QA Quality Assurance Indicator SG Safety Goal

# OASIS DISCHARGE ASSESSMENT

☐ PATIENT ID PERFORMED VIA NAME, DOB, FACE RECOGNITION AND ADDRESS BEFORE SERVICE PROVIDED SG

TIME IN ________ TIME OUT ________

(M0030) **Start of Care Date:** __ __/__ __/ __ __ __ __ month day year

(M0032) **Resumption of Care Date:** __ __/__ __/ __ __ __ __ month day year ☐ NA - Not Applicable

DATE ______/______/______

(M0010) **CMS Certification Number (Provider):** __ __ __ __ __ __  Agency Name: ____________

(M0014) **Branch Identification Branch State:** __ __ ☐ NA - Not Applicable  Phone: ____________

(M0016) **Branch ID Number:** __ __ __ __ __ __ __ __ __ __  Employee's Name/Title Completing the OASIS: ____________

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(M0018) **National Provider Identifier (NPI) for the attending physician who has signed the plan of care:**

__ __ __ __ __ __ __ __ __ __ ☐ **Unknown or Not Available**

**Physician name:** ____________

Address: ____________

Phone Number: ____________

**PHYSICIAN:** Date last contacted ___/___/___  Date last visited ___/___/___

Reason: ____________

**Other Physician** (if any): ____________

Address: ____________

Phone Number: ____________

## Discharge Instruction Completed:

☐ Yes No  MD approved D/C: ☐ Yes ☐ No

Coordination of care with all involved discipline was achieved: Yes No  If not, complete:

Reason: ____________

Comment: ____________

**Discharge Summary Completed:** ☐ Yes ☐ No  If not, document:

Faxed/Sent to Physician on: ____________

(M0020) **Patient ID Number:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ .
**(Medical Record)**

(M0040) **Patient Name:**

**(First)** **(M I)** **(Last)** **(Suffix)**

Address: ____________

Patient Phone: ____________  ☐ ALF / AFHC (circle)

(M0050) **Patient State of Residence:** __ __  Name: ____________

(M0060) **Patient Zip Code:** __ __ __ __ __ __ __ __ __  Phone: ____________

(M0063) **Medicare Number:** __ __ __ __ __ __ __ __ __ __ __ __ __ (including suffix) ☐ **N/A No Medicare**

(M0064) **Social Security Number:** __ __ __ - __ __ - __ __ __ __ ☐ **Unknown or Not Available**

(M0065) **Medicaid Number:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ **N/A No Medicaid**

(M0066) **Birth Date:** __ __/__ __/__ __ __ __ **month / day / year**

(M0069) **Gender:** **1 - Male** **2 - Female**

**Patient/Family Instructed about discharge process:** ☐ Yes ☐ No

**Discharge Instructions completed/left copy to patient/family:** ☐ Yes ☐ No  If yes, complete:

**Patient/Family understood instructions given:** ☐ Yes ☐ No

Comment: ____________

(M0080) **Discipline of Person Completing Assessment:**

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

**Type of Visit:** ☐ Skilled & Discharge ☐ Discharge only

☐ Unable to assess, in office discharge: ☐ Reason: ____________

(M0090) **Date Assessment Completed:** ______/______/______ month day year

(M0100) **This Assessment is Currently Being Completed for the Following Reason:**
**Discharge from Agency - Not to an Inpatient Facility**

☐ 9 - Discharge from agency *[Go to M1041]*

(M1041) **Influenza Vaccine Data Collection Period:** Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

0 - No [Go to M1051]
1 - Yes

(M1046) **Influenza Vaccine received:** Did the patient receive the influenza vaccine for this year's flu season?

1 - Yes; Received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
2 - Yes; Received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
3 - Yes; received from another health care provider (eg. physician, pharmacy)
4 - No; patient offered and declined
5 - No; patient assessed and determined to have medical contraindications)
6- Not indicated; patient does not meet age/condition guidelines for influenza vaccine
7 - No; Inability to obtain vaccine due to declared shortage
8 - No; patient did not receive the vaccine due to reasons other than those listed in response 4-7.

(M1051) **Pneumococcal Vaccine:** Has the patient ever received the pneumococcal vaccination (for e.g. pneumovax)?

0 - No  1 - Yes ***[Go to M1230]***

SAMPLE To order: 305-818-5940

PATIENT NAME - Last, First, Middle Initial | Med. Record #

Patient Name: Med. Record # ____________

## CLINICAL RECORD ITEMS (Cont'd)

**(M1056) Reason Pneumococcal Vaccine not received:** If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:

- ❑ 1 - Offered and declined
- ❑ 2 - Assessed and determined to have medical contraindication(s)
- ❑ 3 -Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine.
- 4- None of the above

Comments: ____________

## SENSORY STATUS

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

- ❑ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- ❑ 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).
- ❑ 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.
- ❑ 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.
- ❑ 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).
- ❑ 5 - Patient nonresponsive or unable to speak.

