



Clinician's Pocket Guide



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- Improvement in Bathing pg 11-16
- Improvement in Status of Surgical Wounds pg 17-34
- Improvement in Transferring, and Ambulation/Locomotion pg 35-40
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Content provided by
The Ohio Department of Health-BCHCFS
Corrine Stevenson, RN/MS, OASIS Education Coordinator
7/2003

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Acute Care Hospitalization & Any Emergent Care

Step 1 Assessment

- On SOC/ROC assess patient risk
 - For rehospitalization
 - For anxiety (M0580)

Step 2 Care planning and 485 development

- If patient identified as at-risk for rehospitalization during the first 2 weeks of care
 - Front-load (increase the frequency) of SN visits
 - During the intervening time between home visits, schedule telephone reassurance calls for specific days
 - Obtain physician orders for prn visits for signs and symptoms of deteriorating disease/condition process

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- If M0580 score is ≥ 2 during the intervening time between home visits, schedule telephone reassurance calls for specific days

Step 3 Patient education

- Instruct patient/caregiver on how to access the HHA for assistance at SOC/ROC and follow-up visits for the first 2 weeks
- Instruct patient/caregiver on non-life-threatening signs and symptoms to report to the nurse
- Provide patient with reminder and post “reminder” in location designated by patient as highly visible
- Provide focused patient education – CHF, COPD, diabetes, wounds
- Instruct patient/caregiver on patient self-monitoring for signs and symptoms of deteriorating disease/condition process

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Check all that apply and total patient's risk at the bottom **SCORE**

PREVIOUS HOSPITAL STAY

- Score = 1 if: No previous hospital stays in the last 6 months
- Score = 2 if: 1 previous hospital stay in the last six months
- Score = 3 if: 2 to 3 previous hospital stays in the last six months
- Score = 4 if: 4 or more previous hospital stays in the last six months

COMORBID DIAGNOSES

- Score = 1 if: 0 to 2 comorbid diagnoses
- Score = 2 if: 3 to 5 comorbid diagnoses
- Score = 3 if: 6 or more comorbid diagnoses

SEVERITY OF ILLNESS

- Score = 0 if: The patient is a CHF or COPD patient
- Score = 1 if: Mildly severe, some symptoms present but have relatively little impact on day-to-day life
- Score = 2 if: Mildly severe and has some impact on day-to-day life
- Score = 3 if: Moderately severe with impact on day-to-day life
- Score = 4 if: Very severe with significant impact on day-to-day life

Rehospitalization Risk Assessment Approved for clinical use only.
Developed by Elizabeth Madigan, PhD, RN
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· COPD information provided by the Global Initiative for Chronic Obstructive Lung Disease

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- Score = 0 if: The patient is not a CHF patient.
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- Score = 2 if: **NYHA Class II (Mild)** Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or SOB
- Score = 3 if: **NYHA Class III (Moderate)** Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or SOB
- Score = 4 if: **NYHA Class IV (Severe)** Unable to carry out any physical activity without discomfort Symptoms of cardiac insufficiency at rest If any physical activity is undertaken, discomfort is increased

COPD PATIENT ONLY *

- Score = 0 if: The patient is not a COPD patient
- Score = 1 if: Usual but not always, chronic cough and sputum production present
- Score = 2 if: Progression of symptoms with SOB typically developing on exertion
- Score = 3 if: Increased SOB that impacts patient's quality of life
- Score = 4 if: Quality of life is very appreciably impaired and exacerbations may be life threatening

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M0100

The assessment is currently being completed for the following reason:

Will HHAs be allowed to change the reason for assessment in HAVEN at OASIS data item M0100 if they have submitted the wrong type of assessment?

NO. HAVEN will require that the HHA inactivate the erroneous assessment and resubmit a corrected assessment. 7-143

If you submit the wrong type of assessment can you change it?

You are required to **inactivate** the erroneous assessment and resubmit a corrected assessment.

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M0855

Data items collected at inpatient facility admission or agency discharge only

To which inpatient facility has the patient been admitted?

For M0855, response 2, “rehabilitation facility” is a certified, distinct rehabilitation unit of a nursing home OR a freestanding rehabilitation hospital. For response 3 “nursing home” includes either a skilled nursing facility or an intermediate care facility.

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M0830

Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)?

When I called to schedule my visit, I learned that my patient was seen in the ER and was then admitted to the hospital. How should I answer M0830?

