed bone, tendon or muscle**.
- **Slough or eschar may be present** on some parts of the wound bed.
- **Often** includes undermining and tunneling.
- Depth varies by anatomical location (bridge of nose, ear, occiput, and malleolus ulcers can be shallow).



Unstageable Pressure Ulcers

- Three types to differentiate
- Number of these unstageable pressure ulcers **present upon admission/ reentry**

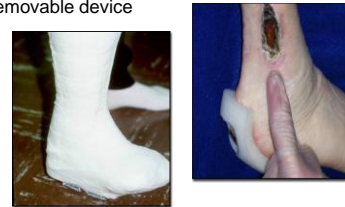
E. Unstageable - Non-removable dressing:

F. Unstageable - Slough and/or eschar:

G. Unstageable - Deep tissue:

M0300E Unstageable Non-Removable Device

- Ulcer covered with eschar under plaster cast
- **Known** but not stageable because of the non-removable device



M0300E Unstageable Non-Removable Dressing

- **Known** but not stageable because of the non-removable dressing







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M0300F Unstageable Slough and/ or Eschar

- **Known** but not stageable related to coverage of wound bed by slough and/ or eschar
- Full thickness tissue loss
- Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/ or eschar (tan, brown or black) in the wound bed







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M0300G Unstageable Suspected Deep Tissue Injury₁

- Localized area of discolored (darker than surrounding tissue) intact skin.
- Related to damage of underlying soft tissue from pressure and/ or shear.
- Area of discoloration 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.






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M0300E, M0300F, M0300G Coding Instructions

- Code **number** of each type of pressure ulcer.
- Code number of each type of ulcer **present upon admission/ reentry**.
- Do not code M0300G when a lesion related to pressure presents with an intact blister **and** the surrounding or adjacent soft tissue does **not** have the characteristics of Deep Tissue Injury.
- Code under M0300B Unhealed Pressure Ulcers -- Stage 2.



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Revised Figure 4- Blistered Pressure ulcers and sDTI (figure from Ayello, EA, Levine, JM, Roberson S, Ayello EA. CMS updates on MDS 3.0 Section M:Skin Conditions.- Change in coding of blister pressure ulcers. *Advances in Skin and Wound Care*. 2010;23(9):394.396-7.1)




Appearance	Acute Care	LTC MDS 3.0 (If signs of suspected deep tissue injury)	LTC MDS 3.0 If (No signs of suspected deep tissue injury)
 Serous Filled Blister	Stage 2 Code	Unstageable sDTI Code under section M0300G	Stage 2 Code under section M0300B
 Blood filled Blister	sDTI- depth unknown	Unstageable sDTI Code under section M0300G	Stage 2 Code under section M0300B
 Intact purple maroon skin injury due to pressure	sDTI- depth unknown	Unstageable sDTI Code under section M0300G	


Table © Ayello 2010
Photos courtesy of Dot Weir and Cindy Labish

Item M0610

Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar

Dimensions of a Pressure Ulcer What to Measure

- Identify pressure ulcer with the largest surface area from the following:
 - Unhealed (nonepithelialized) Stage 3 or 4
 - Unstageable pressure ulcer related to slough or eschar
- Measure every Stage 3, Stage 4, and unstageable related to slough or eschar pressure ulcer to determine the largest.



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M0610 Coding Instructions

- Enter pressure ulcer dimensions in centimeters.
- If depth is unknown, enter a dash in each space.

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
 Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0.
 If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

cm A. Pressure ulcer length: Longest length from head to toe


cm B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

cm C. Pressure ulcer depth: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

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M0610A Length

- Measure the longest length from head to toe using a disposable device.



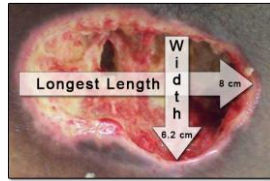
Head

Toe

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M0610B Width

- Measure widest width of the pressure ulcer side to side perpendicular (90° angle) to length.
- The depth of this pressure ulcer is 3.7 cm.




