

CHAPTER 6 – SECTION L

PERCENT OF HIGH-RISK RESIDENTS WHO HAVE PRESSURE SORES

NOTE: This measure is reported on Nursing Home Compare as a paired measure, in conjunction with the percent of low-risk residents who have pressure sores. Therefore, if either measure is selected on Nursing Home Compare, both measures will be displayed.

QM Description

This measure reflects the percent of high-risk residents in the nursing home who have one or more pressure sores.

Rationale for Pressure Sore QM

On average, 3 to 5% (or more) of residents in nursing facilities develop pressure ulcers (also known as pressure sores or bed sores) and another 5-15% will have had the pressure ulcer since admission, with upwards of 25% of all admissions from the hospital having pressure ulcers. Sixty percent or more of residents will typically be at risk of pressure ulcer development. Pressure sores can have serious consequences for the elderly and are costly and time consuming to treat. However, they are one of the most common, preventable and treatable conditions among the elderly who have restricted mobility. Successful outcomes can be expected with preventive and treatment programs. Assessment goals are: (1) to ensure that a treatment plan is in place for residents with pressure sores; and (2) to identify residents at risk for developing a pressure sore who are not currently receiving some type of preventive care program. Successful outcomes (prevention and rapid healing) can be expected with either preventative or treatment programs. Additional clinical information about pressure sores, as well as quality improvement strategies, can be found on CMS's website at www.MedQIC.org.

MDS Assessments Used

- **Target assessment:** OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Latest assessment with assessment reference date (A3a) within the 3-month target period. Note that admission assessments (AA8a = 01) are excluded from measure calculations.

QM Specifications

NUMERATOR

Residents with pressure sores (Stage 1-4) on the target assessment (M2a > 0 OR I3a-I3e = 707.0).

HIGH-RISK DENOMINATOR

All residents with a valid target assessment after exclusions are applied and with any one of the following high-risk inclusion criteria:

1. Impaired in bed mobility or transfer on the target assessment as indicated by G1a(A) = 3, 4, or 8 OR G1b(A) = 3, 4, or 8.
2. Comatose on the target assessment as indicated by B1 = 1.
3. Suffer malnutrition on the target assessment as indicated by I3a through I3e = 260, 261, 262, 263.0, 263.1, 263.2, 263.8, or 263.9.

RISK ADJUSTMENT STRATEGIES USED

Exclusion....Yes

Stratification....Yes

Regression....No

GENERAL EXCLUSIONS FOR BOTH HIGH-RISK AND LOW-RISK RESIDENTS

Residents satisfying any of the following conditions are excluded from all risk groups (high and low):

- ◆ The target assessment is an admission (AA8a = 01) assessment.
- ◆ The QM did not trigger (resident is not included in the QM numerator) AND the value of M2a is missing on the target assessment.
- ◆ The resident does not qualify as high-risk AND the value of G1a(A) or G1b(A) is missing on the target assessment.
- ◆ The resident does not qualify as high-risk AND the value of B1 is missing on the target assessment.

COVARIATES USED IN REGRESSION

There are no covariates used in the calculation of the high-risk pressure sore quality measure.

STRATIFICATION

Residents are stratified into the high-risk category based on the following:

High Risk Criteria

All residents with a valid target assessment and any one of the following inclusion criteria:

1. Impaired in transfer or bed mobility on the target assessment as indicated by G1a(A) = 3, 4, or 8 or G1b(A) = 3, 4, or 8.
2. Comatose on target assessment as indicated by B1 = 1.
3. Suffer malnutrition on the target assessment as indicated by I3a through I3e = ICD-9-Codes 260, 261, 262, 263.0, 263.1, 263.2, 263.8, or 263.9

MDS Elements Related to QM

M2a Type of Ulcer - Presence of Stage 1-4 pressure ulcer

I3a-e Other Current or More Detailed Diagnoses and ICD-9 Codes - Diagnosis of pressure ulcer is coded with ICD-9 Code 707.0

G1a (A) Bed Mobility Self-Performance - How the resident moves to and from lying position, turns side to side, and positions body while in bed, in a recliner, or other type of furniture the resident sleeps in, rather than a bed.

G1b (A) Transfer Self-Performance – How the resident moves between surfaces – i.e., to/from: bed, chair, wheelchair, standing position. Exclude from this definition movement to/from bath or toilet, which is covered under Toilet Use and Bathing.

