

E-Clinical OASIS C Discharged Assessment

(M1034) Overall Status: Which description best fits the patient's overall status? **(Check one)**

Comments

- 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
- 3 - The patient has serious progressive conditions that could lead to death within a year.
- UK - The patient's situation is unknown or unclear.

(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: **(Mark all that apply.)**

- 1 - Smoking
- 3 - Alcohol dependency
- 5 - None of the above
- 2 - Obesity
- 4 - Drug dependency
- UK - Unknown

Comments

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

Comments

- 0 - No
- 1 - Yes [Go to M1050]
- NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050]

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:

Comments

- 1 - Received from another health care provider (e.g., physician)
- 2 - Received from your agency previously during this year's flu season
- 3 - Offered and declined
- 4 - Assessed and determined to have medical contraindication(s)
- 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
- 6 - Inability to obtain vaccine due to declared shortage
- 7 - None of the above

(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

Comments

- 0 - No
- 1 - Yes [Go to M1500 at TRN, Go to M1230 at DC]

(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

Comments

- 1 - Patient has received PPV in the past
- 2 - Offered and declined
- 3 - Assessed and determined to have medical contraindication(s)
- 4 - Not indicated; patient does not meet age/condition guidelines for PPV
- 5 - None of the above

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05

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b. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (e.g., assisted living)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

Comments

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

- | | |
|---|----------|
| <input type="checkbox"/> 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. | Comments |
| <input type="checkbox"/> 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance). | |
| <input type="checkbox"/> 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. | |
| <input type="checkbox"/> 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases. | |
| <input type="checkbox"/> 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible). | |
| <input type="checkbox"/> 5 - Patient nonresponsive or unable to speak. | |

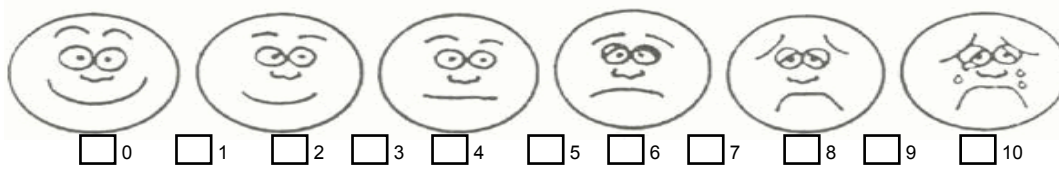
MUSCULOSKELETAL No problem Identified Comments

- Limited ROM (give location)
- Bone or joint problems
- Pain or Cramps
- Redness, Warmth, Swelling
- Decreased Mobility/Endurance
- Tremors
- Amputation of
- Prosthesis/Appliance
- Device use
- Ordered
- instructed on home safety, fall precautions, Home Folder information

(M1242) Frequency of Pain Interfering with patient's activity or movement:

- | | |
|---|----------|
| <input type="checkbox"/> 0 - Patient has no pain
<input type="checkbox"/> 1 - Patient has pain that does not interfere with activity or movement
<input type="checkbox"/> 2 - Less often than daily
<input type="checkbox"/> 3 - Daily, but not constantly
<input type="checkbox"/> 4 - All of the time | Comments |
|---|----------|

Wong-Baker FACES Pain Rating Scale



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Brief word instructions: Point to each face using the words to describe the pain intensity. Ask the child to choose face that best describes own pain and record the appropriate number.

Original instructions: Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. **Face 0** is very happy because he doesn't hurt at all. **Face 2** hurts a little bit. **Face 4** hurts a little more. **Face 6** hurts even more. **Face 8** hurts a whole lot. **Face 10** hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the person to choose which face best describes how he is feeling.

Rating scale is recommended for persons age 3 years and older.

From Hockenberry MJ, Wilson D, Wilkenstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p.1259. Used with permission. Copyright, Mosby.

