


Success with Wound Closure
with the use of OASIS



Presented by
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Why Accurate Assessment of Wounds is Imperative

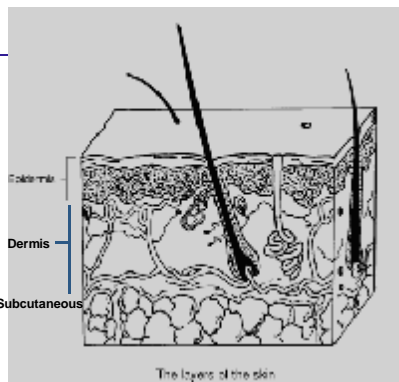
- Oasis responses are used to classify pts into categories for reimbursement
- An HHRG cannot be generated without a completed OASIS
- A small difference in the HHRG can make a **BIG** difference in revenue
- Use of supplies should correlate with diagnosis
- Results are included in Home Health Compare for consumer information

OASIS Answers Drive Care

- Goals are clear: CMS expects no deterioration of wounds, and expects a good percentage of wounds to improve by end of 60 day period of care
- Appropriate care includes aggressive management
 - debridement, cleansing, constant moisture, re-assessment
 - non/slow healing requires stepped up care

Expertise Necessary for Surgical Wound Assessment

- Knowledge of basics of skin and wound healing



Partial Thickness/ Stage II Pressure ulcer

- Partially, or completely through the epidermis, dermis
- No slough or eschar (necrosis)
- No granulation tissue
- Heals by re-epithelialization from within

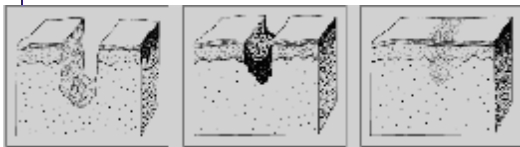
Full Thickness / Stage III or IV pressure ulcers

- Fully through the epidermis, dermis into subcutaneous or deeper tissues
- May have slough or eschar (necrosis)
- Heals by granulation , contraction and epithelialization

Primary Closure




Secondary Intention Closure



Phases of Wound Healing

- Inflammatory phase(1-5 days)
 - Vasoconstriction ÿ vasodilatation
 - Leukocyte migration/macrophage ÿ eliminate bacteria
- Proliferative phase/only Full thickness and Stage III or IV pressure ulcers(5-25 days)
 - Formation of granulation, epithelialization
 - Contraction
- Maturation phase/only Full thickness and Stage III or IV pressure ulcers(may take up to 24 months)
 - Collagen remodeling
 - Strengthening of scar/ tensile strength



**Make sure documentation
and patient record support
OASIS**

**Types of Current Wounds
Addressed by OASIS**

- Pressure ulcers
- Stasis ulcers (venous)
- Surgical Wounds
 - not healed yet
 - open
 - closed
 - dehisced
 - failed flaps

Pressure Ulcers

- A pressure ulcer is 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

Pressure Ulcer Stage I

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.

Further description:

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

NPUAP 2007

Pressure Ulcer Stage II / Partial Thickness

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.

Further description:

Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
*Bruising indicates suspected deep tissue injury

NPUAP 2007

**Pressure Ulcer Stage III /
Full Thickness**

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.

Further description:

- The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers.
- Bone/tendon is not visible or directly palpable.

**Pressure Ulcer Stage IV /
Full Thickness**

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.

Further description:

The depth of a 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. 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.

Unstageable

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.

Further description:

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore 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.

NPUAP 2007

Suspected Deep Tissue Injury:

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. Further description: 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.

OASIS Pressure Ulcers

- MO450 – Current number of pressure ulcers at each stage
 - “a, b, c, d” equal stages “I, II, III, IV”

OASIS Pressure Ulcers: Non-observable

- MO450
 - “e” asks about non-observable pressure ulcers ie, Suspected Deep Tissue Injury and Unstageable
 - Wound is unable to visualized due to an orthopedic device, dressing, etc.
 - A Pressure ulcer cannot be accurately staged until deepest viable tissue layer is visible; wounds covered with slough and eschar (necrosis)

OASIS Pressure Ulcers

- MO460 – Stage of most problematic (Observable) Pressure Ulcer
 - Stage I – IV
 - NA = no observable pressure ulcer



- CMS has directed home health clinicians to code healed pressure ulcers with scar tissue present as pressure ulcers when answering OASIS questions
- Stage them at the worst stage they deteriorated to when they were open wounds

Impact for Increasing Reimbursement

- Admits patient with a stage III pressure ulcer on sacrum
- Also identified and confirmed that a scar on heel was from a previous Stage III pressure ulcer.
- HHRG increases for MO450, because there are 2 or more stage III pressure ulcers.

Impact for Increasing Reimbursement

- Clinician admits a patient for non-wound diagnosis
- During assessment finds a scar from a healed pressure ulcer.
- Confirms that pressure ulcer had been a Stage III
- HHRG increases for MO460, the worst wound is a healed stage III pressure ulcer.

