Section J

Health Conditions

J1. Falls

Intent

To determine whether the person has a history of falling. Persons who have sustained at least one fall are at risk of future falls. Falls are a common cause of morbidity and mortality among persons receiving home care. Serious injury results in from 6% to 10% of falls, with hip fractures accounting for approximately one-half of all serious injuries.

Definition

Fall — Any unintentional change in position where the person ends up on the floor, ground, or other lower level; includes falls that occur while being assisted by others.

Process

First assessment (new admissions)— Consult with the person and the person's family. Review any available clinical documentation.

Reassessments — Review any available records for the person. Consult with the person, an available family member, and any formal care workers. Sometimes a person will fall and, believing that he or she "just tripped," will get up and not report the event to anyone. Therefore, do not rely solely on available clinical records but also ask the person directly if he or she has fallen during the indicated time frame. Accept statements by the person or a family member.

Coding

Enter the number of falls that occurred during the time periods of the last 30 days (Item J1a), 31–90 days (Item J1b), and 91–180 days (Item J1c).

0 No falls

1 One fall

2 Two or more falls

J1a. Last 30 days

J1b. 31–90 days

J1c. 91–180 days

J2. Any Fall with Major Consequences within Last 90 Days

Intent

A minority of falls — less than 10% — result in a referral to a hospital and some sort of consequential trauma to the body. This item records all such events that occurred within the last 90 days.

Definition

Major consequences — Examples include fractures (for example, of hip, shoulder, forearm, spine), concussion, subdural hematoma, other internal bleeding, restriction in walking for a week or more.

Coding

If the person fell in the last 90 days, code for whether any consequential outcome occurred. Note: If there was no fall in the last 90-day period, code **"0"** for "No".

0 No

1 Yes

J3. Limits Activities Because of Fear of Falling

Intent

To determine if, either due to a history of falling or a sense of personal frailty, the person limits how he or she engages in activities within his or her residential and neighborhood environment. This item records such limitations as the person seeks to prevent future falls by not putting him- or herself at risk.

Definition

Examples include limit going outside, will only go out with others, or limit moving inside. The person may refuse to walk to a house of worship or a senior center, may limit how far or how often he or she walks in the home.

Coding

Code for the appropriate response.

0 No

1 Yes

J4. Problem Frequency

Intent

To record the frequency of specific problems or symptoms that affect or could affect the person's health or functional status and to identify risk factors for illnesses, accidents, and functional decline. These problems may be related to medication side effects.

Definitions

Balance

J4a. Difficult or unable to move self to standing position unassisted

J4b. Difficult or unable to turn self around and face the opposite direction when standing

J4c. Dizziness — The person experiences a sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

J4d. Unsteady gait— A gait that places the person at risk of falling. Unsteady gaits take many forms. The person may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

Cardiac or Pulmonary

J4e. Chest pain/discomfort— The person experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, tight chest, radiating pain, for example.

J4f. Difficulty clearing airway secretions— In the last 3 days the person reports being unable, or has been observed to be unable, to cough effectively to expel respiratory secretions (for example, secondary to weakness or pain) or has

been unable to mobilize secretions or sputum from mouth (for example, secondary to dysphagia or pain) or tracheostomy (for example, secondary to viscosity of sputum; inability to physically remove secretions from tracheostomy entrance). Examples include a person with pneumonia who is too weak to cough and expel sputum or a person with amyotrophic lateral sclerosis (ALS) who requires suctioning to manage secretions.

Psychiatric

J4g. **Abnormal thought process** — When the person is observed, there are apparent abnormalities in the form or way in which thoughts are expressed. Included are indicators such as loosening of associations, thought blocking, flight of ideas, tangentiality, circumstantiality, clang association, incoherence, neologisms, punning, etc.

Loose associations — The person jumps from one topic to another without an apparent connection between the topics.

Thought blocking — The person suddenly stops in the middle of a sentence and is unable to recover what he or she intended to say or to complete other thoughts.

Flight of ideas — The person's thoughts are expressed so quickly that the listener has difficulty keeping up.

Tangentiality — The person digresses from the subject under discussion and introduces thoughts that seem unrelated, oblique, or irrelevant.

Circumstantiality — The person exhibits lack of goal-directedness, incorporates unnecessary details, and has difficulty getting to an end point in the conversation.

Clang association — The connection between the person's thoughts is tenuous. The person may use rhyming and punning in his or her speech.

Incoherence — The person's speech is unclear or confused. The communication does not make sense to the intended listener.

Neologism — The person makes up a word, which may be condensed from several words. Neologisms are unintelligible to the listener.

Punning — The person uses words that are similar in sound, but different in meaning.

J4h. **Delusions** — Fixed, false beliefs not shared by others that the person holds even when there is obvious proof or evidence to the contrary. For example, the person may believe that he or she is terminally ill, that his or her spouse is having an affair, or that food served at a restaurant or congregate dining room is poisoned.

J4i. **Hallucinations** — The person has false perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (for example, hearing voices), visual (for example, seeing people or animals), tactile (for example, feeling bugs crawling over the skin), olfactory (for example, smelling poisonous fumes), or gustatory (for example, experiencing strange tastes).

GI Status

J4j. **Acid reflux** — The regurgitation of small amounts of acid from the stomach to the throat. Usually accompanied by a burning sensation in the throat or a sour taste in the mouth.

J4k. Constipation— No bowel movement in 3 days, or difficult passage of hard stool.