Pain Description

Sharp Dull Other

Acceptable Level of Pain

Pain Med

Frequency Used

Effectiveness

Instructed on Pain Medication Instructed on non-pharmacological pain reducing methods Verbalizes understanding

Behavioral Scale

Faces	0 <input type="checkbox"/> No particular expression or smile	1 <input type="checkbox"/> Occasional grimace or frown, withdrawn disinterested	2 <input type="checkbox"/> Frequent to constant frown, clenched jaw, quivering chin
Legs	0 <input type="checkbox"/> Normal Position or relaxed	1 <input type="checkbox"/> Uneasy, restless, tense	2 <input type="checkbox"/> Kicking, or legs drawn up
Activity	0 <input type="checkbox"/> Lying quietly, normal position, moves easily	1 <input type="checkbox"/> Squirming, shifting back and forth, tense	2 <input type="checkbox"/> Arched, rigid, or jerking
Cry	0 <input type="checkbox"/> No cry (awake or asleep)	1 <input type="checkbox"/> Moans or whimpers, occasional complaint	2 <input type="checkbox"/> Crying steadily, screams or sobs, frequent complaints
Consolability	0 <input type="checkbox"/> Content, relaxed	1 <input type="checkbox"/> Reassured by occasional touching, hugging or talking to, distractible	2 <input type="checkbox"/> Difficult to console or comfort

0 - 3 = No risk 4 - 6 = Some risk 7 - 10 = High risk

Total:

INTEGUMENTARY

Skin Turgor Good Fair Poor

Skin Color Pink Fair
 Jaundice Cyanotic

Skin Dry Diaphoretic Moist
 Warm Cool

Skin Wounds Ulcers Incision
 Ostomy Rashes Other

Nails Normal Problems

INFECTION CONTROL

Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Soap
<input type="checkbox"/>	<input type="checkbox"/> Paper Towels
<input type="checkbox"/>	<input type="checkbox"/> Other
<input type="checkbox"/>	<input type="checkbox"/> Instructed on measures to control infection

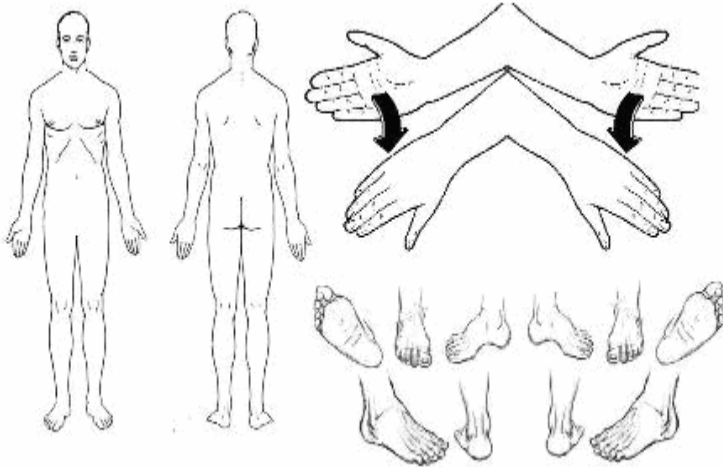
High Risk for infection

Special Needs

HAIR

Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Abnormal Hair Condition
<input type="checkbox"/>	<input type="checkbox"/> Hair Loss
<input type="checkbox"/>	<input type="checkbox"/> Infestation
<input type="checkbox"/>	<input type="checkbox"/> Other

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- | | | |
|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Lesions | <input type="checkbox"/> Rash | <input type="checkbox"/> Bruises |
| <input type="checkbox"/> Scars | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Incisions |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Stasis Ulcer | <input type="checkbox"/> Pruritus |
| <input type="checkbox"/> Abrasions | <input type="checkbox"/> Masses | <input type="checkbox"/> Fistulas |
| <input type="checkbox"/> Dry/Scaling | <input type="checkbox"/> Pressure Ulcer | <input type="checkbox"/> Other |

Overall specifics and details on overall wound care

Comments on Types of Wound and Description

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?

Comments

- 0 - No [Go to M1322]
- 1 - Yes

(M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge

Comments

- 1 - Was present at the most recent SOC/ROC assessment
- 2 - Developed since the most recent SOC/ROC assessment: Record date pressure ulcer first identified

Date:

- NA - No non-epithelialized Stage II pressure ulcers are present at discharge

(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:
(Enter "0" if none; excludes Stage I pressure ulcers)

Stage description - unhealed pressure ulcers	Complete at SOC/ROC/FU & DC, Number Currently Present	Complete at FU and DC - Number of those listed in column 1 that were present on admission (most recent SOC/ROC)
a. Stage II: Partial thickness loss of //dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.		
b. Stage III: Full thickness //tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.		
c. Stage IV: Full thickness tissue loss //with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.		
d. 1 Unstageable: Known or likely but not stageable due to non-removable dressing or device		
d. 2 Unstageable: Known or likely but not stageable due to coverage of wound bed by slough and/or eschar.		
d. 3 Unstageable: Suspected deep tissue injury in evolution.		