## PAIN

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

- ❑ 0 - Patient has no pain
- ❑ 1 - Patient has pain that does not interfere with activity or movement
- ❑ 2 - Less often than daily
- ❑ 3 - Daily, but not constantly
- ❑ 4 - All of the time

What makes pain worse? ❑ Sleep/Time at Bed ❑ Minimal activity ❑ Movement ❑ Ambulation ❑ Immobility ❑ Transfer

❑ Other: ____________

How does the pain interfere with their functional/activity level, ADLs? (explain)

____________

| Pain Assessment | site 1 | site 2 | site 3 |
|---|---|---|---|
| Location / site | | | |
| New Onset/ Exacerbation | | | |
| Present level (0-10) | | | |
| Best Pain Scale 0-10 / Worst Pain Scale 0-10 | | | |
| Frequency: Occasionally, Continuous, Intermittent. Frequently | | | |
| Pain type: (aching, burning, radiating, neuralgia, etc) | | | |
| Feeling of pain: internal, external, acute, chronic. Pain is worse: morning, afternoon, evening, nights | | | |

**Patient complains about pain:** ❑ Yes ❑ No

NON-VERBAL INDICATORS: ❑ Guarding ❑ Crying ❑ Afraid to move ❑ Moaning

Other: ____________

**Intensity:** (using scales below)

Wong-Baker FACES Pain Rating Scale *

NO HURT | HURTS LITTLE BIT | HURTS LITTLE MORE | HURTS EVEN MORE | HURTS WHOLE LOT | HURTS WORSE

0 2 4 6 8 10

No Pain | Moderate Pain | Worst Possible Pain

**Collected using:** ❑ **FACES Scale (Observed)** ❑ **0-10 Scale (patient reporting)**

*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 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 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 that best describes how he is feeling.*

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

What relief pain? ❑ Heat ❑ Ice/unguent ❑ Change position ❑ Rest/Relaxation ❑ Medication: ____________ ❑ Entertainment ❑ Massage/Therapy ❑ Walk ❑ Go to bed

❑ Other: ____________

If taken medication, how often is needed? ❑ Never ❑ Less than daily ❑ Daily ❑ 2-3 times/day ❑ More than 3 times/day

Does one medication relieve pain better than another? If yes which one. ____________

Pain control treatment/meds Side effect? (mark) ❑ Nausea ❑ Vomiting ❑ Sleepy ❑ Confusion ❑ Other: ____________

Is there a regular pattern to the pain? (explain) ____________

Does the pain radiate? ❑ Yes ❑ No

❑ Occasionally ❑ Continuously ❑ Intermittent ❑ Frequently

Current pain control medications adequate: ❑ Yes ❑ No

Comment: ____________

Implications Care Plan: ❑ Yes ❑ No

Has the physician been notified by the: ❑ Patient ❑ Staff

At Discharge what was the outcome? ____________

## CAREGIVER / LIVING ARRANGEMENT

**Primary Caregiver/S.O.** (name) ____________ ❑ **N/A**

Phone Number (if different from patient) ____________

**Relationship to patient:** ____________

Is there any other caregiver(s) detail the specific assistance they give with medical cares, and/or ADLs:

____________

Able to safely care for patient ❑ Yes ❑ No

Other Facility involved in care/Comments: ____________

SAMPLE To order: 305-818-5940

Patient Name: Med. Record # ____________

## FULL SYSTEMS REVIEW

Height: ________ ❑ reported ❑ actual Weight: ________ ❑ reported ❑ actual

Reported weight changes by: ❑ Patient ❑ Caregiver/Family ❑ Nurse

Gain/Loss ________ lb. X ________ wk./mo./yr.

## VITAL SIGNS (Discharge visit)

**Blood Pressure:** ❑ Sitting/lying R ________ L ________
❑ Standing R ________ L ________

**Temperature:** ________ ❑ Oral ❑ Axillary ❑ Rectal ❑ Tympanic

**Pulse:** ❑ Apical ______ ❑ Brachial ______ ❑ Rest ❑ Activity
❑ Radial ______ ❑ Carotid ______ ❑ Cheynes Stokes
❑ Regular ❑ Irregular

**Respirations:** ________ ❑ Death rattle ❑ Apnea periods -sec.
❑ Regular ❑ Irregular ❑ Accessory muscles used

## NUTRITIONAL/DIET STATUS

**DIET (Circle or check all that apply)** ❑ Controlled Carbohydrate

❑ 2 gm Sodium ❑ Low Sodium ❑ NAS ❑ NPO ❑ 1800 cal ADA

❑ Low Fat ❑ Low cholesterol Other: ____________

❑ Increase fluids: ________ amt. ❑ Restrict fluids ________ amt.

