Certification Period:
From:_____ To:_____

ITEM USES:
(=) = Optional Collection ⇔ = Look Back
(0) = Dash is a valid response.
See the OASIS Guidance Manual for specific item.

RECERTIFICATION/ FOLLOW-UP ASSESSMENT
INCLUDING OASIS ELEMENTS WITH PLAN OF CARE INFORMATION

DATE:_____

TIME IN:_____ **TIME OUT:**_____

Follow OASIS items in sequence unless otherwise directed. **REASON FOR ASSESSMENT:** ❍ **Recertification** ❍ **Other Follow-up**

EMERGENCY PREPAREDNESS

★ ★ ★ **PRIORITY CODE:**_____ ★ ★ ★

Name of Emergency Contact:_____
Relationship:_____
Phone:_____
Address:_____
City:_____ State:_____ ZIP Code:_____
Email:_____

Representative Contact Information:
❑ Caregiver ❑ Representative ❑ Family were present during this visit:
❑ Other:_____

Does the patient have a representative? ❍ No ❍ Yes
If yes, is the person: ❍ Court declared ❍ Patient selected
Document below any changes in their information since the last OASIS assessment.

Name and Title of Representative:
_____

Representative Mailing Address:
_____

City:_____ State:_____ ZIP Code:_____
Phone Number(s): Work:_____
Home:_____
Cell:_____
Email:_____

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment

Enter Code ☐
1 RN
2 PT
3 SLP/ST
4 OT

Type of Visit: ❍ Skilled
❍ Skilled & Supervisory
❍ Other _____

(M0090) Date Assessment Completed: ☐☐/☐☐/☐☐☐☐ (month / day / year)

Complete M0090 using the date of the day information was last collected.

(M0100) This Assessment is Currently Being Completed for the Following Reason:

Enter Code ☐
Follow-Up
4 Recertification (follow-up) reassessment ***[Go to M0110]***
5 Other follow-up ***[Go to M0110]***

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

Enter Code ☐
1 Early
2 Later
UK Unknown
NA Not Applicable: No Medicare case mix group to be defined by this assessment.

ADVANCE DIRECTIVES

❑ Does patient have an Advance Directives order? ❍ Yes ❍ No
❑ No change since last OASIS assessment
Since the last OASIS assessment, the patient:
❑ obtained ❑ changed the item(s) checked below:
❑ An order for Advance Directives
❑ Living Will
❑ Cardiopulmonary Resuscitation (CPR)
❑ Do Not Resuscitate Order (DNR)
❑ Do Not Intubate Order (DNI)
❑ No Artificial Nutrition and Hydration
❑ Medical/Durable Power of Attorney: Name:_____ Phone #:_____
❑ Financial Power of Attorney: Name:_____ Phone #:_____
❑ State specific form(s)_____
❑ Copies on file with: ❑ PCP ❑ Other:_____
Comments:_____

PATIENT NAME–Last, First, Middle Initial	ID#

BRIGGS Healthcare

Patient Name_____ ID #_____

PATIENT HISTORY AND DIAGNOSES

(M1021/1023) Diagnoses and Symptom Control: List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only - no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 2: Enter the ICD-10-CM code for the condition described in Column 1 - no surgical or procedure codes allowed. Codes must be entered at the level of highest specificity and ICD-10-CM coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) may not be reported in M1021 (Primary Diagnosis) but may be reported in M1023 (Secondary Diagnoses). Also note that when a Z-code is reported in Column 2, the code for the underlying condition can often be entered in Column 2, as long as it is an active on-going condition impacting home health care.

Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis codes is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:

0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled; history of re-hospitalizations

Note that the rating for symptom control in Column 2 should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.

M1021, M1023 **(=)**

(M1021) Primary Diagnosis & (M1023) Other Diagnoses

Column 1 Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	Column 2 ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses
Description	ICD-10-CM / Symptom Control Rating
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
(M1023) Other Diagnoses b. _____	**All ICD-10-CM codes allowed** b. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
c. _____	c. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
d. _____	d. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
e. _____	e. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
f. _____	f. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
Complete g through y per agency policy for all pertinent secondary diagnoses identified g. _____	g. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
h. _____	h. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
i. _____	i. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
j. _____	j. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4

Patient Name_____ ID #_____

PATIENT HISTORY AND DIAGNOSES (Cont'd)

(M1023) Other Diagnoses (Continued)	All ICD-10-CM codes allowed
k. _____	k. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
l. _____	l. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
m. _____	m. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
n. _____	n. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
o. _____	o. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
p. _____	p. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
q. _____	q. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
r. _____	r. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
s. _____	s. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
t. _____	t. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
u. _____	u. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
v. _____	v. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
w. _____	w. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
x. _____	x. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4
y. _____	y. ☐☐☐ ☐☐☐☐ ❑0 ❑1 ❑2 ❑3 ❑4

Surgical Procedure(s) in past 2 months include date(s) ❑ **N/A**

_____ Date:_____

_____ Date:_____

(M1030) Therapies the patient receives at home: **(Mark all that apply.)** **(=)**

❑ 1 - Intravenous or infusion therapy (excludes TPN)
❑ 2 - Parenteral nutrition (TPN or lipids)
❑ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
❑ 4 - None of the above

Patient Name_____ ID #_____

PATIENT HISTORY AND DIAGNOSES (Cont'd)

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

- ❑ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- ❑ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ❑ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ❑ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ❑ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ❑ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ❑ 7 - Currently taking 5 or more medications
- ❑ 8 - Currently reports exhaustion
- ❑ 9 - Other risk(s) not listed in 1 - 8

  Explain:_____

- ❑ 10 - None of the above

Note: see page 13 fall risk and 18 for summary of risk factors

IMMUNIZATIONS - within the past 12 months:

❑ Influenza (specifically this year's flu season) ❍ No ❍ Yes

If yes, administered by:_____

Date:_____

According to immunization guidelines:

❑ Pneumonia ❑ Tetanus ❑ Shingles ❑ Hepatitis C

❑ Other:_____

Needs:_____

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE

Primary Caregiver

Patient provides their own care: ❍ Total ❍ Partial

Primary caregiver(s) other than patient: ❑ N/A ❑ None available

❑ Family member(s) ❑ Friend(s)

❑ Paid service other than home health staff:

Company name:_____

Phone number:_____

Contact name:_____

Primary Caregiver(s): Information below confirmed with:

❑ Patient ❑ Caregiver during this visit

Make changes as needed:

Name:_____

Relationship:_____ Phone Number:_____

Mailing address:_____

_____

Email address:_____

Name:_____

Relationship:_____ Phone Number:_____

Mailing address:_____

_____

Email address:_____

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE (Cont'd)

Caregiver(s) assist with (ADLs, IADLs and/or medical cares):

_____

_____

_____

Caregiver(s) willing to assist? ❍ Yes ❍ No ❍ Unknown If no or unknown, explain:_____

_____

Does the caregiver feel safe assisting the patient? ❍ Yes ❍ No ❍ Unknown If no or unknown, comment:

_____

_____

_____

List below the hours and days a caregiver is available to provide cares.

AM Hours ❑ There is no set schedule for availability

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

PM Hours

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Nights

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

❑ Check here if this information changed since the last OASIS assessment. What was the change?

_____

_____

_____

_____

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them):

Enter Code ☐ **(=)**

0 Normal vision: sees adequately in most situations; can see medication labels, newsprint.

1 Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.

2 Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.

Patient wears: Glasses: ❑ R ❑ L Contacts: ❑ R ❑ L

Prosthesis: ❑ R ❑ L Hearing aid: ❑ R ❑ L Other:_____

Select all areas that are affected:

What is the patient's structural (sensory) impairment:

❑ Eyes ❑ Ears ❑ Nose ❑ Mouth ❑ Throat

What is the functional impairment:

❑ Sight ❑ Hearing ❑ Smell ❑ Taste ❑ Throat

_____

What is the activity limitation (which ADL(s)/IADL(s) do they need help with to safely complete)?

_____

_____

_____

How do the skills of a nurse or therapist address the specific structural and/or functional impairment(s) and activity limitation(s) cited in steps above?

_____

_____

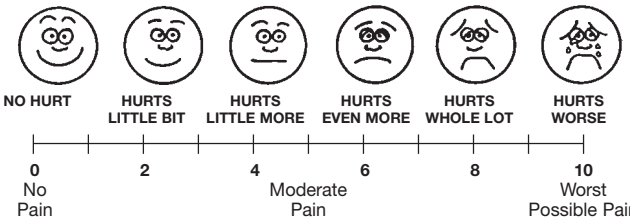
_____

Patient Name_____ ID #_____

PAIN

Intensity: (using scales below)

Wong-Baker FACES Pain Rating Scale**



Check box to indicate which pain assessment was used.

❍ **Wong-Baker** ❍ **PAINAD** ❍ Other:_____

Collected using: ❍ **FACES Scale** ❍ **0-10 Scale** **(subjective reporting)**

If applicable (with or without pain medication) what level of discomfort/ pain did the patient report is tolerable?