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Directions for M1310 and M1312 and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length "head-to-toe" (cm) Comments

(M1312) Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length (cm) Comments

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area (cm) Comments

(M1320) Status of Most Problematic (Observable) Pressure Ulcer: Comments

0 - Newly-epithelialized
 1 - Fully granulating
 2 - Early/partial granulation
 3 - Not healing
 NA - No observable pressure ulcer

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

0
 1
 2
 3
 4 or more Comments

(M1324) Stage of Most Problematic (Observable) Pressure Ulcer: Comments

1 - Stage I
 2 - Stage II
 3 - Stage III
 4 - Stage IV
 NA - No observable pressure ulcer

(M1330) Does this patient have a Stasis Ulcer? Comments

0 - No [Go to M1340]
 1 - Yes, patient has BOTH observable and unobservable stasis ulcers
 2 - Yes, patient has observable stasis ulcers only
 3 - Yes, patient has observable stasis ulcers ONLY (known but not observable due to non-removable dressing)[Go to M1340]

(M1332) Current Number of (Observable) Stasis Ulcer(s): Comments

1 - One
 2 - Two
 3 - Three
 4 - Four or more]

(M1334) Status of Most Problematic (Observable) Stasis Ulcer: Comments

0 - Newly epithelialized
 2 - Early/partial granulation
 1 - Fully granulating
 3 - Not healing

(M1340) Does this patient have a Surgical Wound? Comments

0 - No [Go to M1350]
 1 - Yes, patient has at least one (observable) surgical wound
 2 - Surgical wound known but not observable due to non-removable dressing [Go to M1350]

(M1342) Status of Most Problematic (Observable) Surgical Wound: Comments

0 - Re-epithelialized
 1 - Fully granulating
 2 - Early/partial granulation
 3 - Not healing

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(M1350) Does this patient have a **Skin Lesion** or **Open Wound**, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?

0 - No 1 - Yes Comments

WOUND CARE Old dressing removed per: SN Comments
 Wound care ordered, provide: Patient/Caregiver
 Wound cleansed with Patient tolerated wound care
 Irrigated with Patient / Caregiver instructed on care provided
 Packing with Patient / Caregiver competent/demonstrates
 Applied to wound bed wound care to be provided and frequency of same
 Dressing applied

Cardiovascular Comments

No problem identified Pacemaker Insertion Date
 Palpitations Fatigues easily Poor capillary refill Orthostatic Hypotension
 CAD TIA/CVA Long-term Anticoagulant
 Chest pain Other: (specify)

Heart Rate: No problem identified **EDEMA:** Pedal R/L Dependent Comments
 Regular Irregular Reg/Irreg Pitting +1+2+3+4(site)
 Tachycardia Bradycardia Arrythmia Non-pitting (site)

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?

0 - Patient is not short of breath Comments
 1 - When walking more than 20 feet, climbing stairs
 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
 4 - At rest (during day or night)

(M1410) Respiratory Treatments utilized at home: **(Mark all that apply.)**

1 - Oxygen (intermittent or continuous) Comments
 2 - Ventilator (continually or at night)
 3 - Continuous / Bi-level positive airway pressure
 4 - None of the above

Respiratory No problem identified Comments

Breath Sounds Cyanosis Sputum
 Tracheostomy Cough Orthopnea
 Hemoptysis Smoker O2 Usage
 Instructed on O2 Safety O2 Sat O2 L/Min Other

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

0 - No [Go to M1732 at TRN; Go to M1600 at DC] Comments
 1 - Yes
 2 - Not assessed [Go to M1732 at TRN; Go to M1600 at DC]
 NA - Patient does not have diagnosis of heart failure [Go to M2004 at TRN; Go to M1600 at DC]

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(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

Comments

- 0 - No action taken
- 1 - Patient's physician (or other primary care practitioner) contacted the same day
- 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)
- 3 - Implement physician-ordered patient-specific established parameters for treatment
- 4 - Patient education or other clinical interventions
- 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

(M1600) Has this patient been treated for a Urinary Tract Infection in the past 14 days?