Appetite: ❑ Good ❑ Fair ❑ Poor ❑ Anorexic ❑ Nausea/Vomiting

Hydration adequate: ❑ Yes ❑ No

**Assessment Findings:** Intake adequate: ❑ Yes ❑ No

❑ **Heartburn** (food intolerance): Frequency: ____________

Instructed to maintain the diet restrictions after discharge: ❑ Yes ❑ No

Instructions/Comments: ____________

❑ **No Problem**

## ENTERAL FEEDINGS - ACCESS DEVICE

❑ **TPN** ❑ Nasogastric ❑ Gastrostomy ❑ Jejunostomy ❑ Other (specify): ________

Feedings: Type (amt./rate) ____________

Flush Protocol: (amt./specify) ____________

Performed by: ❑ Patient ❑ SN ❑ Caregiver ❑ Other ________

Interventions /teachings/Comments ____________

❑ **N/A**

## ENDOCRINE STATUS

Any **symptoms** present (circle): ❑ Hyperglycemia, Polyuria, Glycosuria, Polydipsia
❑ Fatigue ❑ Hypoglycemia, Sweats, Weak, Faint, Stupor, Polyphagia

A1c ______ % BS ______ mg/dL Date/Time: ________ ❑ **No Problem**

❑ FBS ❑ Before meal ***Mark:*** ❑ ***Today's visit*** ❑ ***Patient/Caregiver reported***

❑ Blood sugar ranges ________ ❑ Postprandial ❑ Random HS ❑ Lab slip

❑ *Patient/Caregiver Report* **Monitored by:** ❑ Self ❑ Caregiver/Family ❑ Nurse ❑ Other: ____

Able to use Glucometer: ❑ Yes ❑ No ________ Frequency: ________

## INTEGUMENTARY STATUS

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

❑ 0 - No ***[Go to M1322]*** *(Excludes Stage I pressure ulcers and healed Stage II pressures ulcers)*
❑ 1 -Yes

**(M1307) The Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)

❑ 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: ____/____/____ (month day year)

❑ NA - No Stage II pressure ulcers are present at discharge.

Pressure sores/Wounds are easy to develop but very difficult to cure.

Daily skin care plays a large part in prevention.

Summary Procedure for skin maintenance: Explain skin care procedure to patient, bed mobility, increase activities as tolerated, etc.

Leave patient comfortable. Wash hands, follow universal/standadrd precautions and use PPE.

SAMPLE
To order: 305-818-5940

**(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage:**

| | Enter Number |
|---|---|
| **A1. Stage 2: 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 blister. Number of Stage 2 pressure ulcers. If 0 - Go to M1311B1]** | |
| **A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC | |
| **B1. Stage 3: Full thickness tissue loss.** Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers.[If 0 - Go to M1311C1] | |
| **B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC** | |
| **C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers. [If 0 - Go to M1311D1]** | |
| **C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC** | |
| **D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers due to non-removable dressing/device. [If 0 - Go to M1311E1]** | |
| **D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC | |
| **E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar. [If 0 - Go to M1311F1]** | |
| **E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC** | |
| **F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution Number of unstageable pressure ulcers with suspected deep tissue injury in evolution. [If 0 - Go to M1313]** | |
| **F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC** | |

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## INTEGUMENTARY STATUS (Cont'd.)

### (M1313) Worsening in Pressure Ulcer Status since SOC/ROC:

| **Instructions for a-c:** Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0. | **Enter Number** |
|---|---|
| a. Stage 2 | ☐ |
| b. Stage 3 | ☐ |
| c. Stage 4 | ☐ |
| **Instructions for e:** For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC. | **Enter Number** |
| d. Unstageable—Known or likely but Unstageable due to non-removable dressing. | ☐ |
| e. Unstageable—Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar. | ☐ |
| f. Unstageable—Suspected deep tissue injury in evolution. | ☐ |

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

*(Excludes pressure ulcer that cannot be observed due to non-removable dressing/ device)*

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

**(M1322) Current Number of Stage 1 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. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

0 1 2 3 4 or more

**(M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer taht is Stageable:**

*(Excludes pressure ulcer that cannot be observed due to non-removable dressing/ device)*

1 - Stage I
2 - Stage II
3 -Stage III
4 - Stage IV
NA - Patient has no pressure ulcer or no stageable pressure ulcers

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

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 unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) ***[Go to M1340]***

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

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

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

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

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

0 - No ***[Go to M1400]***
1 - Yes, patient has at least one (observable) surgical wound
2 - Surgical wound known but not observable due to non-removable dressing ***[Go to M1400]***

