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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