J4l. Diarrhea— The frequent elimination of watery stools, regardless of cause.

J4m. Vomiting— Regurgitation of stomach contents, regardless of etiology (for example, drug toxicity, influenza, psychogenic).

Sleep Problems

J4n. Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep— For example, the person:

- Experiences an extended time gap between the point at which he or she attempted to fall asleep and the time at which sleep was actually initiated;
- Wakes up well before the desired time due to some factor inherent to him or her (exclude situations in which the person is awakened by some external source);
- Experiences sleep that is accompanied by repeated tossing and turning or dreaming that causes motion or wakefulness, for example, such that the person does not feel rested when awake; or
- Is easily awakened during sleep by sounds or movements, and experiences one or more periods of awakening after sleep is initiated.

J4o. Too much sleep— An excessive amount of sleep that interferes with the person's normal functioning.

Other

J4p. Fever— A rise in the person's body temperature, frequently as a result of infection. Includes precipitous rise in temperature with feeling of being cold and experiencing uncontrolled shaking.

J4q. Sore throat— Pain, irritation, scratchiness in throat. It can occur with and without swallowing, although it is often worse when swallowing. Accompanied with a hoarse voice.

J4r. Cough — Included are new, continuous, or worsening coughs. A cough is a sudden hacking sound whose purpose is to clear airways of mucus and irritants.

J4s. Headache — Painful sensation in any region of the head. Includes a sense of pressure, dull aches, sharp pain, or throbbing pain. Includes migraine headache.

J4t. Gastrointestinal or urogenital bleeding (GI or GU bleeding)— "Gastrointestinal (GI) bleeding" is any documented bleeding as diagnosed by a gastrointestinal evaluation, or any evidence of current bleeding through rectal exam or testing. Bleeding may be frank (such as bright red blood) or occult (such as black stools). "Genitourinary (GU) bleeding" is bleeding that occurs anywhere along the genitourinary tract. Urine that is dark or cloudy should be tested for the presence of blood. There may also be visible blood in the person's urine or frank, bright red blood coming from the urethral opening.

J4u. Hygiene— Unusually poor hygiene, unkempt, disheveled. The person is observed to have unusually poor hygiene well beyond what is considered culturally appropriate. Poor hygiene puts the person at risk for skin breakdown and has other health and psychological ramifications.

J4v. Peripheral edema— Abnormal buildup of fluid in feet, ankles, legs, or sacral area.

Process Ask the person— he or she may not have told others of his or her symptoms. Ask family members or caregivers. Review any available clinical records.

Coding

0 Not present

1 Present but not exhibited in last 3 days

2 Exhibited on 1 of last 3 days

3 Exhibited on 2 of last 3 days

4 Exhibited daily in last 3 days

J5. Dyspnea (Shortness of Breath)

Intent To describe gradations of dyspnea.

Definition The person has reported being, or has been observed to be, breathless or "short of breath." Includes new onset of shortness of breath as well as ongoing conditions. "Moderate activities" include some type of physical activity, such as walking a long distance, climbing two flights of stairs, or gardening. "Normal day-to-day activities" include all ADLs (bathing, toileting, etc.) and IADLs (meal preparation, shopping, etc.).

Process Ask the person if he or she has experienced shortness of breath. If the answer is affirmative, determine if the symptom occurred with strenuous activity, during normal day-to-day activity, or when resting. If the person is unable to respond, review the clinical record and consult with caregivers and family members.

Coding Select the appropriate code from the list below. Code for the most severe occurrence during the last 3 days. If the symptom was absent over the last 3 days but would have been present had the person undertaken activity, code according to the activity level (day-to-day or moderate) that would normally have caused the person to experience shortness of breath.

0 Absence of symptom

1 Absent at rest, but present when performed moderate activities

2 Absent at rest, but present when performed normal day-to-day activities

3 Present at rest

J6. Fatigue

Intent To describe gradations of fatigue or impaired stamina. Fatigue is associated with some chronic diseases and end-stage conditions.

Definition **Fatigue**— An overwhelming or sustained sense of exhaustion, resulting in decreased capacity for physical or mental work.

Process Use observation or discussion with the person or others, exploring how the person's daily schedule impacts on his or her energy levels. Explore both types of fatigue: physical and mental. Physical tiredness results in reduced energy, whereas mental or cognitive tiredness may result in reduced concentration and mental restlessness.

Coding

Select the appropriate code from the list below. If fatigue was absent over the last 3 days but would have been present had the person undertaken activity, code according to the activity level that would normally have caused the person to experience fatigue.

0 None

1 Minimal — Diminished energy but completes normal day-to-day activities.

2 Moderate — Due to diminished energy, **unable to finish** normal day-to-day activities.

3 Severe — Due to diminished energy, **unable to start some** normal day-to-day activities.

4 Unable to commence any normal day-to-day activities — Due to diminished energy.

J7. Pain Symptoms

Intent

To record the frequency and intensity of any pain the person may be experiencing. This item can be used to identify indicators of pain, as well as to monitor the person's response to pain management interventions. A substantial number of persons with pain receive inadequate or no treatment. In particular, persons with chronic, non-cancer-related pain are often overlooked and not treated. One of the biggest reasons for this is that many persons mistakenly believe that pain is to be expected as one ages, or that nothing can be done to relieve their pain. Pain control often enables rehabilitation, greater socialization, and activity involvement.