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

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

**Pressure/Stasis Ulcer, Surgical wound, Skin lesion or Open Wound Documentation Guidelines:**

LOCATION
STAGE per Agency policy
DIMENSIONS: Always measure length, width, and depth and document it in that order. Always recorded in centimeters.
UNDERMINING/TUNNELING: Recorded in centimeters.
WOUND BASE DESCRIPTION: describe the wound bed appearance.
DRAINAGE: (Amount, Color/Consistency, Odor)
WOUND EDGES: Describe area up to 4cm from edge of the wound.
PROGRESS: Improved, No Change, Stable, or Declined.
ODOR: Present or not
PAIN: Associated with the wound. Interventions

**QUICK ASSESSMENT OF LEG ULCERS** *(CMS, Qualitynet)*

VENOUS INSUFFICIENCY (STASIS): LOCATION: • Medial aspect of lower leg and ankle • Superior to medial malleolus

APPEARANCE: • Color: base ruddy • Surrounding Skin: erythema (venous dermatitis) and/or brown staining (hyperpigmentation) • Depth: usually shallow • Wound Margins: irregular • Exudate: moderate of heavy • Edema: pitting or non-pitting; possible induration and cellulitis • Skin Temp: normal; warm to touch • Granulation: frequently present • Infection: less common

PAIN: • Minimal unless infected or desiccated.

PERIPHERAL PULSES: • Present/Palpable

CAPILLARY REFILL: • Normal-less than 3 seconds

SAMPLE To order: 305-818-5940

Patient Name: Med. Record # ____________

## INTEGUMENTARY STATUS (Cont'd.)

| WOUND/LESION ULCER (specify) | #1 | #2 | #3 | #4 | Diagram |
|---|---|---|---|---|---|
| Location (specify in diagram) | | | | | FRONT BACK LEFT FOOT (L) RIGHT FOOT (R) (R) (L) (L) (R) (R) (L) |
| **Type:** Pressure ulcer/Abrasion Diabetic foot ulcer Arterial / Surgical Malignancy / Incision Mechanical/Fistula Venous stasis ulcer | | | | | |
| **Size**(cm) (LengthxWidthxDepth) | | | | | |
| Tunneling/ Undermining (cm) | | | | | |
| Stage (I-II-III-IV) (pressure ulcers only) | | | | | |
| Odor **(Fool, normal, etc)** | | | | | |
| Surrounding Skin *(redness, damage, specify)* / Stoma (Specify) | | | | | |
| Edema (pedal, sacral, pitting, etc) | | | | | |
| Appearance of the Wound Bed | | | | | |
| Treatment Ordered | | | | | |
| Drainage/Amount | ☐ None ☐ Small ☐ Moderate ☐ Large | ☐ None ☐ Small ☐ Moderate ☐ Large | ☐ None ☐ Small ☐ Moderate ☐ Large | ☐ None ☐ Small ☐ Moderate ☐ Large | Is there at least one pressure ulcer that cannot be observed due to the presence of scar or a nonremovable dressing, including casts? ☐ Yes ☐ No |
| Color | ☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other ____ | ☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other ____ | ☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other ____ | ☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other ____ | ____ |
| Consistency | ☐ Thin ☐ Thick | ☐ Thin ☐ Thick | ☐ Thin ☐ Thick | ☐ Thin ☐ Thick | ____ ____ |

SAMPLE To order: 305-818-5940

## FOOT EXAM (DIABETIC) / WOUND CARE

**DIABETIC FOOT EXAM:** *(mark all that apply)*

Frequency of diabetic foot exam: ❑ Daily ❑ Twice a day ❑ Weekly ❑ Every other day ❑ Twice a week ❑ Other: ____

Done by: ❑ RN/PT ❑ Caregiver (name) ____ ❑ Patient ❑ Other: ____

Exam by RN/PT this visit: ❑ Yes ❑ No

Significant integument findings: ____

Pedal pulses: ❑ Present right / left *(please circle)* ❑ Absent right / left *(please circle)*

Observation: ____

Lack of sense of: ❑ Warm right / left *(please circle)* ❑ Cold right / left *(please circle)*

Observation: ____

Neuropathy right / left *(please circle)* ❑ Right for ____ ❑ Left for ____ cm

❑ Tingling right / left *(please circle)* ❑ Burning right / left *(please circle)* Leg hair: ❑ Present right / left *(please circle)* ❑ Absent right / left *(please circle)*

**WOUND CARE PROCEDURE:** *(Check all that apply)*

Authorization to take Photo obtained: ❑ Yes ❑ No

Wound care done during this visit: ❑ Yes ❑ No

Location(s) wound site: ____

❑ Soiled dressing removed by: *(use biohazard waste box)* ❑ RN/PT ❑ Caregiver (name) ____ ❑ Patient ❑ Other: ____