B1 Comatose - The resident has been diagnosed as comatose or in a persistent vegetative state.

Nutritional Deficiencies ICD-9 Codes

260 – Kwashiorkor

261 – Nutritional marasmus

262 – Other severe, protein-calorie malnutrition

263.0 – Malnutrition of moderate degree

263.1 – Malnutrition of mild degree

263.2 - Arrested development following protein-calorie malnutrition

263.8 – Other protein-calorie malnutrition

263.9 – Unspecified protein-calorie malnutrition

MDS RAI Coding Instructions

SECTION M. SKIN CONDITION

NOTE: MDS ITEMS THAT DO NOT TRIGGER THE QUALITY MEASURES ARE INTENTIONALLY IN GRAY TEXT.

CMS's RAI Version 2.0 Manual

CH 3: MDS Items [M]

SECTION M. SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days.

M1. Ulcers (due to any cause) (7-day look back)

Intent: To record the number of ulcers/open lesions, of any type at each ulcer stage, on any part of the body.

Definition: A skin ulcer/open lesion can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Open lesions/sores are skin ulcers that may develop because of circulatory problems, pressure, or in association with other diseases such as syphilis. Rashes without open areas, burns, desensitized skin and surgical wounds are **NOT** coded here, but are included in Item M4. Skin tears/shears are coded in Item M4 unless pressure was a contributing factor.

- a. **Stage 1.** A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
- b. **Stage 2.** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab or shallow crater.
- c. **Stage 3.** A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.
- d. **Stage 4.** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Process: Review the resident's record and consult with the nurse assistant about the presence of an ulcer/open lesion. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, an ulcer/open lesion can be missed.

Assessing a Stage 1 ulcer/open lesion requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers/open lesions in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look; (3) a

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subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding: All skin ulcers/open lesions should be coded in this item. Record the number of ulcers/open lesions at each stage on the resident's body, in the last 7 days, regardless of the ulcer/open lesion cause. If necrotic eschar is present, prohibiting accurate staging, code the ulcer/open lesion as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no ulcers/open lesions at a particular stage, record "0" (zero) in the box provided. If there are more than 9 ulcers/open lesions at any one stage, enter a "9" in the appropriate box.

- Clarifications:**
- ◆ All problems and lesions present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of problems or lesions, as observed during the assessment period.
 - ◆ Staff should code healing ulcers in the MDS using a reverse-staging protocol. For the MDS assessment, Item M2a, pressure ulcers should be coded in terms of what is seen (i.e., visible tissue). For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2". Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the MDS.
 - ◆ Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5 (Skin Treatments).

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Example

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 ulcer over her sacrum and two Stage 1 ulcers over her heels.

Items M1, Ulcers (due to any cause)	Stage	Code
	a. 1	2
	b. 2	0
	c. 3	1
	d. 4	0

Mr. Alaska has five open wounds as a result of frostbite that are not pressure or venous stasis ulcers. Upon examination, these wounds meet the criteria provided in Item M1 (Ulcers) coding definitions: Four ulcers are consistent with Stage 2 ulcer staging and one ulcer appears to be at Stage 3. Assuming that the resident in this scenario has no pressure ulcers, code the resident's condition as follows:

Items M1, Ulcers (due to any cause)	Stage	Code
	a. 1	0
	b. 2	4
	c. 3	1
	d. 4	0

Items M2, Type of Ulcer:

Code "0" (highest stage ulcer is not a pressure ulcer)

Items M4, Other Skin Problems or Lesions Present:

Code Item M4c unless the frostbite wounds are to the foot, then code M6.

Include coding for treatments provided in Items M5 and M6, (Foot Problems and Care) as appropriate.

M2. Type of Ulcer (7-day look back)

Intent: To record the highest stage for two types of ulcers, Pressure and Stasis, that was present in the last 7 days.

Definition: a. **Pressure Ulcer** - Any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.

b. Stasis Ulcer - An open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

Process: Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

Coding: Using the ulcer staging scale in Item M1, record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g., ischemic ulcers). An ulcer recorded in Item M1 may not necessarily be recorded in Item M2 (see last example below).

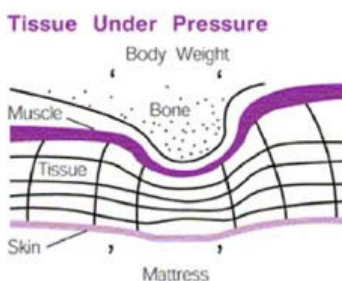
More definitive information concerning pressure ulcers is provided in the AHRQ Guidelines for pressure ulcers in adults at: <http://www.ahrq.gov/consumer/bodysys/edbody6.htm>.