Definitions

Pain — "An unpleasant sensory and emotional experience" that is generally associated with actual or potential tissue damage. Pain refers to any type of physical discomfort in any part of the body. Pain may be localized to one area or may be more generalized. It may be acute or chronic, it may be continuous or intermittent (comes and goes), or it may occur at rest or with movement. The pain experience is subjective; pain is whatever the person says it is.

Shows evidence of pain — Observation of symptoms or indicators by others, because the person either does not complain or is unable to verbalize or describe symptoms.

Process

Pain is highly subjective. There are no objective markers or tests to indicate when someone is having pain, or to measure its severity. What a person experiences may not be proportional to the type or extent of the underlying tissue damage. Sometimes a specific cause for chronic pain cannot be identified. Regardless, unless the person refuses, pain must always be treated, even if its cause is unknown.

The most accurate and reliable evidence of the existence of pain and its intensity is what the person tells you. Even in cognitively impaired persons, self-reports of pain should be considered reliable.

The assessor may not get an accurate answer if you simply ask "Are you in pain?" A person may think of "pain" as a more intense experience after an acute event — such as what may be experienced after surgery or spraining an ankle. For example, a woman may have a sore foot that "acts up" when she pivots to transfer to her wheelchair or the toilet but that does not bother her most of the time. Such a person might deny being "in pain." Persons often use different words in describing pain, referring to what they're feeling as "discomfort," "burning," "hurting," "aching," "tightness," "heaviness," "soreness," or a "twinge" or "pang."

If the person is unable to tell you if he or she is experiencing some type of painful sensation, observe the person for indicators of pain such as moaning, wincing, or guarding. In some persons, the presence of pain can be hard to discern. For example, persons with dementia may not be able to verbalize that they are feeling pain, although they may manifest pain by particular behaviors such as calling out or resisting care. Although such behaviors may not be indicative solely of pain, the assessor needs to make a determination if the behaviors are secondary to pain. If necessary, ask those who have had frequent contact with the person whether he or she complained or showed evidence of pain in the last 3 days. However, first ask the person directly about frequency and intensity.

Use your clinical judgment when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level. Persons having pain will usually require further evaluation to determine the cause and to identify interventions that promote comfort. You never want to miss an opportunity to relieve pain.

J7a. Frequency with which person complains or shows evidence of pain

Definition

Measures how often the person experiences pain (reports or shows evidence of pain); includes grimacing, teeth clenching, moaning, withdrawal when touched, and other nonverbal signs suggesting pain.

Coding

0 No pain

1 Present recently but not exhibited in last 3 days

2 Exhibited on 1–2 of last 3 days

3 Exhibited daily in last 3 days

J7b. Intensity of highest level of pain present

Definition

Measures the level of pain reported by or observed in the person.

Coding

0 No pain

1 Mild

2 Moderate

3 Severe

4 Times when pain is horrible or excruciating

J7c. Breakthrough pain

Definition

The person experienced a sudden, acute flare-up of pain one or more times in the last 3 days. Breakthrough pain might appear as a dramatic increase in the level of pain above that addressed by ongoing analgesics, or the recurrence of pain associated with end-of-dose failure.

Coding

0 No

1 Yes

J8. Instability of Conditions

Intent

To determine if the person's disease or health conditions present over the last 3 days are acute, unstable, or deteriorating.

Definitions

J8a. Conditions/diseases make cognitive, ADL, mood, or behavior patterns unstable (fluctuating, precarious, or deteriorating) — Denotes the changing and variable nature of the person's condition or the difficulty of achieving a balance between treatments for multiple conditions. For example, a person may experience different levels of pain or have variable responses to the analgesic effect of pain medications. On "good days" over the last 3 days, he or she will participate in ADLs, be in a good mood, and enjoy preferred leisure activities. On "bad days," he or she will be dependent on others for care, be agitated, cry, and so on. The person may also have a condition, such as ulcerative colitis, rheumatoid arthritis, or multiple sclerosis, that causes pain or impairs mobility or sensation, resulting in increased dependence on others and depression.

J8b. Experiencing an acute episode or a flare-up of a recurrent or chronic problem — The person is symptomatic for an acute health condition (such as a new myocardial infarction, adverse drug reaction, influenza, or delirium) or recurrent acute condition (such as aspiration pneumonia or urinary tract infection). Also included are persons who are experiencing an exacerbation or flare-up of a chronic condition (for example, new-onset shortness of breath in someone with a history of asthma; increased foot swelling and confusion in a person with heart failure; acute joint pain and swelling in a person with arthritis for many years); or a shingles flare-up. This type of acute episode usually is of sudden onset, has a time-limited course, and requires evaluation by a physician and a significant increase in licensed nursing monitoring.

J8c. End-stage disease, 6 or fewer months to live — The person or family has been told that in the clinical judgment of the physician, the person has end-stage disease with approximately 6 or fewer months to live.

Process

Consult with the person and the person's family. Review any clinical records. Use your clinical judgment to determine whether it is appropriate to ask the person about whether he or she has an "end-stage disease" (Item J8c).

Coding

0 No

1 Yes

J9. Self-Reported Health

Process

Ask the person, "In general, how would you rate your health?" Record the person's response according to one of the categories below. Do not code based on your own inferences about the person's physical health and do not record ratings given by family, friends, or other informants. This item should be treated strictly as a self-report measure. If the person is unable or refuses to respond, do not dwell on the item; instead, code that the person could not (would not) respond.