Technique used: ❑ Sterile ❑ Clean

Procedure: Procedure tolerated well: ❑ Yes ❑ No

❑ Wound cleaned with (specify): ____

❑ Wound irrigated with (specify): ____

❑ Wound packed with (specify): ____

❑ Wound dressing/cover applied (specify): ____

Wound leaved open to the air: ❑ Yes ❑ No

Patient/Caregiver able to care of the wound after discharge: ❑ Yes ❑ No ❑ N/A

Explain: ____

## RESPIRATORY STATUS

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

❑ 0 - Patient is not short of breath
❑ 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)

❑ **Assessed this visit** ❑ **Reported by:** ❑ Patient ❑ Caregiver

Patient's Pharmacy Name/Phone if known: ____

Home Medical equipment Co./phone if known: ____

Patient Name: Med. Record # ____________

## CARDIOPULMONARY

**Breath Sounds:** ❑ Clear
❑ Crackles/rales ❑ Wheezes/rhonchi ❑ Diminished ❑ Absent
❑ Other ____________ ❑ **Deferred** (reason) ____________
❑ Accessory muscles used ____________

Anterior:
Right ____________
Left ____________

Posterior:
Right Upper ____________
Right Lower ____________
Left Upper ____________
Left Lower ____________

$O_2$ @ ______ LPM via cannula, mask, trach O2 saturation ______ % SG
*(Reinforce Fire safety/prevention)*

Trach size/type ____________
Who manages? ❑ Patient ❑ Caregiver/ family ❑ RN
❑ Other ____________

❑ **Cough:** ❑ No
❑ Yes: ❑ Productive ❑ Non-productive
Worse at: ❑ morning ❑ afternoon ❑ evening ❑ sleeping time
Describe: ____________

❑ **Dyspnea:** ❑ Rest ❑ During ADLs ❑ Effort ❑ Sleeping (apnea)
Comments: ____________

Any necessary positioning for improved breathing: ❑ No
❑ Yes, describe: ____________

**Chest Pain:** ❑ Yes ❑ No ❑ Anginal ❑ Postural ❑ Localized ❑ Substernal
❑ Radiating to: ____________
❑ Dull ❑ Ache ❑ Sharp ❑ Vise-like
Associated with: ❑ Shortness of breath/SOBOE ❑ Activity ❑ Sweats
Frequency/duration: ____________
How relieved: ❑ Rest ❑ Medication: ____________
❑ Other: ____________

❑ **Palpitations/Arrhythmias:** ❑ Fast/accelerated ❑ Slow ❑ Fatigue
❑ **Edema:** ❑ Pedal: ❑ Right ❑ Left ❑ Sacral
❑ Dependent: ____________
❑ Pitting +1/+2/+3/+4 ________ ❑ Non-pitting
Site: ____________
❑ **Cramps (site):** ____________ ❑ Claudication
❑ **Capillary refill:** ❑ less than 3 sec ❑ greater than 3 sec
Cardiopulmonary Management Problems (explain) ____________

**Heart Sounds:** ❑ Regular ❑ Irregular ❑ Murmur
❑ Pacemaker: Date ________ Last date checked ________
Type ____________

❑ **No Problem**

**(M1501) 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 the time of or at any time since the most recent SOC/ROC assessment?

- ❑ 0 - No ***[Go to M1600]***
- ❑ 1 -Yes
- ❑ 2 - Not assessed ***[Go to M1600]***
- ❑ NA - Patient does not have diagnosis of heart failure ***[Go to M1600]***

**(M1511) Heart Failure Follow-up**: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)

- ❑ 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 - Implemented 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.)

## ELIMINATION STATUS

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

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

**(M1610) Urinary Incontinence or Urinary Catheter Presence:** QA

- ❑ 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]***

**(M1615) When does Urinary Incontinence** occur?

- ❑ 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

**(M1620) Bowel Incontinence Frequency:**

- ❑ 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

Foley Catheter Yes: ❑ No ❑ If yes, last changed: ____________

## MENTAL STATUS

❑ 1 - Oriented ❑ 3 - Forgetful ❑ 5 - Disoriented ❑ 7 - Agitated
❑ 2 - Comatose ❑ 4 - Depressed ❑ 6 - Lethargic
❑ 8 - Other: ____________
❑ Forgetful at times ❑ Irritable ❑ Anxious ❑ Alert

❑ **No Problem**

SAMPLE
To order: 305-818-5840

Patient Name: Med. Record # ______________________

## NEURO/EMOTIONAL/BEHAVIOR STATUS

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

- ❑ 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)**

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

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

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

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

- ❑ 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)
- ❑ 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.

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

## ADL/IADLs

**(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).

- ❑ 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:

- ❑ 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:

- ❑ 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, washing hands, and shampooing hair).**

- ❑ 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.
- ❑ 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.