Score:_____

**From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Pain Assessment IN Advanced Dementia - PAINAD*

ITEMS	0	1	2	SCORE
Breathing Independent of Vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial Expression	Smiling, or inexpressive	Sad, Frightened, Frown.	Facial grimacing	
Body Language	Relaxed	Tense, Distressed pacing, Fidgeting.	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
****Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain 0 = "no pain" to 10 = "severe pain").**			**TOTAL****	

Instructions: Observe the older person both at rest and during activity/with movement. For each of the items included in the PAINAD, select the score (0, 1, or 2) that reflects the current state of the person's behavior. Add the score for each item to achieve a total score. Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity.

Note: Behavior observation scores should be considered in conjunction with knowledge of existing painful conditions and report from an individual knowledgeable of the person and their pain behaviors. Remember that some individuals may not demonstrate obvious pain behaviors or cues.

***Reference:** Warden, V, Hurley AC, Volicer, V. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. *J Am Med Dir Assoc*, 4:9-15. Developed at the New England Geriatric Research Education & Clinical Center, Bedford VAMC, MA.; Document updated 1.10.2013.

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

Enter Code ☐

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

❑ **No Problem**

Is patient experiencing pain? ❍ Yes ❍ No ❍ Unable to communicate

Non-verbals demonstrated: ❑ Diaphoresis ❑ Grimacing
❑ Moaning ❑ Crying ❑ Guarding ❑ Irritability ❑ Anger
❑ Tense ❑ Restlessness ❑ Change in vital signs
❑ Other:_____
❑ Self-assessment
❑ Implications:

_____
_____

Which activities are affected: (Check all that apply)

❑ Functional cognition/focus ❑ Transfers
❑ Hygiene ❑ Ambulation
❑ Dressing: ❑ upper ❑ lower ❑ Stairs: ❑ ascend ❑ descend
❑ Undressing: ❑ upper ❑ lower ❑ Eating
❑ Toileting ❑ Appetite
❑ Positional changes ❑ Other:_____

How does the pain interfere/impact the patient's functional ability and/or safety? ❑ **N/A** Explain problem:

_____
_____
_____

What makes pain worse? ❑ Movement ❑ Ambulation ❑ Immobility
❑ Other:_____
_____
_____

Is there a pattern to the pain? (explain) _____
_____
_____

What makes pain better? ❑ Heat ❑ Ice ❑ Massage ❑ Repositioning
❑ Rest ❑ Relaxation ❑ Medication ❑ Diversion
❑ Other:_____
_____
_____

How often is breakthrough medication needed? ❍ Never
❍ Less than daily ❍ Daily ❍ 2-3 times/day
❍ More than 3 times/day

Does the pain radiate? ❍ Occasionally ❍ Continuously ❍ Intermittent

Current pain control medications adequate: ❍ Yes ❍ No

Check all pharmacological classification(s) based on the pain medication(s) the patient is receiving:

❑ Analgesics ❑ Corticosteroid
❑ Antianxiety ❑ DMARD
❑ Anticonvulsant ❑ Local Anesthetics
❑ Antidepressant ❑ Narcotic
❑ Antimigraine ❑ NSAIDs
❑ Biologic ❑ Salicylate

Comment:_____
_____
_____
_____

Patient Name_____ ID #_____

PAIN (Cont'd)

Pain Assessment	Site 1	Site 2	Site 3
Location			
Onset			
Present level (0-10)			
Worst pain gets (0-10)			
Best pain gets (0-10)			

Pain description (aching, radiating, throbbing, etc.)

Site 1:

Site 2:

Site 3:

Comments:

INTEGUMENTARY STATUS

Does the patient appear to be at risk for acquiring any type of integumentary problem(s) based on the clinical factors (e.g., immobility, incontinence, skin thinning, impaired sensory, poor nutrition, skin disorder, poor circulation, etc.)?

❍ No ❍ Yes If yes, explain:

How does the patient's integumentary status affect the patient's functional ability and/or safety (i.e., patient has a high risk for skin tears that could result in secondary wound infection)?

❑ **N/A**

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer/ Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)

Enter Code ☐

0 No ***[Go to M1322]***

1 Yes

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (=)

	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**	☐
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**	☐
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**	☐
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**	☐
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**	☐
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

Patient Name_____ ID #_____

INTEGUMENTARY STATUS (Cont'd)

(M1322) Current Number of Stage 1 Pressure Injuries: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Enter Code ☐ (=)

0
1
2
3
4 or more

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable: (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)

Enter Code ☐ (=)

1 Stage 1
2 Stage 2
3 Stage 3
4 Stage 4
NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries

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

Enter Code ☐ (=)

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/device) ***[Go to M1340]***

(M1332) Current Number of Stasis Ulcer(s) that are Observable:

Enter Code ☐ (=)

1 One
2 Two
3 Three
4 Four or more

(M1334) Status of Most Problematic Stasis Ulcer that is Observable:

Enter Code ☐ (=)

1 Fully granulating
2 Early/partial granulation
3 Not healing

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

Enter Code ☐ (=)

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/device ***[Go to M1400]***

(M1342) Status of Most Problematic Surgical Wound that is Observable

Enter Code ☐ (=)

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

How does the patient's integumentary status affect the patient's functional ability and/or safety (i.e., patient has a high risk for skin tears that could result in secondary wound infection) ❑ **N/A**

_____
_____
_____
_____
_____

WOUND CARE: (Check all that apply) ❑ **N/A**

Wound care done during this visit: ❍ No ❍ Yes Location(s) wound site:_____

❑ Soiled dressing removed by: ❍ Patient ❍ Caregiver (name)_____ ❍ Family ❍ RN ❍ PT ❍ Other:_____

Technique: ❍ Sterile ❍ Clean

❑ Hands washed: ❑ before ❑ after dressing change

❑ Wound cleaned with (specify):_____ ❑ Wound irrigated with (specify):_____

❑ Wound packed with (specify):_____ ❑ Wound dressing applied (specify):_____

Patient tolerated procedure well: ❍ No ❍ Yes

❑ Soiled dressing properly disposed of (per agency policy)

Comments:_____

_____

_____

_____

DIABETIC FOOT EXAM: (Check all that apply) ❑ **N/A**

Frequency of diabetic foot exam_____

Done by: ❑ Patient ❑ Caregiver (name)_____ ❑ Family ❑ RN ❑ PT ❑ Other:_____

Exam by clinician this visit: ❍ No ❍ Yes

Integument findings:_____

_____

Pedal pulses: Present ❑ right ❑ left Absent ❑ right ❑ left Comment:_____

Loss of sense of: Warm ❑ right ❑ left Cold ❑ right ❑ left Comment:_____

Numbness ❑ right ❑ left Tingling ❑ right ❑ left Burning ❑ right ❑ left Leg hair: Present ❑ right ❑ left Absent ❑ right ❑ left