Comments

- 0 - No
- 1 - Yes
- NA - Patient on prophylactic treatment

(M1610) Urinary Incontinence or Urinary Catheter Presence:

Comments

- 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620]
- 1 - Patient is incontinent
- 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [Go to M1620]

URINARY	Urinary Color	Amount	Odor	Comments
<input type="checkbox"/> Hematuria	<input type="checkbox"/> Oliguria	<input type="checkbox"/> Burning	<input type="checkbox"/> Polyuria	<input type="checkbox"/> Retention: Cramping/Dysuria/Sediment
<input type="checkbox"/> Incontinence		<input type="checkbox"/> Foley Catheter		

(M1615) When does Urinary Incontinence occur?

Comments

- 0 - Timed-voiding defers incontinence
- 1 - Occasional stress incontinence
- 2 - During the night only
- 3 - During the day only
- 4 - During the day and night

BOWEL:	Last BM	External Genitalia:	Per:	No changes since previous assmt.
	Usual Frequency		<input type="checkbox"/> Physical Assessment	Comments
<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Normal	<input type="checkbox"/> Pt/Cg Reported	
<input type="checkbox"/> Abnormal stools: Gray/Tarry/Fresh Blood		<input type="checkbox"/> Abnormal		
<input type="checkbox"/> Lax/enema use: Type				
<input type="checkbox"/> Constipation: Chronic/Acute/Occasional		<input type="checkbox"/> Ostomy: Type		
<input type="checkbox"/> Hemorrhoids: Internal/External		<input type="checkbox"/> Caregiver/Patient instructed on care		

(M1620) Bowel Incontinence Frequency:

Comments

- 0 - Very rarely or never has bowel incontinence
- 1 - Less than once weekly
- 2 - One to three times weekly
- 3 - Four to six times weekly
- 4 - On a daily basis
- 5 - More often than once daily
- NA - Patient has ostomy for bowel elimination

ENDOCRINE:	No problem identified	Comments
<input type="checkbox"/> Polyuria/Polydipsia/Polyphagia	<input type="checkbox"/> Neuropathy/Radiculopathy	<input type="checkbox"/> Thyroid Disease
		<input type="checkbox"/> Diabetes

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(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

Comments

- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M1710) When Confused (Reported or Observed Within the Last 14 Days):

Comments

- 0 - Never
- 3 - During the day and evening, but not constantly
- 1 - In new or complex situations only
- 4 - Constantly
- 2 - On awakening or at night only
- NA - Patient nonresponsive

(M1720) When Anxious (Reported or Observed Within the Last 14 Days):

Comments

- 0 - None of the time
- 3 - All of the time
- 1 - Less often than daily
- NA - Patient nonresponsive
- 2 - Daily, but not constantly

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?

Comments

- 0 - No
- 1 - Yes, patient was screened using the PHQ-2© scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-c Pfizer	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 -14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>

- 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.
- 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): **(Mark all that apply.)**

Comments

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

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- 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- 6 - Delusional, hallucinatory, or paranoid behavior
- 7 - None of the above behaviors demonstrated

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

Comments

- 0 - Never 2 - Once a month 4 - Several times a week
- 1 - Less than once a month 3 - Several times each month 5 - At least daily

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric

Comments

- 0 - No 1 - Yes

(M1800) Grooming: Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

Comments

- 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- 2 - Someone must assist the patient to groom self.
- 3 - Patient depends entirely upon someone else for grooming needs.

(M1810) Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

Comments

- 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- 2 - Someone must help the patient put on upper body clothing.
- 3 - Patient depends entirely upon another person to dress the upper body.

(M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Comments

- 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- 3 - Patient depends entirely upon another person to dress lower body.

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face and hands only).**

Comments

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
(a) for intermittent supervision or encouragement or reminders, OR
(b) to get in and out of the shower or tub, OR
(c) for washing difficult to reach areas.
- 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.

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- 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- 6 - Unable to participate effectively in bathing and is bathed totally by another person.