- ❑ 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.

SAMPLE To order: 305-818-5940

Patient Name: Med. Record # ______________________________

## ADL/IADLs

**(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.

- ❑ 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.

- ❑ 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.

- ❑ 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.

**(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.

- ❑ 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:

- ❑ 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 effective using the telephone to communicate.

- ❑ 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.

## ALLERGIES

❑ None known / NKA ❑ Aspirin ❑ Eggs ❑ Insect bites
❑ Penicillin ❑ Sulfa ❑ Animal dander and urine ❑ Dairy/Milk products
❑ Iodine ❑ Pollens and mold spores ❑ Dust mites
❑ Other: ______________________________

## MEDICATIONS

**(M2005) Medication Intervention:** Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

0 -No

1 -Yes

9 - NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

**(M2016) Patient/Caregiver Drug Education Intervention:** At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

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

**Patient/Caregiver able to Management Medication Regimen:** ❑ Yes ❑ No

Instructed to continue with Medication Regimen as prescribed: ❑ Yes ❑ No

❑ At discharge, any Medication regimen compliance problem (explain):

______________________________

______________________________

**Maintain financial ability to pay for medications:** ❑ Yes ❑ No

SAMPLE To order: 305-818-5940

Patient Name: Med. Record # ____________

## MEDICATIONS (Cont'd.)

**(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.)**

- ❑ 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.**

- ❑ 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 the injection
- ❑ 3 - Unable to take injectable medication unless administered by another person.
- ❑ NA - No injectable medications prescribed.

## STATUS AT DISCHARGE

Condition/Status upon D/C: ❑ Stable ☐ Unstable ❑ Improved ❑ Expired

Able to care by: ☐ Self ❑ with the help of Caregiver/family

Adjustment to illness/disability: ❑ Yes ☐ No

Explain: ____________

Support System: ____________

Community Referrals made: ❑ Yes ☐ No

Explain: ____________

Transferred to: ____________ ☐ N/A

SELF CARE ACTIVITY ON ADMISSION: ____________

At D/C: ❑ Self care resumed or: ☐ Assist to be provided by:

ADDITIONAL COMMENTS (Referrals Made/Community Resources):

## INFUSION / IV THERAPY

☐ **Infusion / IV Therapy will continue after discharge** ❑ Yes ☐ No ❑ **N/A**

❑ **Peripheral line** ❑ **Central line** ☐ **Medline catheter**

Type/brand ____________

Size: ________ Gauge: ________ Length: ________

❑ Groshong ❑ Non-Groshong ❑ Tunneled ❑ Non-tunneled

Insertion site ________ Insertion date ________

Lumens: ❑ Single ❑ Double ❑ Triple

Flush solution: ________ Frequency: ________

Patent: ❑ Yes ❑ No

Injection cap change frequency ____________

Dressing change frequency ________ ❑ Sterile ❑ Clean

Performed by: ❑ Patient ❑ RN ❑ Caregiver ❑ Other: ________

Site/skin condition ____________

External catheter length ____________

Other/Comment: ____________

**IV Therapy complication observed:** ❑ Pain & irritation ❑ Infiltration & exravasion ❑ Occlusion/obstruction ❑ fluid overload Other: ________ ❑ **N/A**

**PICC Specific:**

Circumference of arm ________ X-ray verification: ❑ Yes ☐ No

**IVAD Port Specific:** Reservoir: ❑ Single ☐ Double

Huber gauge/length ____________

Accessed: ❑ No ❑ Yes, date ________

Intravenous IV Port: ❑ Yes ☐ No *(vascular access device)* Flush Ordered: ❑ Yes ☐ No

Last flushed date: ________

**Epidural/Intrathecal Access:**

Site/skin condition ____________

Infusion solution (type/volume/rate) ____________

Dressing ____________

Other/Comment: ____________

❑ IV-Infusion Medication(s) administered:

Drug Name: ____________

Dose ________ Route ________

Frequency ________ Duration of therapy ________

❑ IV-Infusion Medication(s) administered:

Drug Name: ____________

Dose ________ Route ________

Frequency ________ Duration of therapy ________

❑ Pump: (type, specify) ____________

Administered by: ❑ Patient ☐ Caregiver ❑ RN ❑ Other ________

Purpose of Intravenous Access:

❑ Antibiotic therapy ❑ Pain control ❑ Lab draws

❑ Chemotherapy ❑ Maintain venous access

❑ Hydration ❑ Parenteral nutrition

❑ Other ____________

❑ Infusion care provided during visit ____________

Interventions/ Instructions/Comments ____________

SAMPLE To order: 305-818-5940

## CARE MANAGEMENT

**(M2102) Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Exclude all care by you agency staff (Check only one box in each row.)

