

OASIS ITEM:						
(M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)						
	Pressure Ulcer Stages	0	1	2	3	4 or more
a)	Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.	0	1	2	3	4 or more
b)	Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.	0	1	2	3	4 or more
c)	Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.	0	1	2	3	4 or more
d)	Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.)	0	1	2	3	4 or more
e)	In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes					
DEFINITION:						
Identifies the number of pressure ulcers at each stage present at the time of assessment. Definitions of pressure ulcer stages derive from the National Pressure Ulcer Advisory Panel.						
TIME POINTS ITEM(S) COMPLETED:						
Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility						
RESPONSE—SPECIFIC INSTRUCTIONS:						
<ul style="list-style-type: none"> • Circle the number of ulcers appropriate for each stage. • If there are NO ulcers at a given stage, circle "0" for that stage. • Mark a response for each part of this item: a), b), c), d), and e). • A pressure ulcer covered by eschar or a nonremovable cast or dressing, cannot be staged, and "yes" should be selected for response (e). • A muscle flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer. • A pressure ulcer that has been surgically debrided remains a pressure ulcer. It <u>does not</u> become a surgical wound. 						
ASSESSMENT STRATEGIES:						
Inspect the skin over bony prominences carefully, particularly for patients with known risk factors for pressure ulcers. (See M0445 for listing of risk factors.)						
Recognizing erythema (a Stage 1 ulcer) in darker-skinned individuals requires close examination. Inspect for change in texture, a bluish/purplish skin tone, or extremely dry skin in areas over bony prominences. Palpate for warmth, tissue consistency (firm or boggy feel), or slight edema in these areas. Interview for sensation changes (pain, itching).						
The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed.						
Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). If a pressure ulcer is Stage 3 at SOC and is granulating at the follow-up visit, the ulcer remains a Stage 3 ulcer. 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 impossible 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.						
Consult published guidelines of NPUAP (www.npuap.org) for additional clarification and/or resources for training.						