Emergent care includes all unscheduled visits to medical services as noted in the response options, including a hospital emergency room. You should mark M0830 with response 1 – Hospital emergency room. In this situation, since the patient was admitted to the hospital following the emergency room visit, you would also complete the items for Transfer to the Inpatient facility (RFA #6 or 7 to M0100).

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M0830

The patient was held in the ER suite for observation for 36 hours. Was this a hospital admission or emergent care?

If the patient was never admitted to the inpatient facility, this encounter would be considered emergent care. The time period that a patient can be “held” without admission can vary from location to location, so the clinician will want to verify that the patient was never actually admitted to the hospital.

The patient had a planned visit for cataract surgery at the outpatient surgical center. Is this emergent care?

Emergent care is defined as an “unscheduled visit to any (emergent) medical services.” The situation you described was a planned visit and thus is not considered emergent care.

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If a patient goes for emergent care and is then admitted to the hospital, what is the appropriate response to M0830?

As noted in the item-by-item tips for M0830 (Attachment B to Chapter 8 of the *OASIS Implementation Manual*) current events must be included in the response to this item. Therefore, the patient who goes for emergent care and is admitted to the hospital **did receive** emergent care. The appropriate response to M0830 would be 1, 2, or 3, depending on where the patient received the emergent care.

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Improvement in Bathing

Step 1 Assessment

- On SOC/ROC assess the patient's **ability** to wash entire body excluding face and hands

Ask yourself these questions:

- What assistance does the patient need to be able to bathe in the tub or shower?
- Does the patient's environment impact their ability to complete the bathing task?
- Do medical restrictions apply?
- Is the patient's fear a realistic barrier to their being able to bathe safely?
- What is the patient's preference for bathing?

Step 2 Care planning and 485 development

- Establish a personal self-care goal with the patient
- Referral for home health aide services
- Develop a care plan that includes patient self-care whenever appropriate

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- If MO670 scores ≥ 2 , consider referral to Occupational Therapist (OT) for adaptive equipment needs and upper body strengthening, and to Physical Therapist (PT) for balance and transfer techniques
- When therapy resources permit, schedule the initial Home Health Aide (HHA) visit to be made with the Occupational Therapist (OT).
 - The OT establishes the care plan, sets personal care goals, and orients the HHA to the concept of patient self-care as a goal

Step 3 Patient Education

- Educate patient/caregiver in self-care goals, safety and home exercise program implementation

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M0670

Ability to wash entire body. Excludes grooming (washing face and hands only).

For patients whose regular habit is to sponge bathe themselves at the lavatory, what should be marked for M0670?

As noted in the Item-by-Item Tips found in Chapter 8, the patient who regularly bathes at the sink or lavatory must be assessed in relation to his/her ability to bathe in the tub or shower. What assistance would be needed for the patient to be able to bathe in the tub or shower? For example, if it is determined that the patient would be able to shower or bathe in the tub if stand-by assistance of another person was always available, **response #2 would be marked.**

13

M0670

Ability to wash entire body. Excludes grooming (washing face and hands only).

For patients whose regular habit is to sponge bathe themselves at the lavatory, what should be marked for M0670?

As noted in the Item-by-Item Tips found in Chapter 8, the patient who regularly bathes at the sink or lavatory must be assessed in relation to his/her ability to bathe in the tub or shower. What assistance would be needed for the patient to be able to bathe in the tub or shower? For example, if it is determined that the patient would be able to shower or bathe in the tub if stand-by assistance of another person was always available, **response #2 would be marked.**

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M0670

Given the following situations, what would be the appropriate responses to M0670?

(a) The patient's tub or shower is nonfunctioning or is not safe for use?

The patient's environment can impact his/her ability to complete specific ADL tasks. If the patient's tub or shower is nonfunctioning or not safe, then the patient is currently unable to use the facilities. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities outside the tub/shower.

(b) The patient is on physician-ordered bed rest.

The patient's medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Select response 4 (unable to bathe in shower or tub and is bathed in bed or bedside chair) or 5 (unable to effectively participate in bathing and is totally bathed by another person), whichever most closely describes the patient's ability at the time of the assessment.

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M0670

(c) The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.

If the patient's fear is a realistic barrier to her ability to get in/out of the shower safely, then she is unable to bathe in the tub/shower. If she refuses to enter the shower even with another person present, either response 4 or 5 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present, then response 3 would describe her ability.

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M0670

(d) The patient chooses not to navigate the stairs to the tub/shower.

