Decubitus Ulcers

Did you know?

Decubitus ulcers have specific documentation requirements

1. Document the **exact location** of the ulcer
2. Document the **stage** of the ulcer:
   - **Stage 1:** Non-blanchable erythema of intact skin
   - **Stage 2:** Partial thickness skin loss involving epidermis, dermis or both
   - **Stage 3:** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia
   - **Stage 4:** Full thickness skin loss w/ extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures (i.e. tendons, joint capsule)

- Be sure to investigate for the presence of decubitus ulcers at the time of admission
- Remember to document both the location and the stage at the time of admission, if present
  - Ulcers NOT documented as being Present on Admission count as Hospital Acquired Conditions (HACs) and are quality “red flags” that are tracked by CMS

**Note:** Staging of ulcers can be taken from nursing documentation if you document the ulcer exists