Coding

0 Excellent

1 Good

2 Fair

3 Poor

8 Person could not (would not) respond

J10. Tobacco and Alcohol

J10a. Smokes tobacco daily

Intent

To determine whether the person smokes tobacco.

Definition

Tobacco—Refers to cigar, cigarette, or any other tobacco product that is inhaled. Note: Does not include vaping or use of chewing tobacco.

Process

This information may be sensitive to the person. Begin by asking the person about tobacco usage, with a simple nonjudgmental question, "Do you smoke?" If yes, determine the frequency. Address this issue in a gentle way to avoid the person feeling judged. If possible, validate tobacco usage with a family member or caregiver. This discussion should not take place in front of the person.

Coding

0 No

1 Not in last 3 days but is usually a daily smoker

2 Yes

J10b. Alcohol

Intent

To determine if a person's consumption of alcohol is a potential problem.

Definitions

Alcohol—Includes the highest number of beer, wine, mixed drinks, liquor, and liqueurs the person had in a "single sitting" during **the last 14 days.**

Single sitting—Refers to any given point in time (for example, at dinner, after work, while out at a social event, while watching television).

Process

Ask the person directly about whether he or she consumes alcohol. Consult with a family member if necessary. Sometimes it is prudent to talk to the person and family separately. Start by asking the person, "Do you drink alcoholic drinks?" If he or she says yes, then ask, "When you look back over the last 14 days, what is the highest number of drinks you had in a single sitting?"

Coding

Code for the highest number of drinks ingested by the person at one sitting over the last 14 days.

0 None

1 1

2 2–4

3 5 or more

Section K

Oral and Nutritional Status

K1. Estimated Height and Weight [Measurement Units Are Country Specific to USA]

Intent

To record the person's current height and weight in order to monitor nutrition, hydration status, and weight stability over time. For example, a person who has had edema may experience an expected weight loss as a result of taking a diuretic. Weight loss can also be the intended result of limiting caloric intake and participating in an exercise program, or the unintended consequence of poor intake and malnutrition.

Record **height in inches** (Item K1a) and **weight in pounds** (Item K1b). Base weight on most recent measure in the last 30 days.

K

K1a. Height

Process

Height is measured in inches (note: in many countries measured in centimeters). Either take the person's self-report or assess yourself with a tape measure or other device. If the person's self-report seems inaccurate, consider measuring using a tape measure.

Round height up to the nearest whole inch. Measure height consistently over time in accordance with standard agency practice (shoes off, etc.).

Coding

Enter one digit in each box.

K1b. Weight

Process

Base weight on most recent estimated weight in pounds measured within the last 30 days (note: in many countries measured in kilos). Round the person's weight upward to the nearest whole pound. In most instances, a self-report of weight is acceptable. However, if the self-report appears to be inaccurate, you may weigh the person in accordance with standard agency practice (shoes on or off, etc.). In the unusual instance where this is required assess yourself using a calibrated scale (if available). In its absence, use your own or other's best estimate.

Coding

Enter one digit in each box. If the person weighs less than 100 pounds, use **"0"** as a filler digit in the first box.

K2. Nutritional Issues

Intent

To identify specific problems, conditions, and risk factors related to the intake of food and nourishment that affect or could affect the person's health or functional status. Such problems can often be reversed and the person can improve.

K2a. Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS

Intent

To explore marked declines in weight. Such weight loss can indicate failure to thrive, a potentially serious medical problem, or poor nutritional intake due to physical, cognitive, or social factors.

Process

Ask the person or family about weight changes over the last 30 and 180 days. Use actual records of weight if available. A subjective estimate of weight change from the person (assuming he or she retains the ability to communicate such information) or caregiver can be used if no written records are available. Identifying a particular time approximately 6 months earlier (such as "compared to last New Year's") may help the person remember his or her approximate weight 180 days ago. You may be able to help the person answer the question by asking "How much weight do you think you have lost?" Then mentally compare this with the reported or your estimated current weight of the person. You can also ask, "Have you lost a lot of weight? Do you feel much thinner or weaker?" or "Your clothes seem very loose on you. Were you much heavier 6 months ago?"

Example of How to Calculate Weight Loss

To calculate the percent of weight loss, divide the amount of weight the person has lost by the person's previous weight, and then multiply that number by 100 to get the percent of weight loss. Round weights upward to the nearest whole pound.

For example, you have on record that 6 months ago the person weighed 144 lb.

Currently the person weighs 128 lb, a loss of 16 lb.

16 / 144 = .11

0.11 x 100 = 11%

The person has a weight loss of 11% in 6 months.

K2b. Dehydrated

Process

Identifying dehydration can be difficult. Record your clinical judgment based on signs and symptoms (for example, severe vomiting over a short period of time). Alternatively, laboratory results indicating dehydration may be available (i.e., BUN/creatinine ratio of >25 [note that the standard for this ratio value can be country specific]).

K2c. Fluid intake less than four 8 oz cups per day (or less than 1,000 cc per day)

Definition

Person did not consume all/almost all fluids during the last 3 days.

K2d. Fluid output exceeds input

Definition

Fluid loss exceeds the amount of fluids the person takes in (for example, loss from vomiting, fever, or diarrhea that exceeds fluid replacement).

Coding Select the appropriate code for each of the above (K2a–K2d).