The patient's environment, must be considered when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. While this may appear to penalize the patient whose tub or shower is on another floor, it is within this same environment that improvement or decline in the specific ability will subsequently be measured.

How should I respond to this item for a patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink?

The item addresses the patient's ability to bathe in the shower or tub, regardless of where or how the patient currently bathes. If assistance is needed to bathe in the shower or tub, then the level of assistance needed must be noted, and response 1, 2, or 3 should be selected.

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Improvement in Status of Surgical Wounds

Step 1 Assessment

- Wound assessment
 - Measurement – depth, length and width of margins: perform at least weekly
 - Drainage – amount, color, odor, quality
 - Surrounding skin – redness, warmth, edema
 - Pain – use appropriate pain scale
 - Use WOCN guidelines on OASIS Skin and Wound Status MO Items to establish degree of healing
- Report changes in wound status to the physician on the visit day noted
- Complete agency Nutritional Assessment Tool

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Step 2 Care planning and 485 development

- Establish a wound care treatment goal with the patient
- Establish pain management goal with the patient
- Refer for nutritional consultation based upon agency's protocol
- Identify the appropriate wound care product/s
 - Consult with physician to obtain orders for appropriate wound care product

Step 3 Patient Education

- Educate patient/caregiver in wound care treatment and signs/symptoms of infection, and changes in patient status to report to the clinician

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WOCN Guidance on OASIS skin and wound status MO items

Description/classification of wound healing by primary intention (i.e., approximated incisions)

- Fully granulating/healing: incision well-approximated with complete epithelialization of incision; no signs or symptoms of infection
- Early/partial granulation: incision well-approximated but not completely epithelialized; no signs or symptoms of infection
- Non-healing: incisional separation OR incisional necrosis OR signs or symptoms of infection

Clinical palpitation of a healing ridge is not conclusive and should not be utilized to determine the status of a surgical wound.

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Description/classification of wound healing by secondary intention (i.e., healing of dehisced wound by granulation, contraction and epithelialization)

- Fully Granulating: wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open
- Early/Partial Granulation: \geq 25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (i.e., <25% of the wound bed is covered with avascular tissue); may have dead space; no signs or symptoms of infection; wound edges are open
- Non-healing: wound with \geq 25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite comprehensive appropriate wound management

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M0440

Does the patient have a Skin Lesion or Open Wound? This excludes “Ostomies.”

Please clarify CMS’s interpretation of a skin lesion.

“Lesion” is a broad term used to describe an area of pathologically altered tissue. Wounds, sores, ulcers, rashes, crusts, etc. are all considered lesions. So are bruises. **Does NOT** include “ostomy” or peripheral IV sites. Central line sites are considered to be surgical wounds.

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M0440

How do we document other wounds that are not surgical, pressure or stasis ulcers at M0440?

Remember that OASIS items are only part of a comprehensive assessment and include only those items that have proven useful for outcome measurement and risk factor adjustment. All types of wounds are extremely important to document in the clinical record. The presence of **any** wound or lesion (other than ostomies) should be noted by a “YES” response to M0440.

Are diabetic foot ulcers classified as pressure ulcers, stasis ulcers, or simply as wound/lesions at M0440 and M0445?

If the foot ulcer results from prolonged pressure, it is a pressure ulcer. If it is caused by inadequate venous circulation in the area, then it is a stasis ulcer. If neither of these is true, then the foot ulcer is regarded as a lesion. It is always appropriate to verify the type of ulcer with the patient’s physician to be sure that it has been categorized appropriately.

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M0440

How do we complete M0440 if the patient has a porta cath but we are not accessing it as part of the treatment?

For M0440 you would answer "YES" for a lesion and continue answering the questions until you come to M0482 – Respond "YES". The **porta cath** or mediport site is considered a surgical wound **even if healed over**. The presence of a wound or lesion should be documented regardless of whether the HHA is providing services related to the wound or lesion.

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M0440

On OASIS item M0440, does having a PIC line or any IV access count as a “yes”?

The answer is yes and no. See definition of lesion. Lesions that end in “ostomy” or peripheral IV sites are not considered to be lesions. All other alterations in skin integrity are considered to be lesions.

- Pin sites
- PIC lines
- central lines
- surgical wounds with staples/sutures are all considered lesions or wounds.

Are implanted infusion devices or venous access devices considered surgical wounds at M0440?

YES. These devices are considered surgical wounds at M0440 and are included in the total number of surgical wounds. It does not matter whether the device is accessed at a particular frequency or not.