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

Comments

- 0 - Able to get to and from the toilet and transfer independently with or without a device.
- 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- 4 - Is totally dependent in toileting.

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

Comments

- 0 - Able to manage toileting hygiene and clothing management without assistance.
- 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
- 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
- 3 - Patient depends entirely upon another person to maintain toileting hygiene.

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

Comments

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Comments

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.
-

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(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

Comments

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
(a) meal set-up; OR
(b) intermittent assistance or supervision from another person; OR
(c) a liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding.

(M1880) Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:

Comments

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

Comments

- 0 - Able to dial numbers and answer calls appropriately and as desired.
- 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- 5 - Totally unable to use the telephone.
- NA - Patient does not have a telephone.

(M2004) Medication Intervention: If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?

Comments

- 0 - No 1 - Yes
- NA - No clinically significant medication issues identified since the previous OASIS assessment

(M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?

Comments

- 0 - No 1 - Yes
- NA - Patient not taking any drugs

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Comments

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0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

1 - Able to take medication(s) at the correct times if:
 (a) individual dosages are prepared in advance by another person; OR
 (b) another person develops a drug diary or chart.

2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times

3 - Unable to take medication unless administered by another person.

NA - No oral medications prescribed.

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

Comments

0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

1 - Able to take injectable medication(s) at the correct times if:
 (a) individual syringes are prepared in advance by another person; OR
 (b) another person develops a drug diary or chart.

2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of te injection

3 - Unable to take injectable medication unless administered by another person.

NA - No injectable medications prescribed.

(M2100) Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only **one** box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provides assistance	Caregiver(s) need training / supportive services to provide assistance	Caregiver(s) <u>not likely</u> to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL Assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medication administration (e.g., oral, inhaled, or injectable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Medical procedures / treatments (e.g., changing wound dressing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Management of equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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f. Supervision and safety (e.g., due to cognitive impairment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(M2110) How Often does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?

Comments

- | | |
|---|---|
| <input type="checkbox"/> 1 - At least daily | <input type="checkbox"/> 4 - Received, but less often than weekly |
| <input type="checkbox"/> 2 - Three or more times per week | <input type="checkbox"/> 5 - No assistance received |
| <input type="checkbox"/> 3 - One to two times per week | <input type="checkbox"/> UK - Unknown* |

(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

Comments

- 0 - No [Go to M2400]
- 1 - Yes, used hospital emergency department WITHOUT hospital admission
- 2 - Yes, used hospital emergency department WITH hospital admission
- UK - Unknown [Go to M2400]

(M2310) Reason for Emergent Care: For what reason(s) did the patient receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

Comments

- 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- 2 - Injury caused by fall
- 3 - Respiratory infection (e.g., pneumonia, bronchitis)
- 4 - Other respiratory problem
- 5 - Heart failure (e.g., fluid overload)
- 6 - Cardiac dysrhythmia (irregular heartbeat)
- 7 - Myocardial infarction or chest pain
- 8 - Other heart disease
- 9 - Stroke (CVA) or TIA
- 10 - Hypo/Hyperglycemia, diabetes out of control
- 11 - GI bleeding, obstruction, constipation, impaction
- 12 - Dehydration, malnutrition
- 13 - Urinary tract infection
- 14 - IV catheter-related infection or complication
- 15 - Wound infection or deterioration
- 16 - Uncontrolled pain
- 17 - Acute mental/behavioral health problem
- 18 - Deep vein thrombosis, pulmonary embolus
- 19 - Other than above reasons
- UK - Reason unknown

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(M2400) Intervention Synopsis: (Check only **one** box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	Comments
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d. Intervention(s) to monitor or mitigate pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Formal assessment did not indicate pain since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers <u>OR</u> patient has no pressure ulcers with need for moist wound healing

(M2410) To which Inpatient Facility has the patient been admitted?

- 1 - Hospital [Go to M2430] Comments
 2 - Rehabilitation facility [Go to M0903]
 3 - Nursing home [Go to M2440]
 4 - Hospice [Go to M0903]
 NA - No inpatient facility admission

(M2420) Discharge Disposition: Where is the patient after discharge from your agency?
(Choose only one answer.)