Comments:_____

_____

_____

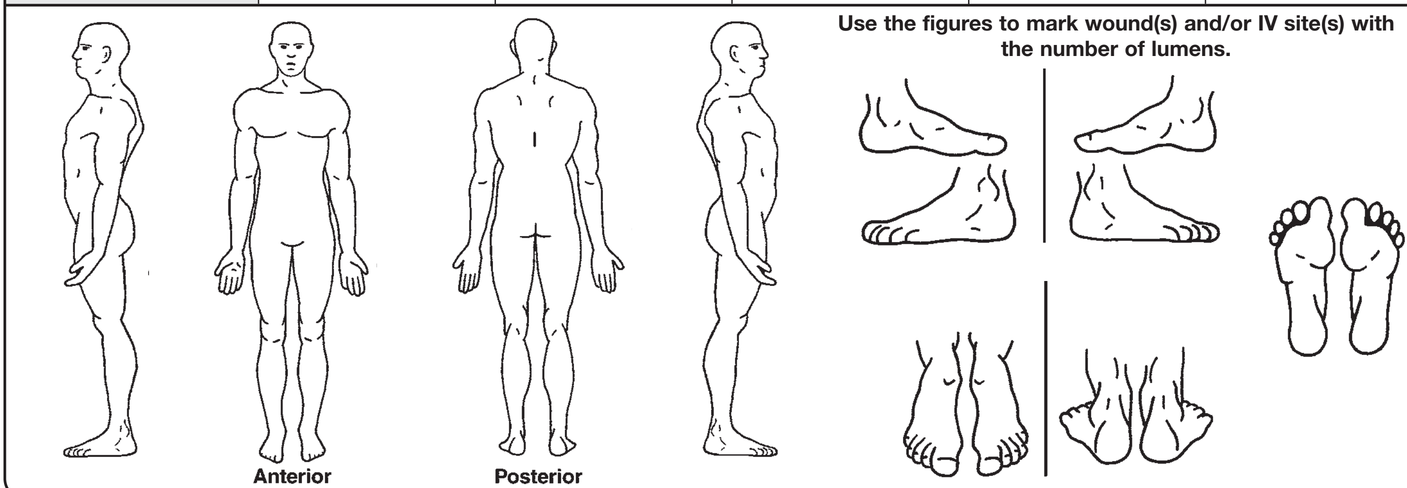
_____

Patient Name____ ID #____________________

BRIGGS INTEGUMENTARY STATUS CHART

WOUND/LESION **Date Originally Reported ➤**	#1 ________	#2 ________	#3 ________	#4 ________	#5 ________
Location					
Type *Include depth of infected surgical wound(s) in **Size** category below ➤	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ Other: __________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ Other: __________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ Other: __________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ Other: __________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ Other: __________
Size (cm) (L x W x D)					
Tunneling/Sinus Tract	length_____cm @ _____o'clock	length_____cm @ _____o'clock	length_____cm @ _____o'clock	length_____cm @ _____o'clock	length_____cm @ _____o'clock
Undermining (cm)	_____cm, from _____ to _____ o'clock	_____cm, from _____ to _____ o'clock	_____cm, from _____ to _____ o'clock	_____cm, from _____ to _____ o'clock	_____cm, from _____ to _____ o'clock
Stage **(pressure ulcers only)**					
Severity of Ulcer (exclude pressure ulcers)	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:________
Odor					
Surrounding Skin					
Edema					
Appearance of the Wound Bed	❑ Slough _______% ❑ Eschar _______% ❑ Granulation _______%	❑ Slough _______% ❑ Eschar _______% ❑ Granulation _______%	❑ Slough _______% ❑ Eschar _______% ❑ Granulation _______%	❑ Slough _______% ❑ Eschar _______% ❑ Granulation _______%	❑ Slough _______% ❑ Eschar _______% ❑ Granulation _______%
Drainage/Amount	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large
Color	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ 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	❍ Thin ❍ Thick
Date Healed					

Use the figures to mark wound(s) and/or IV site(s) with the number of lumens.



Patient Name_____ ID #_____

CARDIOPULMONARY

Disorder(s) of heart/respiratory system (type):_____

Breath Sounds:
(e.g., clear, crackles/rales, wheezes/rhonchi, diminished, absent)
Anterior:
Right_____ Left_____
Posterior:
Right Upper_____ Left Upper_____
Right Lower_____ Left Lower_____

❑ Labored breathing
❍ Non-smoker ❑ Last smoked:_____
❍ Smoker - frequency: ❍ Daily ❍ Occasional ❍ Very Occasional
If daily, (include all types of products that are smoked or vaporized)
how often:_____

Respiratory Treatments utilized at home:
❑ Oxygen ❍ intermittent ❍ continuous
❑ Ventilator ❍ continuous ❍ at night
❑ Continuous ❑ Bi-level positive airway pressure
O_2 @ _____ LPM via ❑ cannula ❑ mask ❑ trach O_2 saturation _____%
Trach size/type_____
Who manages? ❑ Patient ❑ RN ❑ Caregiver ❑ Family

Intermittent treatments (e.g., cough & deep breath, medicated inhalation treatments, etc.)
❍ No ❍ Yes, explain:

❑ **Cough:** ❍ No ❍ Yes: ❍ Productive ❍ Non-productive
Describe:_____
Positioning necessary for improved breathing:
❍ No ❍ Yes, describe:

Heart Sounds: ❍ Regular ❍ Irregular
❑ Pacemaker: Last date checked:_____
Color of nail beds:_____

Circulation:	N/A	Non-Pitting	Pitting	Capillary Refill
Edema Pedal Rt	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
Edema Pedal Lt	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec

❑ Extremity Cramp(s) (location):_____
❑ Pain at rest:_____
❑ Dependent:_____

❑ **Disease Management Problems (explain):**_____

SYSTEMS REVIEW

Height:_____ ❍ reported ❍ actual ❍ Actual Weight:_____ ❍ Not weighed
Weight Change: ❑ N/A
❍ Gain ❍ Loss _____ lb. X _____ ❍ week ❍ month ❍ year

VITAL SIGNS

Blood Pressure:	Left	Right	Sitting/Lying	Standing
At rest				
With activity				
Post activity				

Temperature:_____ F ❍ Oral ❍ Temporal ❍ Rectal ❍ Axillary ❍ Tympanic

Pulse: ❑ Apical_____ ❑ Brachial_____ ❍ Regular ❍ Irregular
❑ Radial_____ ❑ Carotid_____

Respirations:_____ ❍ Regular ❍ Irregular
❑ Apnea periods ____sec. ❍ observed ❍ reported
❍ Non-smoker ❍ Smoker Last smoked:_____

RESPIRATORY STATUS

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

Enter Code ☐

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

❍ **Assessed** ❍ **Reported**

Explain how/when SOB happens (i.e., patient can't walk and talk at the same time in cold weather)

How does the patient's respiratory status affect their functional ability and/or safety? (i.e., patient becomes dizzy when ascending stairs)

❑ **N/A**

Patient Name_____ ID #_____

ABDOMEN

❑ **No Problem**

❑ Tenderness ❑ Pain ❑ Distention ❍ Hard ❍ Soft

❑ Abdominal girth _____ cm

❑ Other:_____

_____

ENDOCRINE/HEMATOLOGY

❑ **No Problem**

Disorder(s) of endocrine system (type):

_____

_____

_____

_____

_____

_____

❑ Fatigue ❑ Intolerance to heat ❑ Intolerance to cold

Disorder(s) of blood (type):_____

❑ Anemia (specify if known):_____

❑ Other:_____

❑ Diabetes: ❍ Type 1 ❍ Type 2

❍ Other diabetes_____

Date of onset:_____

❑ Diabetic diet ❑ Oral medication ❑ Injectable medication

Was there a change in the diabetic medication since the last OASIS assessment: ❍ No ❍ Yes If yes, medication name, dose/frequency (specify):

_____

_____

_____

_____

Administered by: ❑ Patient ❑ Caregiver ❑ Nurse ❑ Family

❑ Other:_____

Reports symptoms of:

❑ Hyperglycemia: ❑ Increased urination ❑ Increased thirst

❑ Hypoglycemia: ❑ Sweats ❑ Increase hunger ❑ Weak ❑ Faint

❑ Stupor

A1C _____% ❑ Patient reported

❑ Lab slip Date:_____

BS _____mg/dL Date:_____ Time:_____

❑ FBS ❑ Before meal ❑ After meal ❑ Random ❑ HS

❑ Blood sugar ranges:_____

Reported by: ❑ Patient ❑ Caregiver ❑ Family

Monitored by: ❑ Patient ❑ Caregiver ❑ Family ❑ Nurse

❑ Other:_____

Frequency of monitoring:_____

Competency with use of Glucometer:_____

❑ **Disease Management Problems (explain):**

_____

_____

_____

_____

_____

_____

_____

FOOD/ENVIRONMENTAL ALLERGIES

❑ **N/A**

_____

_____

NUTRITIONAL STATUS

❑ **No Problem**

❑ NAS ❑ NPO ❑ Controlled Carbohydrate

❑ Other:_____

Nutritional requirements (diet)

_____

❍ Increase fluids:_____amt. ❍ Restrict fluids:_____amt.

Appetite: ❍ Good ❍ Fair ❍ Poor

Food intolerance:_____

Alcohol Use: ❍ No ❍ Yes If yes, frequency: ❍ Daily ❍ Occasional

❍ Very Occasional If daily, amount per day:_____

Nutritional Approaches: Check all that apply

❑ Parenteral/IV feeding

❑ Feeding tube – nasogastric or abdominal (e.g. PEG, NG)

❑ Mechanically altered diet – change of texture with solids or fluids (e.g., pureed or thickened)

❑ N/A

Directions: Check each area with "yes" to assessment, then total score to determine additional risk.	**YES**
Has an illness or condition that changed the kind and/or amount of food eaten.	❑ 2
Eats fewer than 2 meals per day.	❑ 3
Eats few fruits, vegetables or milk products.	❑ 2
Has 3 or more drinks of beer, liquor or wine almost every day.	❑ 2
Has tooth or mouth problems that make it hard to eat.	❑ 2
Does not always have enough money to buy the food needed.	❑ 4
Eats alone most of the time.	❑ 1
Takes 3 or more different prescribed or over-the-counter drugs a day.	❑ 1
Without wanting to, has lost or gained 10 pounds in the last 6 months.	❑ 2
Not always physically able to shop, cook and/or feed self.	❑ 2
TOTAL	

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INTERPRETATION

0-2 Good. As appropriate reassess and/or provide information based on situation.

3-5 Moderate risk. Educate, refer, monitor and reevaluate based on patient situation and organization policy.

6 or more High risk. Coordinate with physician, dietitian, social service professional or nurse about how to improve nutritional health. Reassess nutritional status and educate based on plan of care.