24

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M0440

Is a new ostomy considered an open wound at OASIS item 440?

NO. As noted in M0440, ostomies are to be EXCLUDED from consideration as open wounds or skin lesions. 3-53

The POC usually includes treatment specifics. If the POC does not include specifics for wound care (aseptic, sterile, or clean technique), where would this be cited?

The above example is a failure to revise the POC. The RN should contact the physician for specific orders on wound care. Can cite under G158, G160 and G173. S & C01-14

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M0440

How many different types of skin lesions are there anyway?

Many different types of skin lesions exist.
These may be classified as:

Primary Lesions (arising from previously normal skin), such as: **Vesicles, pustules, wheals** or

Secondary Lesions (resulting from changes in primary lesions), such as crusts, ulcers, or scars.

Other classifications describe lesions as;
Changes in color or texture (maceration, scale, lichenification).

Changes in shape of the skin surface (e.g., cyst, nodule, edema).

Breaks in skin surfaces (e.g., abrasion, excoriation, fissure, incision).

Vascular lesions (e.g., petechiae, ecchymosis).

26

M0440

How many different types of skin lesions are there anyway?

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Vascular lesions (e.g., petechiae, ecchymosis).

26

M0440

Is a pacemaker considered a skin lesion?

A pacemaker itself is an implanted device but is not an implanted infusion or venous access device. The (current) surgical wound or (healed) scar created when the pacemaker was implanted is considered a skin lesion.

How should M0440 be answered if the wound is not observable?

For the OASIS items, a “nonobservable” wound is one that is covered by a nonremovable dressing (or, in the case of pressure ulcers, an ulcer that is partially or entirely covered by eschar). If you know from referral information, communication with the physician, etc. that a wound exists under a nonremovable dressing, then the wound is considered to be present, and M0440 would be answered “YES”.

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27

M0440

Is a new suprapubic catheter, new PEG site, or a new colostomy considered a wound or lesion?

A new suprapubic catheter site (cystostomy), new PEG site (gastrostomy) and a new colostomy have one thing in common – they all end in “-ostomy.” All such ostomies, whether new or long-standing are **excluded** from consideration in responding to M0440. Therefore, none of these would be considered as a wound or lesion.

How should M0440 be answered if the wound/lesion is a burn?

M0440 should be answered “YES” since a lesion is present. Additional documentation that describes the burn should be included in the clinical record, but burns are not addressed in the OASIS items.

28

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28

M0482

Does this patient have a Surgical Wound?

If a patient has a closed healed, surgical wound, do you still consider it a “wound” on the OASIS assessment?

At M0482, Does this patient have a surgical wound? The response would be “NO” if the wound is healed and not considered current. Old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds.

M0482

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At M0482, Does this patient have a surgical wound? The response would be “NO” if the wound is healed and not considered current. Old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds.

M0482

Is a gastrostomy that is being allowed to close on its own considered a surgical wound?

A gastrostomy that is being allowed to close would be excluded from consideration as a wound or lesion (M0440), meaning that it could not be considered as a surgical wound. The “take-down” of an ostomy that was done as a surgical procedure, however would result in both an open wound (“YES” to M0440) and a surgical wound (“YES” to M0482).

Is a peritoneal dialysis catheter considered a surgical wound? If it is, how can the healing status of this site be determined?

A peritoneal dialysis catheter would be considered a surgical wound. The healing status of the wound can only be determined by skilled observation and assessment, utilizing the WOCN guidelines (OASIS Guidance Document) found at <http://www.wocn.org>

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When does a wound no longer qualify as a surgical wound? When does CMS officially consider a wound to be healed?

A wound no longer qualifies as a surgical wound when it is completely healed (thus becoming a scar). Utilizing skilled observation and assessment of the wound, follow the WOCN guidelines (OASIS Guidance Document) found at <http://www.wocn.org> to determine when healing has occurred. CMS does not follow time intervals in determining when a wound has healed, since the healing status of the wound can only be determined by a skilled assessment.

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M0482

How should these items be marked when the patient's surgical wound is completely healed?

If the patient's surgical wound has healed completely, it no longer is considered a current surgical wound. The resulting scar would be noted as a "YES" response to M0440, but M0482 would be marked "NO".

Is a mediport "nonobservable" because it is under the skin?

Please refer to the definition of "**nonobservable**" used in the OASIS surgical wound items – "**nonobservable**" is an appropriate response when a nonremovable dressing is present. This is not the case with a mediport. As long as the mediport is present, whether it is being accessed or not, the patient is considered as having a current surgical wound.

