M0100: Determination of Pressure Ulcer/Injury Risk

M0100. Determination of Pressure Ulcer/Injury Risk	
↓	Check all that apply
☐	A. Resident has a pressure ulcer/injury, 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

Item Rationale

Health-related Quality of Life

- Pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are important contributors to pressure ulcer/injury development.
- The underlying health of a resident's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers/injuries.
- Additional external factors, such as excess moisture, microclimate, and tissue exposure to urine or feces, can increase risk.

Planning for Care

- The care planning process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate based on the individualized needs of the resident.

M0100: Determination of Pressure Ulcer/Injury Risk (cont.)

- Throughout this section, terminology referring to "healed" versus "unhealed" ulcers refers to whether or not the ulcer is "closed" versus "open." When considering this, recognize that Stage 1, Deep Tissue Injury (DTI), and unstageable pressure ulcers although "closed" (i.e., may be covered with tissue, eschar, slough, etc.) would not be considered "healed."
- Facilities should be aware that the resident is at higher risk of having the area of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue. Tensile strength of the skin overlying a closed pressure ulcer is 80% of normal skin tensile strength. Facilities should put preventative measures in place that will mitigate the opening of a closed ulcer due to the fragility of the overlying tissue.

DEFINITION

HEALED PRESSURE ULCER
Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer/injury risk assessments.
2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident.
3. Examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer/injury development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing).

Coding Instructions

For this item, check all that apply:

- **Check A if resident has a Stage 1 or greater pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/ device.** Review descriptions of pressure ulcers/injuries and information obtained during physical examination and medical record review. Examples of non-removable dressings/devices include a primary surgical dressing, a cast, or a brace.

DEFINITIONS

PRESSURE ULCER/ INJURY RISK FACTOR
Examples of risk factors include immobility and decreased functional ability; co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids; impaired diffuse or localized blood flow; resident refusal of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; microclimate, malnutrition, and hydration deficits; and a healed ulcer.

PRESSURE ULCER/ INJURY RISK TOOLS
Screening tools that are designed to help identify residents who might develop a pressure ulcer/injury. A common risk assessment tool is the Braden Scale for Predicting Pressure Sore Risk©.

M0100: Determination of Pressure Ulcer/Injury Risk (cont.)

- **Check B if a formal assessment has been completed.** An example of an established pressure ulcer risk tool is the *Braden Scale for Predicting Pressure Sore Risk*©. Other tools may be used.
- **Check C if the resident's risk for pressure ulcer/injury development is based on clinical assessment.** A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer/injury risk factors. Examples of risk factors include the following:
  - impaired/decreased mobility and decreased functional ability
  - co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;
  - drugs, such as steroids, that may affect wound healing;
  - impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);
  - resident refusal of some aspects of care and treatment;
  - cognitive impairment;
  - urinary and fecal incontinence;
  - malnutrition and hydration deficits; and
  - healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown.
- **Check Z if none of the above apply.**