What are Pressure Ulcers?

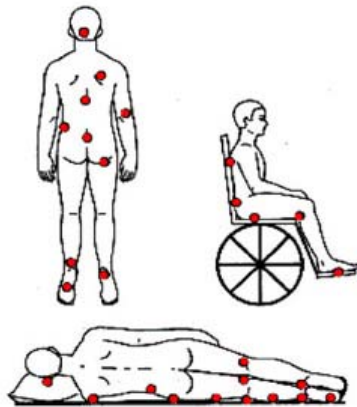
A pressure ulcer is an injury usually caused by unrelieved pressure that damages the skin and underlying tissue. Pressure ulcers are also called decubitus ulcers or bedsores and range in severity from mild (minor skin reddening) to severe (deep craters down to muscle and bone).

Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. When skin is starved of nutrients and oxygen for too long, the tissue dies and a pressure ulcer forms. The affected area may feel warmer than surrounding tissue. Skin reddening that disappears after pressure is removed is normal and not a pressure ulcer.

Other factors cause pressure ulcers, too. If a person slides down in the bed or chair, blood vessels can stretch or bend and cause pressure ulcers. Even slight rubbing or friction on the skin may cause minor pressure ulcers.



Where Pressure Ulcers Form



Pressure ulcers form where bone causes the greatest force on the skin and tissue, and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. In persons who must stay in bed, most pressure ulcers form on the lower back below the waist (sacrum), the hip bone (trochanter), and on the heels. In people in chairs or wheelchairs, the exact spot where pressure ulcers form depends on the sitting position. Pressure ulcers can also form on the knees, ankles, shoulder blades, back of the head, and spine.

Nerves normally tell the body when to move to relieve pressure on the skin. Persons in bed who are unable to move may get pressure ulcers after as little as 1-2 hours. Persons who sit in chairs and who cannot move can get pressure ulcers in even less time because the force on the skin is greater.

NOTE: It is also common for pressure ulcers to form on the ears and scrotum.

The full AHCPR guideline for clinicians can be found at:

<http://www.ahcpr.gov/clinic/cpgonline.htm>.

- Clarifications:** ♦ In order to code Pressure Ulcers in the case of a blister, the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, a blister was found in the area of the incontinence brief waist or leg band, pressure from the band may be a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this is the case, the blister would not be recorded as a pressure ulcer, but would be considered a rash. For additional information, refer to: Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. *Journal of Gerontological Nursing* 23(12), 5-10.
- ♦ If there is persistent redness without a break in the skin that does not disappear when pressure is relieved, the problem should be recorded as a Stage 1 ulcer (M1). Less pressure is needed for a pressure ulcer to form when the skin is soiled with urine and/or feces. If the resident is unable to move, or does not move to relieve pressure on the skin, then pressure is very likely to have helped form the ulcer. Item M1a should be coded as "1" and M2a should be coded for the highest stage. In addition, if this is a situation where there is redness from pressure in combination with a contact rash from incontinence, especially if the resident was wet long enough to develop the rash, code Item M2a (pressure ulcer for the highest stage). If the resident's

mobility status is not impaired (i.e., they can move to relieve pressure on the skin) and the redness is not likely due to pressure, do not code Item M2a. Code the condition in M4, Other Skin Problems or Lesions Present.

Example

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. His hospital course was complicated by delirium (acute confusion) and he spent most of his time on bed rest. Nurses remarked that he would only stay lying on his back. He had only an egg crate mattress on his bed to relieve pressure. A water mattress and air mattress were both tried but aggravated his agitation. He was readmitted to the nursing facility 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

Items M1, Ulcers (due to any cause)	Code (# at stage)
a. Stage 1	3
b. Stage 2	1
c. Stage 3	0
d. Stage 4	0
Items M2, Type of Ulcer	Code (highest stage)
a. Pressure Ulcer	2
b. Stasis Ulcer	0

Rationale for coding: Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

Items M1, Ulcer (due to any cause)	Code (# at Stage)
a. Stage 1	0
b. Stage 2	0
c. Stage 3	1
d. Stage 4	0
Items M2, Type of Ulcer	Code (highest stage)
a. Pressure ulcer	0
b. Stasis ulcer	0

Rationale for coding: Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.