Describe at risk intervention:_____

_____

_____

_____

_____

_____

❑ **N/A**

If applicable, describe safety risk:

_____

_____

_____

_____

_____

❑ **N/A**

Patient Name_____ ID #_____

ELIMINATION STATUS

(M1610) Urinary Incontinence or Urinary Catheter Presence: (=)

Enter Code ☐

0 No incontinence or catheter (includes anuria or ostomy for urinary drainage)
1 Patient is incontinent
2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)

Urinary Elimination: ❑ **No Problem**

Disorder(s) of urinary system (type):_____

_____

(Check all applicable items) ❑ Observed ❑ Reported
❑ Urgency ❑ Frequency ❑ Burning ❑ Pain
❑ Hesitancy ❑ Increased urination at night ❑ Decreased urination
Color: ❍ Yellow/straw ❍ Amber ❍ Brown/gray ❍ Pink/red tinged
❑ Other:_____
Clarity: ❑ Clear ❑ Cloudy ❑ Sediment ❑ Mucous
Odor: ❍ Yes ❍ No
If the patient has incontinence, when does urinary incontinence occur?
❍ Timed-voiding defers incontinence ❍ Day only ❍ Night only
❍ Occasional stress incontinence ❍ During the day and night
❑ Incontinence products:_____

Urinary Catheter: Type:_____ Date last changed:_____
❑ Indwelling catheter changed this visit. Size _____ French
❑ Indwelling catheter inserted this visit. Size _____ French
❑ Single balloon ❑ Double balloon
❑ Single/anchor balloon inflated with _____ mL
❑ Second/tip balloon inflated with _____ mL ❑ Without difficulty
❑ With difficulty (explain):_____
Irrigation solution: Type (specify):_____
Amount_____mL Frequency_____ Returns _____
Patient tolerated procedure well ❍ Yes ❍ No
❑ Patient has suprapubic
❑ Urostomy site (describe skin around stoma):_____

_____

Ostomy care managed by: ❑ Patient ❑ Caregiver ❑ Family

(M1620) Bowel Incontinence Frequency: (=)

Enter Code ☐

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

(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen? **(=)**

Enter Code ☐

0 Patient does not have an ostomy for bowel elimination.
1 Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
2 The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

Bowel Elimination: ❑ **No Problem**

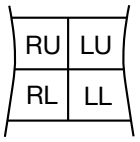
Disorder(s) of GI system (type):_____

_____

_____

❑ Constipation ❑ Diarrhea ❑ Hemorrhoids ❑ Last BM:_____

❑ Bowel sounds: active: _____
absent: _____
hypoactive: _____
hyperactive: _____



❑ Frequency of stools:_____
Bowel regimen/program:_____

_____

❑ Laxative ❑ Enema use/frequency:_____
❑ Other: _____
❑ Involuntary incontinence (details if applicable):_____

_____

❑ Incontinence products/other:_____
❑ Ileostomy ❑ Colostomy site (describe skin around stoma):

_____

_____

Ostomy care managed by: ❑ Patient ❑ Caregiver ❑ Family
❑ Other: _____
How does the ❑ bowel and/or ❑ bladder elimination disorder(s) interfere/impact the patient's functional ability and/or safety? ❑ **N/A**
Explain problem:

_____

_____

_____

_____

GENITALIA

❑ **No Problem**

❑ Discharge/Drainage (describe):_____
❑ Lesions (describe):_____
❑ Inflammation (describe):_____
❑ Prostate problem (describe):_____
❑ Other:_____

NEURO

❑ **No Problem**

Disorder(s) of neurological system (type):_____

_____

_____

_____

❑ History of a traumatic brain injury Date:_____
❑ History of headaches Date of last headache:_____
(Type):_____
❑ Aphasic: ❑ Receptive ❑ Expressive
❑ Tremors: ❑ At Rest ❑ With voluntary movement ❑ Continuous
❑ Spasms (for example; back, bladder, legs)
Location:_____
❑ History of seizures Date of last seizure:_____
(Type):_____
Dominant side: ❍ Right ❍ Left
❑ Hemiplegia: ❍ Right ❍ Left
❑ Paraplegia ❑ Quadriplegia/Tetraplegia
How does the patient's condition affect functional ability and/or safety?

_____

_____

_____

Patient Name_____ ID #_____

COGNITIVE STATUS

Patient's cognitive function:
❍ Alert/oriented to self, person, place and time
❍ Requires prompting when stressed or conditions unfamiliar
❍ Requires some assistance to stay focused when attention needs to shift between activities
❍ Requires considerable assistance to stay focused when attention needs to shift between activities

Patient is confused:
❍ Never ❍ On waking or at night only
❍ During the day and evening but not consistently
❍ Constantly ❍ Non-responsive

Patient is anxious:
❍ None of the time ❍ Less often than daily
❍ Daily, but not constantly ❍ All the time ❍ Non-responsive

Patient has:
❑ Memory deficit ❑ Impaired decision making
❑ Verbal ❑ Physical disruptive behaviors ❑ Delusional
❑ Paranoid behaviors ❑ None of the above

Is the patient receiving psychiatric nursing services at home?
❍ **No** ❍ **Yes**

Note: *If the patient needs further cognitive assessment consider the Confusion Assessment Method (CAM) tool, another cognitive assessment or making a referral.*

MENTAL STATUS

❑ **N/A - No mental/cognitive/behavioral issues noted**

Describe the patient's mental status. Description should include their general appearance, behaviors, emotional responses, mental functioning and their overall social interaction. Include both the clinical objective observations and subjective descriptions reported during this visit. Explain any inconsistencies:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Has there been a sudden/acute change in their mental status since the last comprehensive assessment? ❍ No ❍ Yes

If yes, did the change coincide with something else? For example, a medication change, a fall, the loss of a loved one or a change in their living arrangements etc. ❍ No ❍ Yes If yes, explain:_____

_____
_____
_____
_____

Mental status changes reported by ❑ Patient ❑ Caregiver
❑ Representative ❑ Other:_____

Note: *CMS is looking for potential issues that may complicate or interfere with the delivery of the HHA services and the patient's ability to participate in his or her own care. Consider the Brief Interview for Mental Status (BIMS) for further assessment.*

PSYCHOSOCIAL

Is the patient able to communicate their needs? ❍ Yes ❍ No

If no, explain:_____

What is the patient's primary way to communicate? For example, language, sign language, etc.:_____

If the patient has a communication barrier, what has the HHA done to improve communication? For example, use an interpreter, large print literature supplied, etc.

_____
_____

Was anyone else present during this visit to support the patient?
❍ No ❍ Yes If yes, give name and relationship to the client:

_____
_____
_____

❑ Spiritual resource:_____
Phone:_____
❑ N/A ❑ No change since last visit

Feelings/emotions the patient reports:
❑ Angry ❑ Fear ❑ Sadness ❑ Discouraged ❑ Lonely
❑ Depressed ❑ Helpless ❑ Content ❑ Happy ❑ Hopeful
❑ Motivated ❑ Other:_____
❑ N/A - Nothing reported

Sleep: ❍ Adequate ❍ Inadequate Rest: ❍ Adequate ❍ Inadequate
Frequency of naps:____ Number of hours slept per night:_____
Explain:_____
_____

Inappropriate reactions/behaviors toward: ❑ Caregiver(s)
❑ Clinician(s) ❑ Representative
❑ Others:_____
❍ Reported ❍ Observed ❍ N/A
Describe:_____
_____
_____

Inability to cope with altered health status as evidenced by:
❑ Lack of motivation ❑ Inability to recognize problems
❑ Unrealistic expectations ❑ Denial of problems

Evidence of: ❑ Abuse ❑ Neglect ❑ Exploitation ❑ Verbal
❑ Emotional ❑ Physical ❑ Financial
❍ Potential ❍ Actual ❍ N/A
MSW referral made: ❍ Yes ❍ No
Other intervention:_____
_____
_____

How does the patient's psychosocial condition affect functional ability and/or safety (i.e., patient reports they were robbed two months ago and now they can only sleep for brief periods)?