| Type of Assistance | **No Assistance Needed** - patient is independent or does not have needs in this area | **Non-agency Caregiver(s)** currently provide assistance | **Non-agency Caregiver(s)** need training/ supportive services to provide assistance | **Non-agency Caregiver(s)** are **not likely to** provide assistance OR it is unclear if they will provide assistance | **Assistance needed,** but non non-agency caregiver(s) available | Comments if needed (optional) |
|---|---|---|---|---|---|---|
| a. **ADL Assistance** (e.g., transfer/ambulation, bathing, dressing, toileting, eating/ feeding) | 0 | 1 | 2 | 3 | 4 | |
| b. **IADL Assistance** (e.g., meals, housekeeping, laundry, telephone, shopping, finances) | 0 | 1 | 2 | 3 | 4 | |
| c. **Medication Administration** (e.g., oral, inhaled or injectable) | 0 | 1 | 2 | 3 | 4 | |
| d. **Medical Procedures/ Treatments** (e.g., changing wound dressing, home exercise) | 0 | 1 | 2 | 3 | 4 | |
| e. **Management of Equipment** (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies) | 0 | 1 | 2 | 3 | 4 | |
| f. **Supervision and Safety** (e.g., due to cognitive impairment) | 0 | 1 | 2 | 3 | 4 | |
| g. **Advocacy or Facilitation** of patient's participation in appropriate medical care (includes transportation to or from appointments) | 0 | 1 | 2 | 3 | 4 | |

Instruct the patient to reach Emergent Care in any sign of exacerbation of his/her disease, condition or trauma, and if any injure, accident, or fall occur.
Explain also that they can ask his/her physician for any new help from the Agency after any emergent care or new development.

## EMERGENT CARE

**(M2301) Emergent Care:** At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

- ❑ 0 - No ***[Go to M2401]***
- ❑ 1 - Yes, used hospital emergency department WITHOUT hospital admission
- ❑ 2 - Yes, used hospital emergency department WITH hospital admission
- ❑ UK - Unknown ***[Go to M2401]***

If Yes, Hospital, Emergency institution used:

____________________

Date: ____________

The OASIS Transfer to In-patient Facility was used/submitted:

❑ Yes ❑ No ❑ **N/A** ____________

## EMERGENT CARE (Cont'd.)

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

- ❑ 1 - Improper medication administration, adverse drug reactions, 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

SAMPLE To order: 305-818-5940

Patient Name: Med. Record # ____________________________

## DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

**(M2401) Intervention Synopsis:** (Check only **one** box in each row.) At the time of, or at any time 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 | |
|---|---|---|---|---|
| a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care | ❑ 0 | ❑ 1 | ❑ NA | Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee) |
| b. Falls prevention interventions | 0 | 1 | NA | Every standardized, validated multi-factor fall risk assessment conducted at or since the last OASIS assessment indicates the patient has no risk for falls. |
| c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment | 0 | 1 | NA | Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the last OASIS assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used. |
| d. Intervention(s) to monitor and mitigate pain | ❑ 0 | ❑ 1 | ❑ NA | Every standardized, validated pain assessment conducted at or since the last OASIS assessment indicates the patient has no pain. |
| e. Intervention(s) to prevent pressure ulcers | ❑ 0 | ❑ 1 | ❑ NA | Every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers. |
| f. Pressure ulcer treatment based on principles of moist wound healing | ❑ 0 | ❑ 1 | ❑ NA | Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated. |

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

❑ 1 -Hospital ***[Go to M2430]***
❑ 2 - Rehabilitation facility ***[Go to M0903]***
❑ 3 - Nursing home ***[Go to M0903]***
❑ 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)
❑ 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 ***[Go to M0903]***

SAMPLE To order: 305-818-5940

## SKILLED CARE PROVIDED THIS VISIT

☐ **Skilled Observation / Assessment** ☐ **Foley Change** ☐ **Foley irrigation** ☐ **Wound Care / Dressing Change** ☐ **Prep. / Admin. Insulin** ☐ **Diabetic Observation / Care**

☐ INJECTION ROUTE:______ SITE: _____ MED. GIVEN: ____________________ DOSE: _________ REACTION: __________________________ ☐ Procedure/Tx well tolerated by Pt.