Head

Toe

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M0610C Depth

- Moisten a cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water.
- Place applicator tip in deepest aspect of the wound and measure distance to the skin level.



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M0700 Most Severe Tissue Type for Any Pressure Ulcer

- Determine type(s) of tissue in the wound bed.
- Code for most severe type of tissue present in pressure ulcer wound bed.
- Code for most severe type if wound bed is covered with a mix of different types of tissue.


M0700. Most Severe Tissue Type for Any Pressure Ulcer
 Select the best description of the most severe type of tissue present in any pressure ulcer bed.

Enter Code

- Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
- Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
- Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
- Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

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MO700 Epithelial Tissue



Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin

MO700 - Most Severe Tissue Type for Any Pressure Ulcer


Select the best description of the most severe type of tissue present in any pressure ulcer bed

Enter Code

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

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MO700 Granulation Tissue



Granulation tissue - pink or red tissue with shiny, moist, granular appearance

MO700 - Most Severe Tissue Type for Any Pressure Ulcer


Select the best description of the most severe type of tissue present in any pressure ulcer bed

Enter Code

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

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MO700 Slough



Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous

MO700 - Most Severe Tissue Type for Any Pressure Ulcer


Select the best description of the most severe type of tissue present in any pressure ulcer bed

Enter Code

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

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MO700 Necrotic Tissue (Eschar)



Necrotic tissue (Eschar) - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

MO700 - Most Severe Tissue Type for Any Pressure Ulcer


Select the best description of the most severe type of tissue present in any pressure ulcer bed

Enter Code

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

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Does this look familiar?



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PUSH Tool: Version 3.0

Length	0 0 cm ²	1 <0.3 cm ²	2 0.3-0.6cm ²	3 0.7-1.0 cm ²	4 1.1-2.0cm ²	5 2.1-3.0 cm ²	
X Width		6 3.1-4.0 cm ²	7 4.1-8.0 cm ²	8 8.1-12.0 cm ²	9 12.1-24.0 cm ²	10 >24.0 cm ²	Sub-Score
Exudate Amount	0 None	1 Light	2 Moderate	3 Heavy			Sub-Score
Tissue Type	0 Closed	1 Epithelial Tissue	2 Granulation Tissue	3 Slough	4 Necrotic Tissue		Sub Score
							Total Score

Source: NPUAP (www.npuap.org)

M0800 Assessment Guidelines

- Complete only if this is **not** the first assessment since the most recent admission (A0310E = 0).
- Look-back period is back to the ARD of the prior assessment.

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBR, PPS, or Discharge)
 Complete only if A0310E = 0
 Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBR, PPS, or Discharge). If no current pressure ulcer at a given stage, enter 0.

Enter/Date	<input type="checkbox"/> A. Stage 2
Enter/Date	<input type="checkbox"/> B. Stage 3
Enter/Date	<input type="checkbox"/> C. Stage 4



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M0900 Healed Pressure Ulcers

- Complete only if this is **not** the first assessment since the most recent admission (A0310E=0).

M0900. Healed Pressure Ulcers
 Complete only if A0310E = 0

A. Were pressure ulcers present on the prior assessment (OBR, PPS, or Discharge)?
 0. No → Skip to M1030, Number of Venous and Arterial Ulcers
 1. Yes → Continue to M0900, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBR, PPS, or Discharge) that have completely closed (re-epithelialized) with epithelium. If no healed pressure ulcer at a given stage since the prior assessment (OBR, PPS, or Discharge), enter 0.

Enter/Date	<input type="checkbox"/> B. Stage 2
Enter/Date	<input type="checkbox"/> C. Stage 3
Enter/Date	<input type="checkbox"/> D. Stage 4



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M1030 Coding Instructions

- Enter the total number of venous and arterial ulcers present.