- 1 - Patient remained in the community (without formal assistive services) Comments
 2 - Patient remained in the community (with formal assistive services)
 3 - Patient transferred to a non-institutional hospice
 4 - Unknown because patient moved to a geographic location not served by this agency
 UK - Other unknown

E-Clinical OASIS C Discharged Assessment

(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? **(Mark all that apply.)**

Comments

- 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- 2 - Injury caused by fall
- 3 - Respiratory infection (e.g., pneumonia, bronchitis)
- 4 - Other respiratory problem
- 5 - Heart failure (e.g., fluid overload)
- 6 - Cardiac dysrhythmia (irregular heartbeat)
- 7 - Myocardial infarction or chest pain
- 8 - Other heart disease
- 9 - Stroke (CVA) or TIA
- 10 - Hypo/Hyperglycemia, diabetes out of control
- 11 - GI bleeding, obstruction, constipation, impaction
- 12 - Dehydration, malnutrition
- 13 - Urinary tract infection
- 14 - IV catheter-related infection or complication
- 15 - Wound infection or deterioration
- 16 - Uncontrolled pain
- 17 - Acute mental/behavioral health problem
- 18 - Deep vein thrombosis, pulmonary embolus
- 19 - Scheduled treatment or procedure
- 20 - Other than above reasons
- UK - Reason unknown

(M2440) For what Reason(s) was the patient Admitted to a Nursing Home? (Mark all that apply.)

Comments

- 1 - Therapy services
- 2 - Respite care
- 3 - Hospice care
- 4 - Permanent placement
- 5 - Unsafe for care at home
- 6 - Other
- UK - Unknown

(M0903) Date of Last (Most Recent) Home Visit:

Comments

Date:

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

Comments

Date:

Outcomes

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Goals met | <input type="checkbox"/> Stabilized | <input type="checkbox"/> Improved functional status | <input type="checkbox"/> Lack of progress | <input type="checkbox"/> Deterioration of status |
| <input type="checkbox"/> Conditioned improved | <input type="checkbox"/> Improved knowledge of self care management | <input type="checkbox"/> Improved independence | <input type="checkbox"/> Others | |

E-Clinical OASIS C Discharged Assessment

Resource Ongoing

Nursing home Meals on Wheels State program Other (specify)

Discharge instructions? Yes No Counseled to use medical follow up and PT verbalizes Yes No
 Able to comprehend? Yes No Instructed to call agency of choice for future home care needs? Yes No

Living Arrangements at Discharge

Own home Relative home Nursing home Other (specify)

Discharge from Home Health Care All disciplines notified and discontinued Office scheduler notified Knowledgeable Re: Medication schedule
 Private duty services offered Report given to institution or agency assuming care w/ notification of Order and summary completed
 Physician notified Advance Directive Other Instruction sheet left with client

Skilled Interventions: (Procedure and Teaching)

<p>DIABETES MANAGEMENT</p> <p><input type="checkbox"/> DM</p> <p><input type="checkbox"/> Manifestation of DM</p> <p><input type="checkbox"/> Diabetes Type I / Type II</p> <p> <input type="checkbox"/> Insulin / Oral Agent <input type="checkbox"/> Diet controlled</p> <p><input type="checkbox"/> Knowledge deficit</p> <p>Comments</p> <p>Diabetic Foot Care Teaching</p>	<p><input type="checkbox"/> Glucometer use / monitor in home</p> <p><input type="checkbox"/> FSBS range / Results</p> <p><input type="checkbox"/> Manifestations</p> <p> <input type="checkbox"/> Renal <input type="checkbox"/> Neuropathy / Neurological <input type="checkbox"/> Ophthalmic</p> <p> <input type="checkbox"/> Others</p> <p><input type="checkbox"/> Others</p>
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PROGNOSIS:

Poor Guarded Fair Good Excellent

Orders:

Goals:

DischargedSummary

<p>Nurse's Signature and Date:</p> <p>Name and Title</p>	<p>HHA USE ONLY</p>	<p>Checked By:</p> <p>Date:</p>	<p>Entered By:</p> <p>Date:</p>	<p>Transmitted By:</p> <p>Date:</p>
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E-Clinical OASIS C Discharged Assessment

Patient's Signature

Caregiver's Signature