K2e. Physician ordered therapeutic diet [Missouri Item]

Intent The intent of this item is to determine whether a specific diet, as explicitly ordered and documented by a personal physician, is implemented for the purpose of altering a person's dietary (food and drink) intake to support medical management of a diagnosis. This does not include mechanically altering diets to avoid swallowing problems or aspiration.

Definition Weighing, measuring, calculating, and/or restricting select nutrient components (e.g. calories, fat, sodium, and potassium).

Coding Select appropriate code.

0 No

1 Yes

K3. Mode of Nutritional Intake

Intent The ability to swallow safely can be affected by many disease processes and by functional decline. Alterations in one's ability to swallow could result in choking and aspiration, both of which can cause morbidity and mortality. Often persons with swallowing difficulties require altered consistencies of food and fluids in order to ingest nutrition by mouth. This item details any dietary modifications necessary to address swallowing difficulties.

Definitions

Feeding tube — Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes.

Mechanically altered diet— A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, and ground meat. Diets for persons who can only take liquids that have been thickened to prevent choking are also included in this definition.

Parenteral feeding only— Includes all types of parenteral feedings, such as total parenteral nutrition (TPN) and peripheral parenteral nutrition (PPN). Parenteral feeding involves the intravenous administration of nutrition for persons who cannot absorb enough food by mouth and feeding tube to maintain good nutritional status.

Process Observe and talk with the person, family, or caregiver. If available, review the person's clinical record.

Coding Using the codes provided, indicate which item best describes the dietary prescription used to accommodate swallowing difficulties.

0 Normal— Person swallows all types of foods.

1 Modified independent— For example, liquid is sipped, or person takes limited solid food; need for modification may be unknown.

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2 **Requires diet modification to swallow solid food**—For example, mechanical diet (puree, minced, etc.) is required, or person is only able to ingest specific foods.

3 **Requires modification to swallow liquids**—For example, liquids must be thickened.

4 **Can swallow only pureed solids AND thickened liquids**

5 **Combined oral and parenteral or oral and any tube feeding**

6 **Nasogastric tube feeding only**

7 **Abdominal feeding tube only**—For example, a PEG tube.

8 **Parenteral feeding only**—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN).

9 **Activity did not occur**—Person did not eat or receive any form of nutritional supplementation during the last 3 days.

K4. Swallowing Problems

Intent

To document oral complications in swallowing.

Definition

Aspiration—Accidentally breathing food or liquid into airways; in extreme case, food stuck in throat (unable to cough out).

Process

Ask the person, family member, nurse assistant/personal care worker, or a dietary staff member if present.

K4a. Aspiration

K4b. Food or fluid escapes from or dribbles from mouth during eating or drinking

K4c. Ate one or fewer meals a day in AT LEAST 2 OF LAST 3 DAYS

K4d. Noticeable decrease in the amount of food person normally eats or fluids usually consumes

Coding

Code for the appropriate response.

0 No

1 Yes

K5. Oral Issues

Intent

To record any oral problems present in the last 3 days.

Definitions

K5a. Dry mouth—Whenever possible, ask the person (for example, ask: "Do you have dry mouth?"). The person reports having a dry mouth or difficulty in moving a food bolus in his or her mouth.

K5b. Difficulty chewing—Whenever possible, ask the person (for example, ask: "Do you have difficulty chewing?"). The person is unable to chew food easily

and without pain or difficulties, regardless of cause (for example, the person might use ill-fitting dentures or might have a neurologically impaired chewing mechanism, temporomandibular joint pain, or a painful tooth).

Coding

Code for problem present in last 3 days.

0 Not present

1 Present recently but not exhibited in last 3 days

2 Exhibited on 1 of last 3 days

3 Exhibited on 2 oflast 3 days

4 Exhibited daily in last 3 days

K6. Dental/Oral Cavity Issues

Intent

To record any oral problems present in the last 3 days. To determine whether assistance with oral hygiene is required and whether referral to a dentist is necessary.

Definitions

K6a. Broken, loosely fitted denture(s) (removable prosthesis)— The person has a nonfunctional denture that was intended to replace all or some of the teeth of the upper or lower jaw. A denture is removable by the person or a helper.

K6b. Broken, decayed, fragmented, or loose natural teeth— The person has natural teeth that are broken, decayed (orange/brown cavities that can be surrounded by a white zone), fragmented (a piece of the tooth is missing), or loose (tooth is movable when touched). This does not include a small chip that has no impact on the person.

Process

Code for conditions based on self-report and oral cavity review. Ask the person about difficulties in the item areas.

Coding

0 No

1 Yes

Section L

Skin Condition

Intent

To determine the condition of the person's skin, identify the presence and stage of ulcers, document other skin conditions, and note any foot problems that may be present.

L1. Most Severe Pressure Ulcer/Injury

Intent

To record the highest stage of pressure ulcers/injuries on any part of the body present in the last 3 days.

Definitions

Pressure ulcer/injury— Any lesion caused by unrelieved pressure. Pressure ulcers usually occur over bony prominences and are staged to classify the degree of tissue damage observed.

Any area of persistent skin redness— An area of skin that appears continually reddened and does not disappear when pressure is relieved. There is no break in the skin. Also known as "Stage 1."

Partial loss of skin layers— A partial-thickness loss of skin that presents clinically as an abrasion, blister, or shallow crater. Also known as "Stage 2."

Deep craters in the skin— A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining of adjacent tissue. Also known as "Stage 3."

Breaks in skin exposing muscle or bone— A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. Also known as "Stage 4."

