

Wound, Ostomy and Continence Nurses Society's Guidance on OASIS-C2 Integumentary Items: Best Practice for Clinicians



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Acknowledgments

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The Wound, Ostomy and Continence Nurses Society™ suggests the following format for bibliographic citations:

Wound, Ostomy and Continence Nurses Society. (2016). *Wound, Ostomy and Continence Nurses Society's guidance on OASIS-C2 integumentary items: Best practice for clinicians*. Mt. Laurel, NJ: Author.

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Wound, Ostomy and Continence Nurses Society's Guidance on OASIS-C2 Integumentary Items: Best Practice for Clinicians

Introduction

OASIS-C2, scheduled for implementation in January 2017, is a modification to the Outcome and Assessment Information Set (OASIS) that Home Health Agencies must collect in order to participate in the Medicare program (Centers for Medicare & Medicaid Services [CMS], 2015a). The new version of OASIS-C2 includes some modifications in the integumentary status item set including use of Arabic numerals (1, 2, 3, 4) for pressure ulcer staging (CMS, 2015a, 2015b).

Note: The terms, definitions, and illustrations describing pressure ulcer stages in this document do not reflect the National Pressure Ulcer Advisory Panel's (NPUAP) 2016 Pressure Injury Classification System and related illustrations. When discrepancies exist between the NPUAP's Pressure Injury terms, definitions, and illustrations and the OASIS-C2 scoring instructions, the home care clinician should rely on the CMS OASIS-C2 Manual instructions (CMS, 2016).

Purpose

The Wound, Ostomy and Continence Nurses Society (WOCN) developed the following guidelines to facilitate the classification of wounds by home health clinicians. This guidance document was developed by consensus among a panel of WOCN Society content experts. The document updates a previous document: *Wound, Ostomy and Continence Nurses Society's Guidance on OASIS-C1 Integumentary Items: Best Practice for Clinicians* (WOCN, 2014). The original guidance document was developed in 2001 and has been previously updated in 2006 and 2009.

OASIS-C2 Integumentary Status (CMS, 2015b)

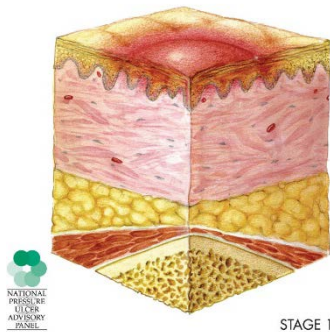
- **Item Set**
 - **(M1300) Pressure Ulcer Assessment:** Was this patient assessed for **Risk of Developing Pressure Ulcers?**
 - **(M1302)** Does this patient have a **Risk of Developing Pressure Ulcers?**
 - **(M1306)** Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers.)

- **Pressure Ulcer Definition**

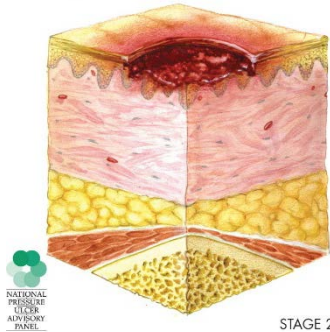
In the OASIS-C2 Guidance Manual (CMS, 2016), in accordance with the NPUAP's 2007 definition, "pressure ulcers are defined as localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction" A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated (NPUAP, 2007; NPUAP, European Pressure Ulcer Advisory Panel [EPUAP], & Pan Pacific Pressure Injury Alliance, 2014, p.12).

Note: In 2009, friction was removed from the NPUAP and EPUAP's definition of a pressure ulcer (NPUAP & EPUAP, 2009).

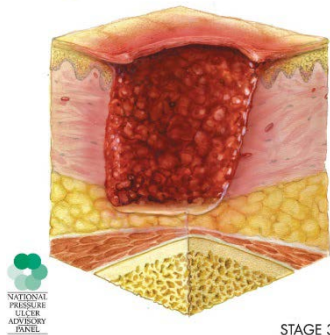
- **Pressure Ulcer Classification System** (NPUAP et al., 2014):



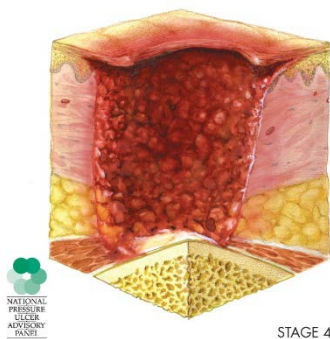
Category/Stage I: Nonblanchable erythema. Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” individuals (a heralding sign of risk; p. 12).