M1030. Number of Venous and Arterial Ulcers

Enter Number

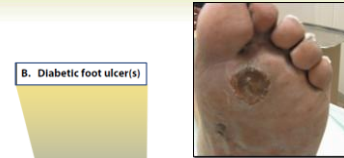
Enter the total number of venous and arterial ulcers present



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M1040B Diabetic Foot Ulcers



B. Diabetic foot ulcer(s)

M1040. Other Ulcers, Wounds and Skin Problems
 Check all that apply

Foot Problems

<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot

Other Problems

<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
--------------------------	---



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M1200 Skin and Ulcer Treatments₁

M1200. Skin and Ulcer Treatments
 Check all that apply

<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided



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https://www.cms.gov/NursingHomeQuality/Inits/45_NHQIMDS30TrainingMaterials.asp

The following files are now available under the downloads section of the CMS webpage:

- **MDS 3.0 Training Slides - MDS 3.0 PowerPoint Training Slides** to facilitate MDS 3.0 training.
- **MDS 3.0 Instructor Guides - MDS 3.0 Instructor Guides** to facilitate MDS 3.0 training.
- **MDS 3.0 Training Materials Change Document September 2010** - changes to the Training Slides and Instructor Guides from previously published versions.
- **MDS 3.0 Training Aides** – contains algorithms and assessment aides that may be helpful when performing assessments or coding the MDS.

Source: CMS website



Do you have questions?

- Questions regarding the "MDS 3.0 RAI Manual" on this page should be directed to **MDS30Comments@cms.hhs.gov**
- Please note that CMS will not be providing an individualized response to each inquiry; however, CMS will make sure the issues or comments are addressed in the upcoming MDS 3.0 training sessions or updates to the information provided on this page.

Source: CMS website



Home Care

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Outcome and Assessment Instrument Set OASIS- C

- Approved 7/09
- Modified version of OASIS B1
- Effective 1/1/2010
- Website

http://www.cms.hhs.gov/HomeHealthPPS/15_OASIS_Attachment_D_Guidance.asp

http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp

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Oasis C- Integumentary Status Chapter 3 F-1 to F-21

Integumentary Status Items M1300 – M1350

- **M1300** Was patient assessed for risk of Developing Pressure Ulcers?
- **M1302** At risk of developing pressure ulcer
- **M1306** Unhealed stage II or higher pressure ulcer
- **M1307** Date of oldest stage II pressure ulcer
- **M1308** Current number of unhealed pressure ulcer



Example - M1308

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

Stage description - unhealed pressure ulcers	Column 1 Complete at SOPROCFU & DIC	Column 2 Complete at PU & DIC
	Number of Ulcers	Number of Ulcers
1. Stage I: 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.	---	---
2. Stage II: Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	---	---
3. Stage III: Full thickness skin 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.	---	---
4.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	---	---
4.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar	---	---
4.3 Unstageable: Suspected deep tissue injury in evolution.	---	---



Oasis C- Integumentary Status Chapter 3 F-1 to F-21

- **M1310** Pressure Ulcer Longest length
- **M1312** Pressure Ulcer width
- **M1314** Pressure ulcer Depth
- **M1320** Status of most problematic (observable pressure ulcer)
- **M1322** Current number of Stage I pressure ulcer
- **M1324** Stage of most problematic unhealed (observable) pressure ulcer



Oasis C - Integumentary Status Chapter 3 F-1 to F-21

- **M1330** Stasis Ulcer Present
- **M1332** Current number of stasis ulcer(s)
- **M1334** Status of most problematic (observable) status ulcer
- **M1340** Surgical wound present
- **M1342** Status of most problematic (observable) Surgical wound
- **M1350** Other Skin lesion or Open wound



<http://www.wocn.org/pdfs/GuidanceOASIS-C.pdf>

Wound Ostomy and Continence Nurses Society Guidance on OASIS-C Integumentary Items 8 page document



Wound
Ostomy and
Continence
Nurses
Society



Acute Care

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Continuity Assessment Record & Evaluation C.A.R.E. Tool

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Framework for CARE Patient Assessment tool

- I. Administrative Items
- II. Admission Information
- III. Current Medical Items
- IV. Cognitive Status
- V. Impairments
- VI. Functional Status
- VII. Engagement
- VIII. Frailty/Life Expectancy
- IX. Discharge Status
- X. Other Useful Information



Slide from S. Baranoski



CARE TOOL

25 pages

Slide from S. Baranoski



CMS : Continuity Assessment Record and Evaluation

III. Current Medical Items

G. Skin Integrity

- **G1- 4 PRESENCE OF PRESSURE ULCERS**
- **G5 Major Wounds, excluding pressure ulcers**
- **G6 Turning Surfaces Not Intact**

Slide from S. Baranoski



So what does all this mean?