Process

Review the person's record and as necessary consult with person, family, or caregiver about the presence of one of these major skin problems.

Consult with the person and family about the presence of an ulcer. They are the primary source of this information. If an ulcer is present, use the above definitions as the basis of your discussion.

In an unusual situation, a skin exam may be called for, assuming your agency supports such a review. For example, the person or family member says that an ulcer is newly present, it has not been reviewed by a health professional, and you are invited to check on the extent of skin injury. Note: If you have not been trained to complete such a review, say so, and suggest that the person speak with a health professional.

Even if you are trained, recognize that it could be difficult to examine the person's entire skin, as you are a guest in the person's home. In most instances, a referral to their physician would be the best option.

Bottom line, assume that for persons who are cognitively intact, you can get good information about their skin condition from the person without conducting a skin examination.

In the unlikely event that you do proceed with a skin examination, recognize that for a chair-bound or bedfast person, it is necessary to pay particular attention to the person's hips, thighs, buttocks, low back, and heels. Follow the protocol as mandated by your agency.

It is sometimes difficult to determine the presence of a reddened area (a Stage 1 ulcer) in persons with darker skin tones. To recognize Stage 1 ulcers, look for:

- Any change in the feel of the tissue in a high-risk area;
- Any change in the appearance of the skin in high-risk areas, such as an "orange-peel" look or a subtle purplish hue; and
- Extremely dry crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding

Code for the appropriate response.

0 No pressure ulcer

1 Any area of persistent skin redness — An area of skin that appears continually reddened and does not disappear when pressure is relieved. There is no break in the skin (Stage 1).

2 Partial loss of skin layers — A partial-thickness loss of skin that presents clinically as an abrasion, blister, or shallow crater (Stage 2).

3 Deep craters in the skin — A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining of adjacent tissue (Stage 3).

4 Breaks in skin exposing muscle or bone — A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone (Stage 4).

5 Not codeable — Necrotic eschar predominant.

6 Not codeable — Suspected deep tissue injury, depth unknown.

L2. Prior Pressure Ulcer/Injury

Intent

To document a history of pressure ulcers, which is a risk factor for the development of pressure ulcers in the future.

Process

Ask the person if he or she has ever had a pressure ulcer that is now healed. A review of old records (including discharge summaries), clinical progress notes, flow sheets, or care plans may also yield this information. If necessary, check with a family member or care provider who has prior knowledge of the person's skin condition.

Coding

Code for the appropriate response.

0 No

1 Yes

L3. Presence of Skin Ulcer/Injury Other Than Pressure Ulcer

Intent

To identify the presence of any skin ulcer that is not a pressure ulcer — for example, a venous ulcer, arterial ulcer, mixed venous-arterial ulcer, or diabetic foot ulcer.

Definition

Skin ulcer — An open lesion caused by poor circulation in the lower limbs.

Process

Ask the person if he or she has a venous or arterial ulcer. Review the person's record and consult with caregivers about the presence of this type of ulcer.

Coding Code for the appropriate response.

0 No

1 Yes

L4. Major Skin Problems

Definitions **Major skin problems**— This item includes lesions, second- or third-degree burns, and healing surgical wounds.

Burn — Injury to tissues resulting from thermal, electrical, chemical, or radioactive exposure. The effect of the injury may be local or systemic.

Process Review the person's record and as necessary consult with person, family, or caregiver about the presence of one of these major skin problems.

Coding Code for the appropriate response.

0 No

1 Yes

L5. Skin Tears or Cuts (Other Than Surgery)

Definition Any traumatic break in the skin penetrating to the subcutaneous tissue. Does not include surgical incisions.

Process Review the person's record and as necessary consult with person, family, or caregiver about the presence of a skin tear or cut.

Coding Code for the appropriate response.

0 No

1 Yes

L6. Other Skin Conditions or Changes in Skin Condition

Intent To document the presence of skin problems other than ulcers, skin tears, or cuts, and the major skin problems represented in the earlier items.

Definitions **Other skin conditions or changes in skin condition** — For example, bruises, rashes, itching, mottling, herpes zoster, intertrigo, or eczema.

Bruises— Black and blue areas (ecchymosis).

Rashes— Include inflammation or eruption of the skin that may include change in color, spotting, and blistering characterized at times by itching, burning, or pain. Record rashes from any cause.

Mottling— A condition characterized by areas of skin discoloration.

Herpes zoster (shingles)— A type of viral infection that can lay latent for years. Once active it presents with pain, itching, and blisters over affected veins.

Intertrigo — Reddish rash (skin inflammation) between the folds of skin.

Eczema— Major features include pruritus, atypical morphology and distribution, and a tendency toward dry skin and itching. Flaking of skin may occur.

Vesiculobullous— Condition characterized by fluid-filled lesions (for example, blisters) with vesicles being less than 5 to 10 mm and bullae being larger (for example, pemphigus bullous pemphigoid).

Process

Review the person's record and as necessary consult with person, family, or caregiver about the presence of any of the listed skin problems.

Coding

Code for the appropriate response.

0 No

1 Yes

L7. Foot Problems

Definition

Includes bunions, hammertoes, overlapping toes, structural problems, infections, deformed toenails, and ulcers.

Process

Ask the person and as necessary consult with family or caregiver about the presence of these types of problems. If the opportunity arises, you should be prepared to examine the feet, including toenails, to see if the person has any of the indicated foot problems.

Coding

Code for the appropriate response.