_____
_____
_____
_____

Note: *CMS is looking for potential issues that may complicate or interfere with the delivery of the HHA services and the patient's ability to participate in his or her own care. A psychosocial evaluation includes the patient's mental health, social status, and functional capacity within the community by looking at issues surrounding both a patient's psychological and social condition (for example, education and marital history).*

Patient Name_____ ID #_____

MUSCULOSKELETAL

❑ **No Problem**

Current disorder(s) of musculoskeletal system (type) affecting functional activity or safety:

_____
_____
_____
_____
_____
_____

❑ Fracture (location):_____
❑ Swollen, painful joints (specify):_____
❑ Contracture(s): Location_____
❑ Contracture(s): Location_____
Hand grips: ❍ equal ❍ unequal ❑ strong: ❑ R ❑ L ❑ weak: ❑ R ❑ L
❑ Motor changes: ❑ Fine ❑ Gross (specify):_____
❑ Weakness: ❑ UE ❑ LE
(details):_____
❑ Atrophy:_____
❑ Decreased ROM:_____
❑ Shuffling ❑ Wide-based gait
❑ Amputation ❑ BK ❑ AK ❑ UE; ❑ R ❑ L (specify):
_____
❑ Other (specify):_____

How does the patient's condition affect their functional ability and/or safety? (explain):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

FUNCTIONAL LIMITATIONS

❑ Amputation
❑ Bowel/Bladder (Incontinence)
❑ Contracture
❑ Hearing
❑ Paralysis
❑ Endurance
❑ Ambulation
❑ Speech
❑ Legally blind
❑ Dyspnea with minimal exertion
❑ Other (specify):_____

_____
_____
_____
_____
_____
_____
_____

FALL RISK REASSESSMENT

Any falls reported since last OASIS assessment?
❍ No ❍ Yes (describe the fall and the severity of injuries, if applicable):

_____
_____
_____

Have fall risk factors changed since prior assessment?
❍ No ❍ Yes (describe):_____

_____
_____
_____

Complete the MAHC 10 and score as appropriate.

MAHC 10 - FALL RISK ASSESSMENT TOOL

REQUIRED CORE ELEMENTS **Assess one point for each core element "yes".** *Information may be gathered from medical record, assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment.*	**Points**
Age 65+	
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis.	
Prior history of falls within 3 months An unintentional change in position resulting in coming to rest on the ground or at a lower level.	
Incontinence Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.	
Visual impairment Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	
Impaired functional mobility May include patients who need help with IADLs or ADLs or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	
Environmental hazards May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	
Poly Pharmacy (4 or more prescriptions – any type) All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	
Pain affecting level of function Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	
Cognitive impairment Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patient's ability to adhere to the plan of care.	
A score of 4 or more is considered at risk for falling **TOTAL**	

MAHC 10 reprinted with permission from ***Missouri Alliance for*** **HOME CARE**

Plan/Comments re: ADLs and fall risk

_____
_____
_____
_____
_____
_____
_____

Patient Name_____ ID #_____

ADL/IADLs

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

Enter Code ☐

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:

Enter Code ☐

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:

Enter Code ☐

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).**

Enter Code ☐

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.
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.

Enter Code ☐

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.

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

Enter Code ☐

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.

Enter Code ☐

0 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
1 With the use of a one-handed device (for example, 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 (for example, 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.

Indications for Home Health Aides: ❍ Yes ❍ No ❍ Refused
Order obtained: ❍ Yes ❍ No
Reason for need: _____

MEDICATION ALLERGIES

Allergies: ❑ No known medication allergies

MEDICATIONS

(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. (=)**

Enter Code ☐

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.

Psychotropic drug use: ❍ No ❍ Yes (see med sheet)
Financial ability to pay for medications: ❍ Yes ❍ No
❑ No change since last assessment
If no, was MSW referral made? ❍ Yes ❍ No/comment:

Patient Name_____ ID #_____

MEDICATIONS (Cont'd)

Does the patient have special needs or problems administering any of their medications by any route?

_____

_____

_____

_____

_____

INFUSION

❑ **N/A**

Does the patient have an IV? ❍ No ❍ Yes

If yes, type(s):_____ | _____

If yes, number of site(s):_____

Site location(s)_____ | _____

Total number of lumen(s):_____

Mark the location site(s) with the number of lumens on the body figures on page 8.

Insertion date(s):_____ | _____

Flush solution/frequency:_____ | _____

INFUSION (Cont'd)

Lumen(s) patent: ❍ Yes ❍ No If no, explain:_____

_____

❑ N/A not flushed

Injection cap change frequency:_____

Dressing change during visit: ❍ Yes ❍ No

Dressing change frequency:_____

❑ Sterile ❑ Clean

Performed by: ❑ Patient ❑ RN ❑ Caregiver ❑ Family

❑ Other:_____

Site/skin condition:_____

Infusion solution (type/volume/rate):_____

❑ Pump: (type, specify):_____

Administered by: ❑ Patient ❑ Caregiver ❑ RN ❑ Family

❑ Other:_____

Purpose of Intravenous:_____

Infusion provided during this visit? ❍ No ❍ Yes, (specify):

_____

Review medication profile for details

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

GG0130. Self-Care (H)

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.

Coding:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

4. Follow-Up Performance ↓ Enter Codes in Boxes	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

See GG0130 and GG0170 Quick Key at the back of this form

SECTION GG: FUNCTIONAL ABILITIES AND GOALS (Cont'd)

GG0170. Mobility

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.

Coding:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

4. Follow-Up Performance ↓ Enter Codes in Boxes	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Follow-Up performance is coded 07, 09, 10 or 88 → skip to GG0170M, 1 step (curb).*
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If Follow-up performance is coded 07, 09, 10 or 88, skip to GG0170Q, Does patient use wheelchair and/or scooter?*
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail.
☐	**Q. Does patient use wheelchair and/or scooter?** **0. No** → Skip GG0170R **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns.
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

Patient Name_____ ID #_____

ACTIVITIES PERMITTED

- ❑ Complete bedrest
- ❑ Bathroom privileges
- ❑ Up as tolerated
- ❑ Transfer bed/chair
- ❑ Exercises prescribed
- ❑ Partial weight bearing
- ❑ Independent in home
- ❑ Crutches
- ❑ Cane
- ❑ Wheelchair
- ❑ Walker
- ❑ No restrictions
- ❑ Other (specify):_____

SAFETY MEASURES

- ❑ Bleeding precautions
- ❑ O_2 precautions
- ❑ Seizure precautions
- ❑ Fall precautions
- ❑ Aspiration precautions
- ❑ Siderails up
- ❑ Elevate head of bed
- ❑ 24 hr. supervision
- ❑ Clear pathways
- ❑ Lock w/c with transfers
- ❑ Infection control measures
- ❑ Walker ❑ Cane
- ❑ Other: _____

Were there any changes with the emergency preparedness plan since the last assessment? ❍ No ❍ Yes If yes, explain:

_____

_____

THERAPY NEED AND PLAN OF CARE

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(=)

(☐☐☐) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

❑ NA - Not Applicable: No case mix group defined by this assessment.

STRENGTHS/LIMITATIONS

Based upon the patient's comprehensive assessment (physical, psychosocial, cognitive, mental status and functional status):

List the patient's strengths that contributed to the progress toward their goal(s), both personal and the HHA measurable goals since prior assessment. For example, involved family, interest in returning to prior activities, cheerful attitude, cooperative, etc.

_____

_____

_____

_____

***** It is recommended that you not use checkboxes and generalized terms and restating requirements would not be adequate without corroborating documentation.***

Describe the patient's structural impairment (physical or pathophysiological impairment, e.g., fracture, MI, blindness, etc.)

_____

_____

_____

_____

Describe the patient's functional impairment (e.g., dyspnea, pain, weakness, etc.)

_____

_____

_____

STRENGTHS/LIMITATIONS (Cont'd)

How does the impairment limit the patient's activities (climbing stairs, ambulating, making decisions, etc.)

_____

_____

How does the skill(s) of a nurse address the specific structural and/or functional impairments and activity limitations cited in this section?

_____

_____

_____

_____

Has anything significant changed since the last visit? ❍ No ❍ Yes

If yes, explain:_____

_____

_____

_____

_____

Note: *CMS is looking for potential issues that may complicate or interfere with the delivery of the HHA services and the patient's ability to participate in his or her own plan of care.*

CARE PREFERENCES

Did the ❑ Patient ❑ Representative ❑ Other:_____ communicate care preferences that involve the home health provided services?

For example, preferred visit times or days, etc. ❍ No ❍ Yes

If yes, list preferences:_____

_____

_____

_____

_____

_____

_____

_____

Did the ❑ Patient ❑ Representative ❑ Other:_____ communicate any specific information about a personal goal(s) the patient would like to achieve from this home health admission?

❍ Yes ❍ No

If no, the ❑ Patient ❑ Representative ❑ Other:_____

❑ Do not want a personal goal(s)

❑ Already have a goal(s) they are working at this time.

❑ Other:_____

_____

If yes, the ❑ Patient ❑ Representative ❑ Other:_____ discussed/communicated about the goal(s) with the assessing clinician and:

❍ Agreed their personal goal(s) was realistic based on the patient's health status

❍ Agreed their personal goal(s) needed to be modified based on the patient's health status

❍ Agreed to and identified actions/interventions the patient is willing to safely implement, so the patient will be able to meet their goal(s) by the anticipated discharge date

❑ The ❑ Patient ❑ Representative ❑ Other:_____ helped write a measurable goal(s), understandable to all stakeholders.