OASIS Pressure Ulcers

- MO464 – Status of Most Problematic (Observable) Pressure Ulcer
- Use the most extensive pressure ulcer
- “Fully Granulating”
 - Granulation tissue to level of surrounding skin or new epithelium
 - No dead space
 - No signs or symptoms of infection
 - Wound edges are open

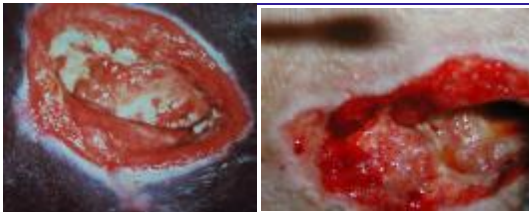
Pressure Ulcers: Fully Granulating



OASIS Pressure Ulcers

- MO464 – Status of Most Problematic (Observable) Pressure Ulcer
- Use the most extensive pressure ulcer
- “Early/Partial Granulation”
 - $\geq 25\%$ of the wound bed is covered with granulation tissue ($< 25\%$ of the wound bed is covered with avascular tissue)
 - May have dead space
 - No signs or symptoms of infection
 - Wound edges are open

MO464: Early/Partial Granulation



OASIS Pressure Ulcers

- MO464 – Status of Most Problematic (Observable) Pressure Ulcer
- Use the most extensive pressure ulcer
- “Non-Healing”
 - Wound with $\geq 25\%$ avascular tissue OR
 - Signs / symptoms of infection OR
 - Clean but non-granulating wound bed OR
 - Closed / hyperkeratotic wound edges OR
 - Persistent failure to improve despite comprehensive appropriate wound management

MO 464: Non-Healing



MO 464: Non-Healing

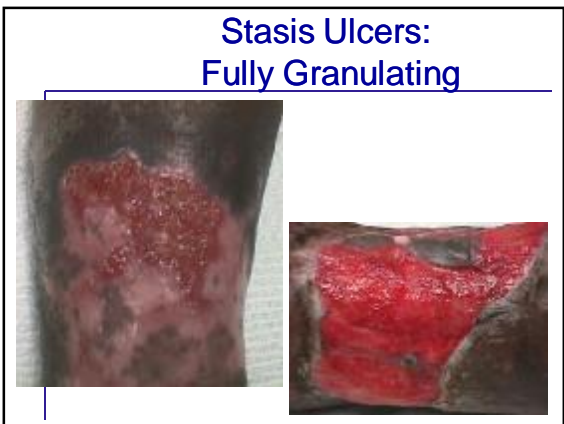


**Types of Current Wounds
Addressed by OASIS**

- Pressure ulcers
- Stasis ulcers (venous)
- Surgical Wounds
 - not healed yet
 - open
 - closed
 - dehisced
 - failed flaps

- **M0 468: Does the patient have a Stasis Ulcer?**
- **M0 470: Current number of observable ulcer(s)**
- **M0 474: Does the patient have at least one Stasis Ulcer that cannot be observed?**

- **M0 476: Status of the most problematic (Observable) Stasis Ulcer**
- **1 Fully granulating/healing**
 - Wound bed filled with granulation tissue to the level of surrounding skin or new epithelium
 - no dead space
 - no avascular tissue
 - no signs or symptoms of infection
 - wound edges are open



- **M0 476: Status of the most problematic (Observable) Stasis Ulcer**
- **2 Early/partial granulation**
 - $\geq 25\%$ of the wound bed is covered with granulation tissue ($< 25\%$ of the wound bed is covered with avascular tissue)
 - May have dead space
 - No signs or symptoms of infection
 - Wound edges are open



- **M0 476: Status of the most problematic (Observable) Stasis Ulcer**
- **3 Not healing**
 - Wound with $\geq 25\%$ avascular tissue OR
 - Signs / symptoms of infection OR
 - Clean but non-granulating wound bed OR
 - Closed / hyperkeratotic wound edges OR
 - Persistent failure to improve despite comprehensive appropriate wound management

Stasis Ulcers: Non-Healing



- **M0 476: Status of the most problematic (Observable) Stasis Ulcer**
 - NA No observable stasis ulcer
 - Wound is unable to be visualized due to a non-removable dressing ie, orthopedic device dressing, etc.