0 No foot problems

1 Foot problems, no limitation in walking

2 Foot problems limit walking

3 Foot problems prevent walking

4 Foot problems, does not walk for other reasons

Section M

Medications

Medication use in the adult population is growing steadily. Of particular concern are medications taken to prevent or treat chronic conditions, including hypertension, diabetes, heart disease, arthritis, or selected psychiatric conditions; such medications may be taken for years. In addition, having multiple health conditions (multiple morbidity) often results in the use of multiple medications (polypharmacy) and a complicated drug regimen. Further, over-the-counter medications, such as analgesics, non-steroidal anti-inflammatory drugs, and sleep medications, are consumed by a large number of adults, resulting in increased risk of morbidity: the higher the number of medications a person takes, the greater the risk of drug interactions and adverse drug reactions. Long-term medication use, complicated drug regimens, and polypharmacy also increase the risk of non-adherence.

The aim of this section is to help identify persons with potential risk factors for medication-related health problems, as well as persons who may have difficulties with medication management. These individuals may benefit from a more thorough medication review by a physician or pharmacist, or from strategies to improve their medication management skills. It may also help identify medications that might be causing specific problems for the person, such as delirium or constipation. The focus is on medications that the person has taken, not on medications prescribed.

M1. Total Number of Medications

Intent

To facilitate medication management, by having a total count of the number of different medications (prescribed and over-the-counter medications) that the person has taken in the last 7 days, excluding supplements.

Definitions

Medications — Include all medications (prescription and over-the-counter medications) taken in the last 7 days; for example, pills, creams, ointments, eye drops, artificial tears. This includes all the following:

- **Prescription medications** — Includes medications that are now discontinued but were taken in the last 7 days, as well as drugs prescribed PRN (as needed) that were taken during this period. Be sure to include maintenance medications that are prescribed on a regular schedule, such as vitamin injections given once a month, even if they were not administered in the last 7 days.
- **Over-the-counter medications** — Includes all drugs obtained without a prescription.
- **Compounded medications** — Includes medications composed of two or more compounds (for example, co-amoxiclav, in which clavulanic acid is combined with amoxicillin). Any multicompounded or compounded drug is counted as one medication.

Process

Ask the person, family, or caregiver to identify all prescribed and over-the-counter medications taken over the last 7 days. This is best achieved by asking to see all medication bottles, or to review the person's pill cases. If a current, updated

printout of medications is available, review. If a new medication was prescribed but not taken in the last 7 days, do not count. You will need to count the total and note a small list of specific medications to be listed under Item M8 below.

Count the total number of different medications the person took during the assessment period.

Coding

Enter the exact number of different medications taken in the last 7 days. Enter 15 if the person has taken 15 or more than 15 medications.

M2. Total Number of Herbal and Nutritional Supplements

Intent

To determine the total number of different supplements taken regularly or on an occasional basis in the last 7 days. Selected supplements may interact with other medications taken by the person.

Definition

Supplements — A group of products used for their potential therapeutic properties or to augment the nutritional content of diets. These include minerals, vitamins, herbs, meal supplements, sports nutrition products, natural food supplements, and other related products.

Process

Consult with the person, family, or caregiver to identify all such substances, and then count the number of different supplements that the person has taken during the last 7 days.

Coding

Enter the number of different supplements taken in the last 7 days. Note: Multivitamins are counted as one supplement. Enter 15 if the person has taken 15 or more than 15 different supplements.

M3. Disregard—this item not utilized in Missouri

M4. Self-Reported Need for Medication Review

Intent

To determine whether the person has concerns about the medications he or she is taking that should be discussed with a health professional. These concerns may signal medication safety issues (potential medication-related adverse events), medication inefficiency, medication management, or adherence problems.

Process

Ask: "Do you have concerns about your medications that you want to discuss with a health professional?"

Coding

Code for the appropriate response.

0 No

1 Yes

8 Person could not (would not) respond

M5. Recently Changed Medications

Intent

To determine whether the person has been prescribed a new medication or had a medication stopped or altered in the last 14 days by a prescribing health professional. A person with a recent medication change is at higher risk of medication-related adverse events, including side effects, drug-drug interactions, drug-disease interactions, non-adherence, or difficulty managing medications independently.

Process

Ask the person, or a family member or caregiver, if medications have been changed in the last 14 days. As an alternative, review the medication bottles themselves.

Coding

Code for the appropriate response.

0 No

1 Yes

M6. Cannabis Use

Intent

To determine whether the person used some form of cannabis for any purpose, including medicinal, recreational, or ceremonial reasons. Included are botanical products (for example, marijuana) and manufactured products (for example, nabiximols) that contain tetrahydrocannabinol (THC) or cannabidiol (CBD) in any form (for example, smoked, edible, oils, topical). As such products are becoming legal in different jurisdictions (for example, Canada and some U.S. states) their use can be expected to increase, and their potential effects will need to be monitored.

Process

Ask person, or family and caregiver, if cannabis products were used in the last 90 days and, if used, what was the most recent use. Exclude illicit or illegal "synthetic cannabis" (for example, bath salts) that are not produced by licensed pharmaceutical manufacturers.

Coding

Code for the appropriate response.