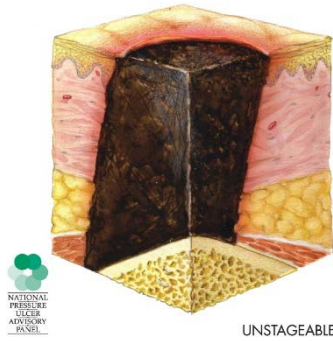
Category/Stage II: Partial thickness skin loss. Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury. (p. 12)



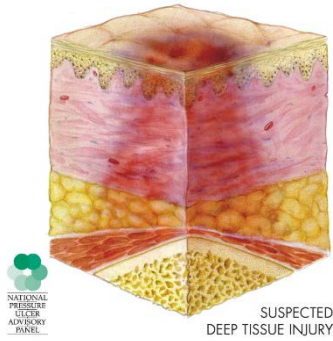
Category/Stage III: Full thickness skin loss. Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable. (p. 12)



Category/Stage IV: Full thickness tissue loss. Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. (p. 13)



Unstageable: Depth unknown. Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as ‘the body’s natural (biological) cover and should not be removed. (p. 13)



Suspected Deep Tissue Injury: Depth unknown. 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. (p. 13)

- **Item Set Continued**

- **(M1307) The Oldest Stage 2 Pressure Ulcer** that is present at discharge. (Excludes healed Stage 2 pressure ulcers.)
- **(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage.**
- **(M1313) Worsening in Pressure Ulcer Status since SOC/ROC.**
- **(M1320) Status of Most Problematic Pressure Ulcer that is Observable.** (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device.)
 - **0 – Newly epithelialized**
 - **1 – Fully granulating**
 - **2 – Early/partial granulation**
 - **3 – Not healing**
 - **NA – No observable pressure ulcer**
- **Definitions for M1320:**
 - **Newly epithelialized**
 - Wound bed completely covered with new epithelium; and
 - no exudate; and
 - no avascular tissue (eschar and/or slough); and
 - no signs or symptoms of infection.
 - **Fully granulating**
 - Wound bed filled with granulation tissue to the level of the surrounding skin; and
 - no dead space; and
 - no avascular tissue (eschar and/or slough); and
 - no signs or symptoms of infection; and
 - wound edges are open.
 - **Early/partial granulation**
 - Wound bed covered with $\geq 25\%$ of granulation tissue; and
 - wound bed covered with $< 25\%$ of avascular tissue (eschar and/or slough); and
 - no signs or symptoms of infection; and
 - wound are edges open.
 - **Not healing**

- Wound with $\geq 25\%$ avascular tissue (eschar and/or slough); or
- signs/symptoms of infection; or
- clean but nongranulating wound bed; or
- closed/hyperkeratotic wound edges; or
- persistent failure to improve despite appropriate and comprehensive wound management.

- **Item Set Continued**

- **(M1322) Current Number of Stage 1 Pressure Ulcers.**
- **(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable.**
(Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)
- **(M1330) Does this patient have a Stasis Ulcer?**
- **(M1332) Current Number of Stasis Ulcer(s) that are Observable.**
- **(M1334) Status of Most Problematic Stasis Ulcer that is Observable.**
 - **1 – Fully granulating**
 - **2 – Early/partial granulation**
 - **3 – Not healing**
- **Definitions for M1334:**
 - **Fully granulating**
 - Wound bed filled with granulation tissue to the level of the surrounding skin; and
 - no dead space; and
 - no avascular tissue (eschar and/or slough); and
 - no signs or symptoms of infection; and
 - wound edges are open.
 - **Early/partial granulation**
 - Wound bed covered with $\geq 25\%$ of granulation tissue; and
 - wound bed covered with $< 25\%$ of avascular tissue (eschar and/or slough); and
 - no signs or symptoms of infection; and
 - wound are edges open.
 - **3 - Not healing**
 - Wound with $\geq 25\%$ avascular tissue (eschar and/or slough); or
 - signs/symptoms of infection; or
 - clean but nongranulating wound bed; or
 - closed/hyperkeratotic wound edges; or
 - persistent failure to improve despite appropriate and comprehensive wound management.

- **Item Set Continued**

- **(M1340) Does this patient have a Surgical Wound?**
- **(M1342) Status of Most Problematic Surgical Wound that is Observable:**
 - **0 – Newly epithelialized**
 - **1 – Fully granulating**
 - **2 – Early/partial granulation**
 - **3 – Not healing**
- **Definitions for M1342:**
 - **Newly epithelialized**
 - Wound bed completely covered with new epithelium; and
 - no exudate; and
 - no avascular tissue (eschar and/or slough); and
 - no signs or symptoms of infection.