❑ The ❑ Patient ❑ Representative ❑ Other:_____ was informed, appeared to understand and agreed the personal goal(s) would be added to the patient's individualized plan of care and submitted to the physician responsible for reviewing and signing the plan of care

Patient Name_____ ID #_____

CARE PREFERENCES/PATIENT'S PERSONAL GOALS

Document what the patient reports/says about their progress towards their personal goal(s) (if applicable) and the HHA measurable goals since prior assessment?

_____

_____

_____

_____

_____

_____

_____

_____

REFUSED CARES

Did the ❑ Patient ❑ Representative ❑ Other:_____ refuse ❑ Care(s) ❑ Service(s) since the last assessment? ❍ No ❍ Yes

If yes, explain:_____

Are the ❑ Care(s) ❑ Service(s) they refused a significant part of the recommended plan of care? ❍ No ❍ Yes

If yes, explain how:_____

_____

_____

_____

_____

RISK FACTORS/HOSPITAL ADMISSION/EMERGENCY ROOM

Risk factors identified and followed up on by: ❑ Discussion ❑ Education ❑ Training Literature given to: ❑ Patient ❑ Representative ❑ Caregiver ❑ Family Member ❑ Other:_____ ❑ N/A this visit

List identified risk factors the patient has related to an unplanned hospital admission or an emergency department visit (Consider including information collected for item M1033):

_____

_____

_____

_____

_____

_____

_____

_____

❑ **N/A**

Note: *Following a patient's hospital discharge, HHA are required by CMS to include an assessment of the patient's level of risk for hospital ED visits and hospital admission. Interventions are required in the patient's plan of care. When assessing the patient, pay particular attention to patients with CHF, AMI, COPD, CABG, pneumonia, diabetes or hip and knee replacements. Consider these factors co-morbidities, multiple medications, low health literacy level, history of falls, low socioeconomic level, dyspnea, safety, confusion, chronic wounds, depression, lives alone, support system, etc.*

PATIENT/CAREGIVER/REPRESENTATIVE/FAMILY/EDUCATION AND TRAINING (Check all that apply)

Assess each person's current knowledge deficit and/or inability to perform items listed below that are applicable to the plan of care. Check **N/A** (Not applicable, not on the care plan). Check **I** (Independent) or **N** (Needs additional education/training) in the box next to the appropriate person for items on the care plan.

❑ **N/A** Pressure reduction	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Wound care	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Diabetic foot exam	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Diabetic care	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Insulin administration	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Glucometer use	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Nutritional management	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Medication(s) administration: ❑ Oral ❑ Injected ❑ Infused ❑ Inhaled ❑ Topical	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Pain management	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Oxygen use	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Use of medical devices	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Catheter care	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Trach care	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Ostomy care	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Emergency Preparedness Plan	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Infection control	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** S/S Report to agency	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**
❑ **N/A** Patient's Rights	❑ Patient: ❍ **I** ❍ **N**	❑ Caregiver: ❍ **I** ❍ **N**	❑ Representative: ❍ **I** ❍ **N**	❑ Family: ❍ **I** ❍ **N**

Teach back method used to: ❑ Educate ❑ Train ❑ Patient ❑ Caregiver ❑ Representative ❑ Family

❑ Patient ❑ Caregiver ❑ Representative ❑ Family educated this visit specifically for:_____

❑ Patient ❑ Caregiver ❑ Representative ❑ Family made aware that ❑ education ❑ training will continue during follow-up visits as needed.

Does the ❑ Patient ❑ Caregiver ❑ Representative ❑ Family have an action plan when disease symptoms exacerbate (e.g., when to call the homecare agency vs. emergency services): ❍ Yes ❍ No

After completing this section document the education and training outcome(s), per agency policy. Go to page 20 under Rehabilitation Potential/Anticipated Discharge for Plan of Care to document status of patient's anticipated discharge.

Patient Name_____ ID #_____

SKILLED INTERVENTIONS/INSTRUCTIONS DONE THIS VISIT (Check all applicable)

NURSING INTERVENTIONS/INSTRUCTIONS

❑ Skilled observation & assessment
❑ Foley care
❑ Wound care ❑ Wound dressing
❑ Decubitus care
❑ Venipuncture
❑ Change: ❑ NG tube ❑ G tube
❑ Admin. of vitamin B_{12}
❑ Prep. ❑ Admin. insulin

❑ Teach ❑ Admin. ❑ IVs ❑ Clysis
❑ Teach ostomy ❑ Ileo. conduit care
❑ Teach ❑ Admin. tube feedings
❑ Teach ❑ Admin. care of trach.
❑ Teach care - terminally ill
❑ IM injection ❑ SQ injection
❑ Psych. intervention
❑ Observe S/S infection

❑ Diabetic observation
❑ Teach diabetic care
❑ Observe ❑ Teach medication (N or C)
❑ effects ❑ side effects
❑ Physiology/Disease process teaching
❑ Diet teaching
❑ Safety factors
❑ Prenatal assessment

❑ Post-partum assessment
❑ Teach care of: ❑ infant ❑ child
❑ Pain Management
❑ Fall Safety Teaching
❑ Other:_____
_____
_____
_____

SUPERVISORY VISIT: ❍ Yes ❍ No

SUPERVISORY VISIT: ❍ Scheduled ❍ Unscheduled **STAFF:** ❍ Present ❍ Not present ❑ **AIDE** ❑ **LPN/LVN**

CARE PLAN UPDATED? ❍ No ❍ Yes **NEXT SCHEDULED SUPERVISORY VISIT:** _____

CARE PLAN FOLLOWED? ❍ Yes ❍ No (explain):_____

_____

IS ❑ **PATIENT** ❑ **FAMILY** ❑ **REPRESENTATIVE SATISFIED WITH CARE?** ❍ Yes ❍ No (explain):

_____

_____

OBSERVATION OF:_____

_____

_____

EDUCATION/TRAINING OF:_____

_____

_____

RECERTIFICATION SUMMARY

CONFINED TO HOME (homebound): ❍ No ❍ Yes, and the patient either

1. Criteria One: because of illness or injury, (must choose at least one):

❑ Dependent upon adaptive device(s)

Check all that apply: ❑ crutches ❑ canes ❑ walker ❑ wheelchair: ❑ manual ❑ motorized ❑ prosthetic limb

❑ scooter ❑ a helper ❑ other:_____

❑ Needs special transportation as indicated by:_____

❑ Needs physical assist to leave as indicated by:_____

AND/OR

❑ Leaving home is medically contraindicated due to:_____

2. Criteria Two:

❑ There exists a normal inability to leave the home as indicated by:_____

AND

❑ Leaving home requires a considerable and taxing effort due to functional impairment caused by diagnosis, as indicated by effort such as:

_____

SUMMARY OF SETBACKS/IMPROVEMENTS SINCE PRIOR ASSESSMENT

Patient continues to be involved with decision-making towards personal goals. The following is noted:

Improvements noted with the desired functional tasks: ❑ N/A

_____

_____

Patient continues to have difficulty/no gains made with the desired functional tasks: ❑ N/A

_____

_____

Continued nursing care needed in order to (expresses new goals, continue with/modify present goals, etc.): ❑ N/A

_____

_____

Patient Name_____ ID #_____

SUMMARY CHECKLIST

CARE PLAN:

❍ Reviewed ❍ Revised with ❑ Patient ❑ Representative ❑ Caregiver involvement ❑ Outcome achieved

MEDICATION STATUS:

❑ Medication regimen completed/reviewed: ❍ No change ❍ Order obtained

Check if any of the following were identified: ❑ Potential adverse effects ❑ Drug reactions ❑ Ineffective drug therapy ❑ Significant side effects ❑ Significant drug interactions ❑ Duplicate drug therapy ❑ Non-compliance with drug therapy ❑ Other:_____

CARE COORDINATION:

❑ Certifying Physician ❑ SN ❑ PT ❑ OT ❑ SLP ❑ MSW ❑ Aide ❑ Other (specify):_____

Was a referral made to MSW for assistance with:

❑ Community resources ❑ Living will ❑ Counseling needs ❑ Unsafe environment

❑ Other: _____

Date:_____ ❍ Yes ❍ No ❍ Refused ❍ N/A

Comment:_____

_____

_____

REFERRAL TO:_____

REASON FOR REFERRAL:_____

_____

APPROXIMATE NEXT VISIT DATE:_____

PLAN FOR NEXT VISIT:_____

RECERTIFICATION: ❍ No, complete discharge summary ❍ Yes, complete remaining sections, as appropriate

Document the reason(s)/medical necessity that supports the continuation/recertification of services:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Note: *Medical necessity is always based on the patient's condition. Identify the skilled service and the reason this skilled service is necessary in objective terms. For example, "Wound care completed per POC to diabetic ulceration left foot. No s/s of infection, but patient remains at risk due to diabetic status." Or "Range of motion (ROM) as tolerated to lower extremities. Unsafe to teach caregiver ROM due to the patient's displaced fracture."*