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And the care settings are aligning in terms of PU.....



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So what is happening?

- **Emphasis on quality and patient safety**
- **System is moving to patient centered rather than provider centered**
- **Use the assessment data to develop a comprehensive plan of care**
- **Care needs to be evidence based**
- **Communicate care across settings**
- **All disciplines are to be accountable**
- **Need for education is great- inconsistent wound and skin care education and practice**
- **Need to decrease pressure ulcer incidence**

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Ayello's Suggested Competencies

Pre MD

- **Present on Admission**
- **Risk Assessment**
- **Etiology and wound identification**
- **Measurement of Ulcer**
- **Documenting wound characteristics**

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Pre MD Present on Admission

- **Now on MDS 3.0 and OASIS C**
- **Requires clinical observation of the person**
- **System for capturing the assessment**
- **Are our assessment tools and wound detection adequate?**

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Pre
MD

Risk Assessment



- **On all three tools** (MDS 3.0, OASIS C, C.A.R.E)
- **Need to review institution policies**
- **Frequency varies per care setting**
- **Interdisciplinary communication of risk**

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Are some intrinsic factors beyond usual care measures?

- *Shanks, H.T, Kleinhelter, P, Baker, J. Skin failure: A retrospective review of patients with hospital-acquired pressure ulcers. WCET 2009, 29(1):6-10*
- *Brennan, M.R., Trombley, K. Kennedy Terminal Ulcers – a palliative care unit's experience over a 12-month period of time. WCET 2010, 30(3):20-22*

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Pre
MD

Etiology and Wound Identification



- **Different types of wounds included and excluded on the different CMS tools**
- **Getting the etiology correct can be challenging**
- **Increased need for interdisciplinary collaboration**

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Increased need for ability to differentiate wounds

- **Pressure Ulcers**



- **Vascular ulcers**

- Venous
- Arterial



- **Neuropathic/DM ulcers**
- **Other skin problems**



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But what about this?



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Photo J. Fore



Or this skin?




Photo Dr. J. Fore

 **Pre MD Measurement of Ulcer** 

- Now part of all 3 tools
- Number of the section is different on each tool
 - OASIS C M1310, M1312, M1314
 - MDS 3.0 M0610
 - C.A.R.E. G3
- Accurate measurement of pressure ulcers in centimeters

Size does matter



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 **NPUAP recommendation for measuring also part of MDS 3.0 Section M Skin conditions**

Use a measuring device


- Measure head to toe
- Longest length **head to toe**
- **Widest width** side to side
 - Perpendicular (90°) to length

Source: NPUAP. Inside the NPUAP volume 21, Fall 2007 Page 2, www.npuap.org

 **Pre MD Documenting wound characteristics** 


- Tissue type required on MDS 3.0 and OASIS –C but scales not the same



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 **Stage 2 Pressure ulcer**

- How should this be coded in terms of tissue on MDS 3.0?



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 **Minimal pressure ulcer documentation, *but is this the same in all care settings?***

- **S**ize
- **L**ocation and staging
- **E**xudate
- **E**dge and surrounding tissue
- **P**ain  www.hartfordign.org
- **B**ed- color and type of wound tissue 




From Tag F 314

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 **Documentation across care settings** 

Good Transitions

None of the tools (OASIS C, MDS 3.0, C.A.R.E.) are comprehensive assessments; Comprehensive assessments still needed

C.A.R.E Acute care	MDS 3.0 Long Term Care	OASIS C Home Care
		

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The key will be Electronic Health Records



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The end or the beginning?

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