0 Not in last 90 days (or no cannabis use)

1 31–90 days ago

2 8–30 days ago

3 4–7 days ago

4 In last 3 days

M7. Medicinal Use of Cannabis

Intent

To determine whether cannabis was used for medicinal reasons. This would include cannabis prescribed by a health professional to address a specific problem — for example, pain, nausea, cancer side effects, glaucoma, epilepsy. However, in jurisdictions where a prescription is not required, the person or family may purchase such products over the counter. In that case, the person's self-reported reasons for use of cannabis should be considered.

Process

Ask the person if cannabis is used for medicinal reasons. Alternatively, check whether there is an existing prescription provided by an authorized health professional. If the person provides a non-specific answer (for example, "I take it to feel

good"), ask whether he or she uses cannabis to treat a symptom that would otherwise bother him or her if not treated (for example, anxiety, pain, nausea).

Coding

Code for the appropriate response.

0 None (or no cannabis use)

1 Sometimes used for medicinal purposes

2 Always used for medicinal purposes

M8. Disregard—this item not utilized in Missouri

M9. Adherent with Medications Prescribed by Physician or Other Health Professional

Intent

To determine if the person is taking/using medications as prescribed by a physician, nurse practitioner, or physician assistant.

Definition

The person is actually taking medications **as prescribed**.

Process

You will have already solicited information from the person about his or her medications. Compare the person's responses with available medication and known medication orders. Does the supply remaining seem appropriate considering when the prescription was filled? Did the person and caregiver give accurate information about medication administration? Remember, this item is not intended to evaluate the appropriateness of the medication prescribed or the reason for the non-consumption. For example, the person may say that he or she avoids taking a prescribed medication because of perceived side effects (for example, nocturnal incontinence), and while the physician should be made aware of the issue, you would still score this as not taking a prescribed medication.

Coding

0 Always adherent

1 Adherent 80% of time or more— Over the last 7 days, the person deviated from prescribed medication regime 20% or less of the time.

2 Adherent less than 80% of the time, including failure to purchase prescribed medications— Over the last 7 days, the person deviated from prescribed medication regime more than 20% of the time.

8 No medications prescribed— Person is not receiving any prescribed medication.

Section N

Treatments and Procedures

N1. Prevention

Intent

This item helps the assessor identify whether the person has unmet needs for health counseling and preventive care.

Process

Ask the person if he or she received the following specific health measures.

N1a. Colonoscopy in LAST 5 YEARS— The entire colon (from anus to cecum) was viewed by means of a fiber-optic colonoscopy.

N1b. Dental exam in LAST YEAR— The person underwent a dental examination by a dentist, oral surgeon, or dental hygienist during the past year.

N1c. Influenza vaccine in LAST YEAR— The person has received vaccination for influenza prevention during the past year.

N1d. Pneumovax vaccine in LAST 5 YEARS or after age 65— The person received the vaccine for prevention of pneumonia within the past 5 years or after age 65.

N1e. COVID-19 vaccine in LAST YEAR (or as required).

Coding

Code for the appropriate response.

0 No

1 Yes

N2. Treatments and Programs Received or Scheduled in the Last 3 Days

Intent

To review prescribed treatments and determine the extent of the person's adherence to the prescription. This item includes special treatments, therapies, and programs received or scheduled during the last 3 days, as well as adherence to the required schedule. It includes services received in the home or on an outpatient basis.

Definitions

Treatments

N2a. Chemotherapy— Includes any type of chemotherapy (anticancer drug) given by any route.

N2b. Dialysis— Includes peritoneal or renal dialysis that occurs at home or at a facility.

N2c. IV medication— Includes any drug or biological (for example, contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication.

N2d. Oxygen therapy— Includes continuous or intermittent oxygen via mask, cannula, or other means.

N2e. Radiation— Includes radiation therapy or having a radiation implant.

N2f. Suctioning— Includes oropharyngeal, nasopharyngeal, or tracheal aspiration.

N2g. Tracheostomy care— Includes removal of cannula and cleansing of tracheostomy site and surrounding skin with appropriate solutions.

N2h. Transfusion— Includes transfusion of whole blood or any type of blood products.

N2i. Ventilator or respirator— Mechanical device designed to provide adequate ventilation in persons who are, or may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed-system mechanical ventilator support devices. Includes any person who was in the process of being weaned off the ventilator or respirator in the last 3 days.

N2j. Wound care— Includes the application of bandages (for example, dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, or dressings with hydrocolloid or hydroactive particles); wound irrigation; the application of ointments and topical medications to treat skin conditions (for example, cortisone, antifungal preparations, or chemotherapeutic agents); debridement (chemical or surgical) to remove dirt or dead tissue from a wound; and suture removal.

Programs

N2k. Hospice/palliative care program for end of life— A formal program (at the person's home or in a hospice setting) in which care is focused on the relief of pain and other uncomfortable symptoms such as dyspnea. Persons receiving palliative care generally have end-stage disease but may or may not have a prognosis of 6 months or less to live (that is, the person may live for many months or years).

Process

Ask the person, or a family member or caregiver, if he or she received specific treatments or programs. If needed, review any available records on treatments received.

Coding

0 Not ordered AND did not occur

1 Ordered, not implemented

2 Implemented but not received in last 3 days

3 1–2 of last 3 days

4 Daily in last 3 days

N3. Formal Care—Number of Days Provided and Total Number of Minutes of Care Provided in Last 7 Days (or Since Last Assessment or Admission If Less Than 7 Days)

Intent

To capture the number of minutes spent by formal (paid) caregiving agencies or privately paid individuals in providing care or care management in the last 7 days (or since last assessment or admission, if less than 7 days).