Verbal Order obtained: ❍ No ❍ Yes, specify date:_____

REHABILITATION POTENTIAL/ANTICIPATED DISCHARGE FOR PLAN OF CARE

❑ Return to an independent level of care (self-care)

❑ Able to remain in residence with assistance of: ❑ Primary caregiver ❑ Support from community agencies

❑ Restorative Potential, based on clinical objective assessment and evidence-based knowledge supports the patient's condition is likely to undergo functional improvement and benefit from rehabilitative care

Discussed discharge plan with: ❑ Patient ❑ Representative ❑ Other:_____

Anticipated discharge status:_____

_____

_____

_____

_____

_____

_____

_____

Patient Name_____ ID #_____

CURRENT DME/MEDICAL SUPPLIES/HCBS

DME Company:_____ Phone:_____ Oxygen Company:_____ Phone:_____

Community: ❑ Organizations ❑ Services:_____

_____

Contact:_____ Phone:_____

Comments:_____

_____

❑ **NONE USED**

WOUND CARE:

❑ 2x2's
❑ 4x4's
❑ ABD's
❑ Cotton tipped applicators
❑ Drain sponges
❑ Hydrocolloids
❑ Kerlix size_____
❑ Nu-gauze
❑ Saline
❑ Tape
❑ Transparent dressings
❑ Wound cleanser
❑ Wound gel
❑ Other_____

IV SUPPLIES:

❑ Alcohol swabs
❑ Angiocatheter size_____
❑ Batteries size_____
❑ Central line dressing
❑ Extension tubings
❑ Infusion pump
❑ Injection caps

IV SUPPLIES (Cont'd):

❑ IV pole
❑ IV start kit
❑ IV tubing
❑ Syringes size_____
❑ Tape
❑ Other_____

URINARY/OSTOMY:

❑ External catheters
❑ Ostomy pouch (brand, size)
❑ Ostomy wafer (brand, size)
❑ Skin protectant
❑ Stoma adhesive tape
❑ Underpads
❑ Urinary bag ❑ Pouch
❑ Other_____

CATHETER SUPPLIES:

❑ Acetic acid
❑ _____Fr catheter kit (tray, bag, foley)

CATHETER SUPPLIES (Cont'd)

❑ Irrigation tray
❑ Saline
❑ Straight catheter
❑ Other_____

DIABETIC:

❑ Chemstrips
❑ Syringes
❑ Other_____

MISCELLANEOUS:

❑ Enema supplies
❑ Feeding tube: type_____ size_____
❑ Gloves: ❑ Sterile ❑ Non-sterile
❑ Staple removal kit
❑ Steri strips
❑ Suture removal kit
❑ Other_____

SUPPLIES/EQUIPMENT:

❑ Augmentative and alternative communication device(s) (type)
❑ Bath bench
❑ Brace ❑ Orthotics (specify)
❑ Cane
❑ Commode
❑ Dressing Aid Kit/Hip Kit (e.g. reacher, long handle sponge, long handle shoe horn, etc.)
❑ Eggcrate
❑ Enteral feeding pump
❑ Grab bars: Bathroom/Other
❑ Hospital bed: ❑ Semi-electric
❑ Hoyer lift
❑ Knee scooter
❑ Medical alert
❑ Nebulizer

SUPPLIES/EQUIPMENT (Cont'd)

❑ Oxygen concentrator
❑ Pressure relieving device
❑ Prosthesis: ❑ RUE ❑ RLE ❑ LUE ❑ LLE ❑ Other
❑ Raised toilet seat
❑ Special mattress overlay
❑ Suction machine
❑ TENS unit
❑ Transfer equipment: ❑ Board ❑ Lift
❑ Ventilator
❑ Walker
❑ Wheelchair
❑ Other Supplies Needed

PHYSICIAN VERBAL ORDER (Complete if applicable per agency policy)

❑ Physician (name)_____ called to report comprehensive assessment findings (including medical, nursing, rehabilitative, social and discharge planning needs).

❑ Verbal order received to recertify home health intermittent (reasonable and necessary) skilled services for:_____

_____
(specify amount/frequency/duration for discipline(s) and treatment(s)

X_____ _____ _____
Signature/Title of Person Who Received Verbal Order *Date* *Time*

X_____ _____ _____
Physician Signature for Verbal Order *Date* *Time*

SIGNATURE/DATE

X_____ _____ _____
Patient/Family Member/Caregiver/Representative (if applicable) *Date* *Time*

X_____ _____ _____
Person Completing This Form (signature/title) *Date* *Time*

_____ _____
Agency Name *Phone Number*

OASIS INFORMATION

Date Reviewed_____ **Date Entered & Locked**_____ **Date Transmitted**_____

INTEGUMENTARY STATUS DEFINITIONS

DEFINITIONS:

- **Unhealed:** The absence of the skin's original integrity.
- **Non-epithelialized:** The absence of the regeneration of the epidermis across a wound surface.
- **Pressure Ulcer:** A *pressure ulcer/injury* is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear. *A number of contributing or confounding factors also are associated with pressure*
- **Slough Tissue:** Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.
- **Eschar Tissue:** Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.
- **Newly epithelialized:**
  - Wound bed completely covered with new epithelium.
  - No exudate.
  - No avascular tissue (eschar and/or slough).
  - No signs or symptoms of infection.
- **Fully granulating:**
  - Wound bed filled with granulation tissue to the level of the surrounding skin.
  - No dead space.
  - No avascular tissue (eschar and/or slough).
  - No signs or symptoms of infection.
  - Wound edges are open.
- **Early/partial granulation:**
  - ≥25% of the wound bed is covered with granulation tissue.
  - <25% of the wound bed is covered with avascular tissue (eschar and/or slough).
  - No signs or symptoms of infection.
  - Wound edges open.
- **Not healing:**
  - Wound with ≥25% avascular tissue (eschar and/or slough) OR
  - Signs/symptoms of infection OR
  - Clean but non-granulating wound bed OR
  - Closed/hyperkeratotic wound edges OR
  - Persistent failure to improve despite appropriate comprehensive wound management.

RESPONSE SPECIFIC INSTRUCTIONS:

- Home health agencies may adopt the NPUAP guidelines in their clinical practice and documentation. However, since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP. When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&A's, providers should rely on the CMS OASIS instructions.
- Pressure ulcers/injuries are defined as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
- If pressure is not the primary cause of the lesion, do not report the wound as a pressure ulcer/injury.
- Terminology referring to "healed" vs. "unhealed" ulcers can refer to whether the ulcer is "closed" vs. "open". Recognize, however, that Stage 1 pressure injuries and Deep Tissue Injury (DTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers/injuries, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Clinical standards require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has healed.
- NPUAP defines a Stage 1 pressure injury as follows: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Stage 1 injuries may be difficult to detect in individuals with dark skin tones and may indicate "at risk" persons (a heralding sign of risk)."
- Recognize that although Stage 1 pressure injuries are closed (intact skin), they would not be considered healed.
- If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the highest numerical stage of the wound. The clinician should make every effort to contact previous providers (including patient's physician) to determine the highest numerical stage of the pressure ulcer.

INTEGUMENTARY STATUS DEFINITIONS (Continued)

DEFINITIONS – Pressure Ulcer/Injury Stages

Stage 1 Pressure Injuries: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues.

Stage 2 Ulcers

- Definition: Stage 2 pressure ulcers are characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister.
- Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to or surrounding the blister demonstrates signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), these characteristics suggest a deep tissue injury (DTI) rather than a Stage 2 pressure ulcer.

Stage 3 and 4 Ulcers

- Definition: Stage 3 pressure ulcers are characterized by 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 or tunneling.
- Definition: Stage 4 pressure ulcers are characterized by 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.
- If any bone, tendon or muscle or joint capsule (Stage 4 structures) is visible, the pressure ulcer should be reported as a Stage 4 pressure ulcer, regardless of the presence or absence of slough and/or eschar in the wound bed.
- A previously closed Stage 3 pressure ulcer that is currently open again should be reported as a Stage 3 pressure ulcer. A previously closed Stage 4 pressure ulcer that is currently open again should be reported as a Stage 4 pressure ulcer.

