Quality Measure Tip Sheet:
Pressure Injuries – Long Stay

Quality Measure Overview
Numerator:
• This measure captures the percentage of long-stay, high-risk residents with Stage II through IV pressure injuries.
• This measure will trigger if the resident presents as having a Stage II, III or IV pressure injury and if the resident is considered high-risk for pressure injuries.
• A high-risk resident is identified as meeting one or more of the following three criteria of the target assessment:
  1. Impaired bed mobility or transfer indicated by either or both of the following = [3], [4], [7], [8]:
     - Bed mobility self performance (G0110A1)
     - Transfer self performance (G0110B1)
  2. Comatose (B0100)
  3. Malnutrition or at risk for malnutrition (I5600) is checked

Denominator:
• All long-stay residents with a selected target assessment who meet the definition of high risk, except those with exclusions

Exclusions:
• Target assessment is an admission assessment or a PPS 5-day or readmission/return assessment.
• Resident does not meet pressure injury conditions for the numerator and any of the following coded as [-]: M0300B1, M0300C1 or M0300D1.

MDS Coding Requirements
In the Minimum Data Set (MDS):
• Indicate whether the pressure injuries were present on admission.
• Provide base assessment on highest stage of existing injury at its worst. Do not use reverse-staging.
• Determine the resident’s pressure injury risk.
• Document the current number of unhealed pressure injuries and the stage of each.
• Indicate the dimensions of any unhealed Stage III or IV pressure injury or eschar.
• Indicate the most severe tissue type (i.e., epithelial, granulation, slough, eschar, none).
• Note any worsening or improvement in pressure injuries since prior assessment.


Ask These Questions…
• Was the MDS coded per Resident Assessment Instrument (RAI) requirements?
• Are risk assessments completed per policy (usually on admission, quarterly and after change in condition), and based on the identified risk factors, are interventions implemented for prevention?
• Is the skin evaluated immediately upon admission and at least weekly thereafter for changes?
• Are interventions immediately implemented based on the identified risk factors?
• Has the resident’s bed, cushions and other positioning products been evaluated?

• Does a criteria guide exist for the type of interventions to use, and is it accessible to floor nurses?
• Are the interventions communicated to frontline staff?
• Does a quality rounding process exist to ensure application of devices and other prevention interventions?
• Are nurses evaluated for competency in wound assessment?
• Are certified nursing assistants evaluated for competency in positioning and transfers?
• Are at-risk residents reviewed on at least a weekly basis for potential changes and care plan prevention/treatment modifications?

In Alaska, contact:
Leiza Johnson, RN, BSN
ejohnson@mpqh.org

In Hawaii, contact:
Joy Yadao, RN
jyadao@mpqh.org

In Montana, contact:
Pamela Longmire, RT, BAS
plongmire@mpqh.org

In Wyoming, contact:
Carol Cutler, RN
ccutler@mpqh.org

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