- **Fully granulating**
 - Wound bed filled with granulation tissue to the level of the surrounding skin; and
 - no dead space; and
 - no avascular tissue (eschar and/or slough); and
 - no signs or symptoms of infection; and
 - wound edges are open.
- **Early/partial granulation**
 - Wound bed is covered with $\geq 25\%$ of granulation tissue; and
 - wound bed is covered with $< 25\%$ of avascular tissue (eschar and/or slough); and
 - no signs or symptoms of infection; and
 - wound edges are open.
- **Not healing**
 - Wound with $\geq 25\%$ avascular tissue (eschar and/or slough); or signs/symptoms of infection; or
 - clean but nongranulating wound bed; or
 - closed/hyperkeratotic wound edges; or
 - persistent failure to improve despite appropriate and comprehensive wound management.
- (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?

Glossary

Avascular. Lacking in blood supply; synonyms are dead, devitalized, necrotic, and nonviable. Specific types of avascular tissue include slough and eschar.

Clean Wound. Wound is free of avascular tissue, purulent drainage, foreign material, or debris.

Closed Wound Edges. Edges of the top layers of epidermis have rolled down to cover the lower edge of the epidermis, including the basement membrane, so that epithelial cells cannot migrate from the wound edges. This condition is also known as epibole. It presents clinically as a sealed edge of mature epithelium, which may be hardened, thickened, and discolored (e.g., yellowish, gray, or white).

Dead Space. A defect or cavity in a wound.

Epidermis. The outermost layer of skin.

Epithelialized. Regeneration of the epidermis across a wound surface.

Eschar. Black or brown avascular tissue; tissue can be loose or firmly adherent, hard, soft or soggy.

Full Thickness. Tissue damage involving a total loss of the epidermis and dermis that extends into the subcutaneous tissue and possibly into the muscle or bone.

Granulation Tissue. The pink/red, moist tissue comprised of new blood vessels, connective tissue, fibroblasts, and inflammatory cells, which fills an open wound when it starts to heal; and typically appears deep pink or red with an irregular, “berry-like” surface.

Healing. A dynamic process involving synthesis of new tissue for repair of skin and soft tissue defects.

Hyperkeratotic. Hard, white/gray tissue surrounding the wound resulting from thickening/hypertrophy of the horny layer (stratum corneum) of the epidermis (Farlex Partner Medical Dictionary, 2012).

Infection. The presence of bacteria or other microorganisms in sufficient quantity to damage tissue or impair healing. Infection has been defined as a bacterial bioburden of equal to or greater than 10^5 colony forming units per gram of tissue or cm^2 swab, and/or the presence of *Beta-hemolytic Streptococci* (NPUAP et al., 2014; Weir & Schultz, 2016). Typical signs and symptoms of infection include purulent exudate, odor, erythema, warmth, tenderness, edema, pain, fever, and an elevated white blood cell count. However, clinical signs of infection may not be present, especially in the immunocompromised patient or the patient with poor perfusion.

Necrotic Tissue. See avascular.

Newly epithelialized. The process of regeneration of the epidermis across a wound surface or regeneration of the epidermis across a wound surface.

Nonepithelialized. Absence of the regeneration of the epidermis across a wound surface.

Nongranulating. Absence of granulation tissue; the wound surface appears smooth as opposed to granular. For example, in a wound that is clean but nongranulating, the wound surface appears smooth and red as opposed to “berry-like”.

Partial Thickness. Tissue damage confined to the skin layers; damage does not penetrate below the dermis and may be limited to the epidermal layers only.

Sinus Tract. A course or path of tissue destruction occurring in any direction from the surface or edge of the wound (also called “tunneling”), which results in dead space with a potential for abscess formation. It can be distinguished from undermining by the fact that a sinus tract involves a small portion of the wound edge; whereas, undermining involves a significant portion of the wound edge.

Slough. Soft, moist, avascular tissue; may be white, yellow, tan, or green; and may be loose or firmly adherent.

Stage IV Structures. Anatomical structures, any of which when visible in a full-thickness pressure ulcer, indicate the wound is reportable as a Stage IV pressure ulcer. Stage IV structures include bone, muscle, tendon, and joint capsule.

Tunneling. See sinus tract.

Undermining. An area of tissue destruction extending under intact skin along the periphery of a wound that is commonly seen in shear injuries. It can be distinguished from a sinus tract by the fact that undermining involves a significant portion of the wound edge; whereas, a sinus tract involves only a small portion of the wound edge.

Unhealed. Absence of the skin’s original integrity.

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Acknowledgment about Content Validation

This document was reviewed in the consensus-building process of the Wound, Ostomy and Continence Nurses Society known as Content Validation.