Types of Current Wounds Addressed by OASIS

- Pressure ulcers
- Stasis ulcers (venous)
- **Surgical Wounds**
 - not healed yet
 - open
 - closed
 - dehisced
 - failed flaps

Current Surgical Wounds Include

- Orthopedic pin sites, central line sites, wounds with staples or sutures, wounds with drains
- Approximated edges with a scab or crust are *current* surgical wounds
- Mediport (or equivalent) sites
- Each opening in a surgical wound is a *separate* surgical wound

...www.cms.hhs.gov 1-2008

Observable Surgical Wounds

- MO484
 - If a wound is partially closed but has more than one opening, consider each one as a separate wound

• M0 488: Status of the most problematic (Observable) Surgical Wound

- 1 Fully granulating/healing
- 2 Early/partial granulation
- 3 Not healing
- NA No observable surgical wound

- Description/classification of wounds healing by **primary intention** (i.e., approximated incisions)
- **Fully granulating/healing**: incision well-approximated with complete epithelialization of incision; no signs or symptoms of infection



- Description/classification of wounds healing by **primary intention** (i.e., approximated incisions)
- **Early/partial granulation**: incision well-approximated but not completely epithelialized; no signs or symptoms of infection





- Description/classification of wounds healing by **primary intention** (i.e., approximated incisions)
- **Non-healing:**
 - incisional separation *OR*
 - incisional necrosis *OR*
 - signs or symptoms of infection

Non-healing: Incisional Separation



Non-healing: Incisional Necrosis

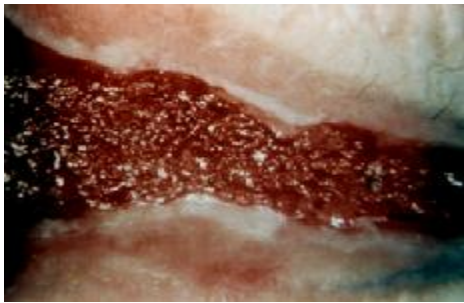


Non-healing: Sx and Sx of Infection

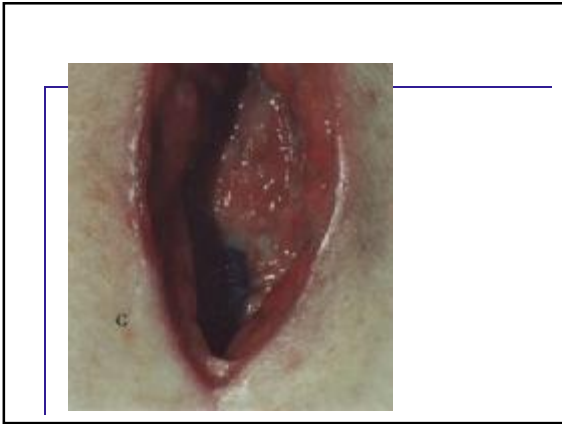


Surgical Wounds: Secondary Intention Healing

- Description/classification of wounds healing by secondary intention (i.e., healing of dehisced wound by granulation, contraction and epithelialization)
- **Fully Granulating:** Wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open.



- Description/classification of wounds healing by secondary intention (i.e., healing of dehisced wound by granulation, contraction and epithelialization)
- **Early/Partial Granulation:**
≥25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (i.e., <25% of the wound bed is covered with avascular tissue);
may have dead space;
no signs or symptoms of infection;
wound edges are open.



Secondary Intention

- Description/classification of wounds healing by secondary intention (i.e., healing of dehisced wound by granulation, contraction and epithelialization)
- **Non-healing:**
 - Wound with > 25% avascular tissue *OR*
 - Signs/symptoms of infection *OR*
 - Clean but non-granulating wound bed *OR*
 - Closed/hyperkeratotic wound edges *OR*
 - Persistent failure to improve despite comprehensive appropriate wound management.



OASIS Answers Drive Care

- If you have a fully or partially granulating wound, your goal is to get wound healed by end of period of care.
 - Wounds with 'crusts' need 'crusts' removed for optimal healing
- Non-healing requires appropriate intervention, upgrade from standard care

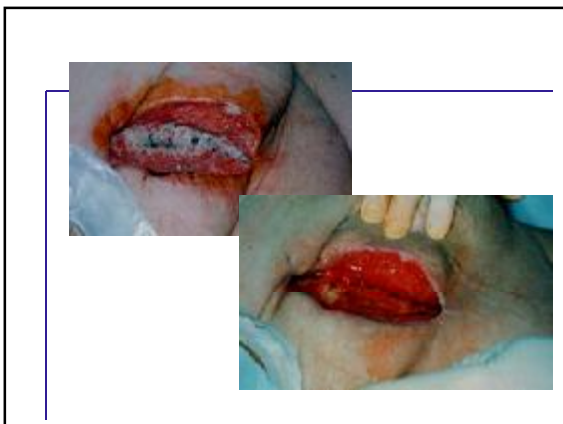
Assessment Questions That Drive Care

- Is the **Wound** healing?
- What is drainage level/ **Optimal** moist environment/ achieved with moisture retentive dressings?
- **Understand** the surrounding skin
- Is tissue in the wound **Necrotic**?
- Does wound have **Depth**?











In Conclusion

- Accurate wound assessment will
 - assist your agency to get appropriate reimbursement
 - Help drive appropriate care
 - Potentially serve as a marketing tool for your agency
 - physicians
 - patients