☐ Standard/Universal Precautions Followed ☐ Aseptic Tech. Used. ☐ Quality Control of Glucometer Performed ☐ Sharps Discarded Inside Sharps Container

## SIGNATURE/DATES

X ________________________________
Staff Completing the OASIS (signature/title)

X ________________________________
Patient Signature if required / optional if itinerary is used

_______/_______/_______
Date

## OASIS INFORMATION

**QA Date Reviewed:**________/________/________ **Data Entry Date & Locked:**________/________/________ **Date Submitted:**________/________/________

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Discharge January/2017

Patient Name: Med. Record # ______________

# DISCHARGE/CARE SUMMARY

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

____/____/____
month day year

❑ DISCHARGE COMPLETE

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

____/____/____
month day year

**DISCIPLINES INVOLVED DURING THIS ADMISSION/SERVICES PROVIDED:**

❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide ❑ Other (specify) ______________

DIAGNOSIS *(Primary)*: ______________

Medicare Provider Non-Coverage Form given to Patient: ❑ Yes ❑ No ❑ N/A

Advance Beneficiary Notice Form given to Patient: ❑ Yes ❑ No ❑ N/A

**REASON FOR DISCHARGE:**

❑ Patient-centered goals met
❑ Patient expired
❑ Move out of area of services
❑ Patient refused further care/services
❑ No longer home bound
❑ Hospitalized ______________
❑ Rehabilitated to Potential
❑ Patient/Family request
❑ Physician request
❑ Repeatedly not home/not found
❑ Patient refused to accept care/treatments as ordered
❑ Persistent noncompliance with POC
❑ Do not qualify for services ______________
❑ Failure to maintain services of an attending physician
❑ Transfer to an In-patient Facility (Hospice, Nursing Home/Rehab Facility)
❑ Home Health Agency decision
Explain: ______________
❑ Other (specify) ______________

**CARE SUMMARY PROVIDED DURING THIS ADMISSION:** (including progress toward goals to date, rehabilitation to potential, and understanding disease management)

______________

**MEDICATION STATUS:** SG ❑ Medication regimen reviewed with patient/family

Medication Record/Schedule Form Updated given to Patient: ❑ Yes ❑ No

Check if any of the following were identified: ❑ Potential adverse effects/drug reactions ❑ Ineffective drug therapy ❑ Significant side effects ❑ Duplicate drug therapy ❑ Non-compliance with drug therapy ❑ No change ❑ Significant drug interactions

**DISPOSITION OF THE PATIENT:**

❑ ABLE TO CARE FOR SELF
❑ INSTITUTIONALIZED
❑ FAMILY TO ASSIST
❑ HOMEMAKER TO ASSIST
❑ DECEASED
❑ Other (specify) ______________

**SUMMARY OF SERVICES RENDERED AND GOALS ACHIEVED**

❑ VERBALIZES KNOWLEDGE OF MEDICATIONS, SIDE EFFECTS, PRECAUTIONS, DIET. FLUIDS, DISEASE PROCESS, TREATMENT PROGRAM. S/S NECESSITATING MEDICAL ATTENTION.
❑ RETURN TO PREVIOUS LIFESTYLE WITH MODIFICATIONS WITHIN DISEASE LIMITATIONS.
❑ HOME FREE OF HAZARDS USING PROPER SAFETY MEASURES.
❑ PRESENTING SYMPTOMS ABSENT AND/OR CONTROLLED BY APPROPRIATE INTERVENTION.
❑ INDEPENDENCE IN SELF CARE WITHIN DISEASE LIMITATIONS.
❑ MAXIMUM POTENTIAL OF SKILLED SERVICES ATTAINED WITHIN HOME SETTING.
❑ REHABILITATED TO POTENTIAL WITHIN DISEASE LIMITATIONS.

**Reviewed:** ❑ Basic Home Safety ❑ Fall safety/prevention SG ❑ Medication safety/plan ❑ When to contact/call physician ❑ Next appointment with physician ❑ Standard precautions ❑ Other (describe) ______________

Was a referral made to MSW for assistance with community resources/assistance with a counseling needs (depression/suicidal inclination) living will/DNR, and/or safety environment problems? Date ______________ ❑ Yes ❑ No ❑ Refused ❑ N/A

Comment: ______________

**DISCHARGE INSTRUCTIONS (specify future follow-up, referrals, etc.)** ❑ DISEASE PROCESS ❑ INJECTION ADMINISTRATION ❑ DIABETIC MANAGEMENT ❑ DIET/FLUID INTAKE ❑ ACTIVITY RESTRICTIONS ❑ INFECTION CONTROL ❑ Other (describe): ______________

**Written instructions given to patient/caregiver:** ❑ Yes ❑ No, explain ______________

**Patient/Caregiver demonstrates understanding of instructions:** ❑ Yes ❑ No, explain ______________

*Dear Physician, Thank you for allowing us to take care of your patients. This is the Discharge Summary for your records.*

RN/PT CONTACTED PHYSICIAN ON DATE: ______________ AND DISCHARGE ORDER WAS APPROVED.

SUMMARIZE: ______________

Signature/Title of Staff Completing the DC summary ______________ Date ____/____/____

SAMPLE To order: 305-818-5940