Unstageable Ulcer

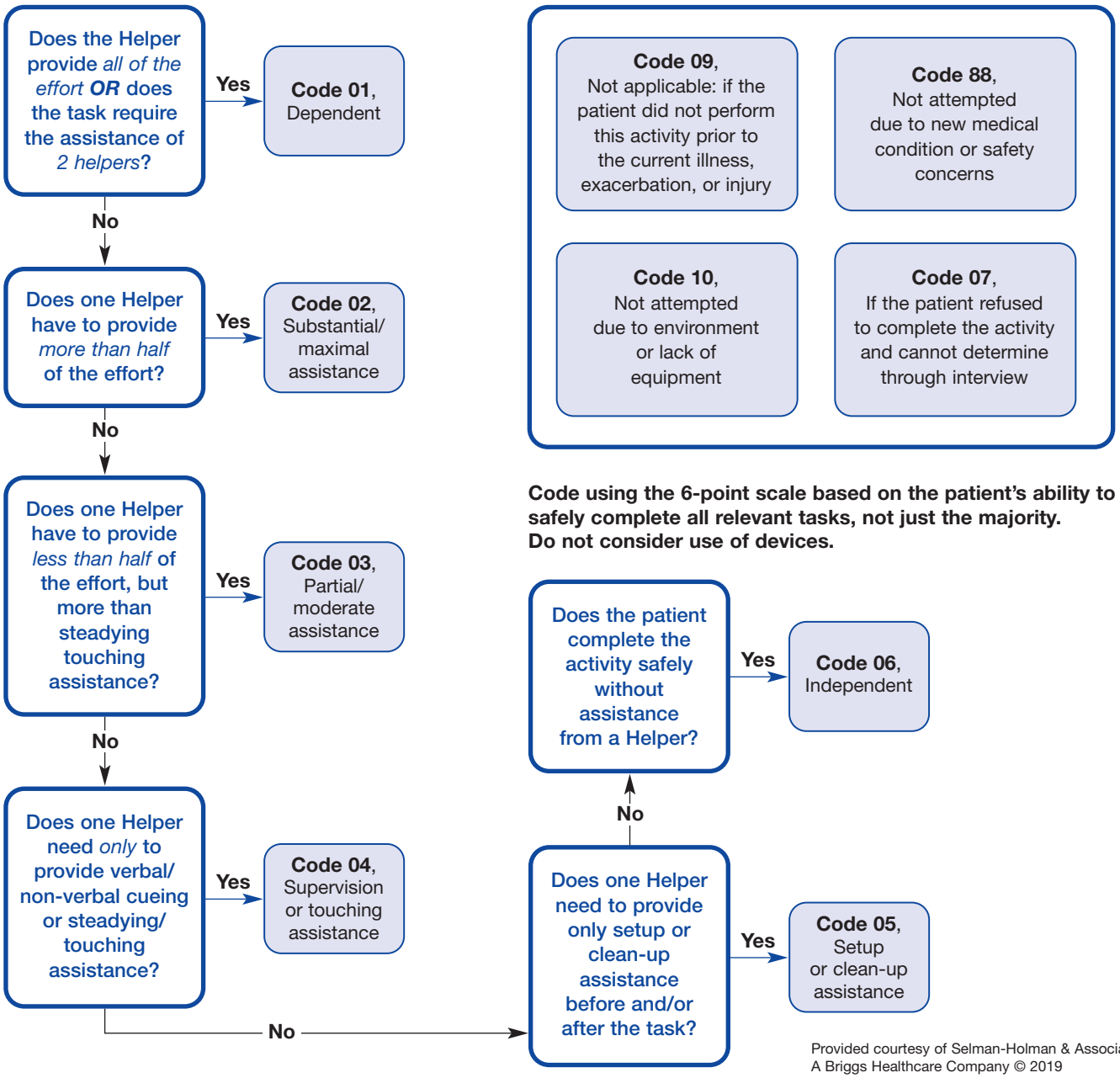
- Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized in the wound bed, should be classified as unstageable. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized, numerically stage the ulcer, and do not code this as unstageable.
- Determine which pressure ulcer(s)/injur(ies) are stageable or Unstageable. A pressure ulcer/injury is considered Unstageable if:
  - it is covered with a non-removable dressing/device, such as a cast, that cannot be removed.
  - it presents as a deep tissue injury, or
  - the wound bed is obscured by some degree of necrotic tissue AND no bone, muscle, tendon, or joint capsule (Stage 4 structures) are visible. Note that if a Stage 4 structure is visible, the pressure ulcer is reportable as a Stage 4 even if slough or eschar is present.

ITEM-SPECIFIC INSTRUCTIONS

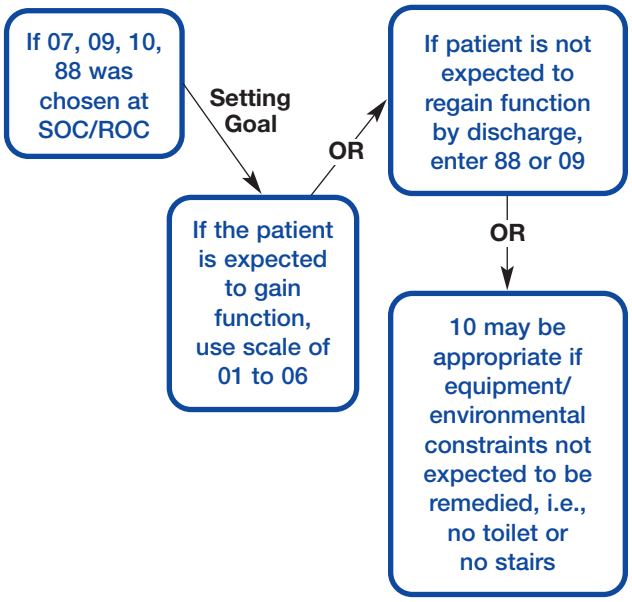
- A pressure ulcer treated with any type of graft is no longer reported as a pressure ulcer/injury, and until healed, should be reported as a surgical wound on M1340.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer and should not be reported as a surgical wound on M1340.
- Any type of flap procedure performed to surgically replace a pressure ulcer is reported as a surgical wound, until healed. It should not be reported as a pressure ulcer/injury on M1311.
- Pressure ulcers/injuries that are known to be present but that are Unstageable due to a non-removable dressing/device, such as a cast that cannot be removed to assess the skin underneath, should be reported in M1311D1, Unstageable. “Known” refers to when documentation is available that states a pressure ulcer/injury exists under the non-removable dressing/device. Examples of a non-removable dressing/device include a dressing that is not to be removed per physician’s order (such as those used in negative-pressure wound therapy [NPWT], an orthopedic device, or a cast).
- If an unknown pressure ulcer/injury is discovered upon removal of a non-removable dressing/device, that pressure ulcer/injury should be considered new, and not be coded as present at the most recent SOC/ROC for M1311X2.
- Response F1 refers to deep tissue injury, which is defined as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. The number of pressure injuries meeting this definition should be counted to determine the response to F1. Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- A deep tissue injury with intact skin at SOC/ROC, that becomes stageable, is considered present at the most recent SOC/ROC at the stage at which it first becomes numerically stageable.

GG0130 and GG0170 Quick Key

- **06** - Independent: no assistance from another person
- **05** - Set-up/Clean-up Assistance: assistance from ONE other person before *and/or* after the activity but not during the actual performance of the activity
- **04** - Supervision/Touching Assistance: verbal/non-verbal cueing or touching/steadying/contact guard assistance from ONE person
- **03** - Partial/Moderate Assistance: physical assistance from ONE person who provides **LESS** than half the effort of the activity
- **02** -Substantial/Maximal Assistance: physical assistance from ONE person who provides **MORE** than half the effort of the activity
- **01** - Dependent: physical assistance from ONE person who provides ALL the effort to complete the activity, OR patient requires the assistance of TWO or MORE persons to complete the activity



Code using the 6-point scale based on the patient's ability to safely complete all relevant tasks, not just the majority. Do not consider use of devices.



Difference between 09 and 88

Code 09
Patient did not perform this activity prior to the current illness, exacerbation, or injury and still is unable.
Examples: Quadriplegic patient; patient with preexisting and ongoing need of Hoyer lift.
No + No = 9

If the patient is unable but a helper does it for them, score 01

Code 88
Not attempted due to new medical or safety concerns.
New condition related to current illness, exacerbation, or injury preventing activity from being performed safely on this assessment
Example: New compression fracture requiring bed rest.
(88 is a brand new state)

Discharge Goals

Goals may be determined by the clinician's consideration of:

- Patient's medical condition(s)
- Expected treatments
- Patient motivation to improve
- Anticipated length of stay based on patient's condition(s)
- Prior self-care and mobility status
- Current multiple diagnoses
- Discussions with patient and family concerning discharge goals
- Anticipated assistance for patient at planned discharge setting/home

REASON ACTIVITY WAS NOT ATTEMPTED QUICK KEY

Code 09
Not applicable: if the patient did not perform this activity prior to the current illness, exacerbation, or injury

Code 88
Not attempted due to *new* medical or safety concerns.
New condition related to current illness, exacerbation, or injury preventing activity from being performed safely on this assessment
Example: New compression fracture requiring bed rest.
(88 is a brand new state)

Code 07
If patient refused and the information could not be obtained any other way

Code 10
Not attempted due to environment or lack of equipment

Code the reason activity was not attempted if:

- A patient does not attempt the activity AND
- A helper does not complete the activity AND
- The patient's usual status cannot be determined based on patient/caregiver report

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