32

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32

M0488

This patient has an (observable) surgical wound/surgical incision from an abdominal procedure 7 days ago. There is slight incisional separation along the middle portion of the incision; there is a small amount of serous drainage but no signs of infection; there is no palpable healing ridge. How should I classify the status of this wound for the OASIS items?

According to the description of the wound presented in the question, the status of this may be classified as nonhealing if there is incisional separation.

The OASIS Team and clinical wound care experts from WOCN are not able to assess a specific wound status without actually seeing the wound. Please contact the WOCN Web site at www.wocn.org (exit DHFS) for further clarification about their guidelines regarding wound healing.

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M0488

My patient is post-op CABG. The sternal incision is well-approximated, and there is new pink skin covering the entire incision. There is a well-defined healing ridge and no signs of infection though there is very mild erythema along the wound borders. How should I classify the status of this wound for the OASIS items?

According to the description presented in the question, the status of this wound may be classified as fully granulating because the incision has completely epithelialized and there are no signs of infection. The OASIS Team and clinical wound care experts from WOCN are not able to assess a specific wound status without actually seeing the wound. Please contact the WOCN Web site at www.wocn.org (exit DHFS) for further clarification about their guidelines regarding wound healing.

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Improvement in Transferring, and Ambulation/Locomotion

Step 1 Assessment

- Request the patient to walk if appropriate. What is the patient's ability to transfer and ambulate? Ask yourself these questions:
 - What is the patient's stability? What is the patient's risk for falls?
 - Is human assistance needed?
 - What assistive devices are used? What assistive devices are available but not being used?
 - Does the patient understand the request?
 - Is the environment safe?
 - Are there medical restrictions?

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Step 2 Care planning and 485 development

- If MO690 score is ≥ 2 a referral is made for physical therapy
- If MO700 score is ≥ 1 a referral is made for physical therapy
- Nurse consults with therapist on the findings of their assessments
- Institute fall precautions as appropriate
- Develop the care plan for the home health aide to include transfer/ambulation/locomotion activities if appropriate
 - Update frequently based on changes in patient's ability

Step 3 Patient Education

- Educate patient/caregiver in goals to improve independence and patient safety at home

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M0690

Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

My patient must be lifted from the bed to a chair. He cannot turn himself in bed and is unable to bear weight or pivot. How would I respond to M0690?

Response 3 is the option that most closely resembles the patient's circumstance you describe. The patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast ("confined to the bed") even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast.

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M0690

If other types of transfers are being assessed (e.g., car, floor transfers), should they be considered when responding to M0690?

Because standardized data are required, only the specific transfer tasks listed in M0690 should be considered when responding to the item. Based on the patient's unique needs, home environment, etc., transfer assessment beyond bed to chair, toilet/commode, or tub/shower transfers may be indicated. Note in the patient's record the specific circumstances and patient's ability to accomplish other types of transfers.

If a patient takes extra time and pushes up with both arms, is this considered using an assistive device?

Because standardized data are required, only the specific transfer tasks listed in M0690 evaluates the patient's ability to safely perform three types of transfers: bed to chair, on and off toilet or commode, and into and out of the tub or shower.

38

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If other types of transfers are being assessed (e.g., car, floor transfers), should they be considered when responding to M0690?

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If a patient takes extra time and pushes up with both arms, is this considered using an assistive device?

Because standardized data are required, only the specific transfer tasks listed in M0690 evaluates the patient's ability to safely perform three types of transfers: bed to chair, on and off toilet or commode, and into and out of the tub or shower.

38

M0690

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“Pushing up with both arms” could apply to two of these transfer types – bed to chair and on/off toilet or commode. Taking extra time and pushing up with both arms can help ensure the patient’s stability and safety during the transfer process but does not mean that the patient is not independent. If standby human assistance is necessary to assure safety, then a different response level would apply to these types of transfers. Remember that transfer ability can vary across these three activities. The level of ability applicable to the majority of the activities should be recorded.

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M0700

Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, or on a variety of surfaces.

What if my patient has physician-ordered activity restrictions due to a joint replacement? What they are able to do and what they are allowed to do may be different. How should I respond to this item?

The patient's medical restrictions must be considered in responding to the item, as the restrictions address what the patient is able to safely accomplish at the time of the assessment.

Does M0700 include the ability to use a powered wheelchair or only a manual one?

The OASIS item does not differentiate between the ability to use a powered wheelchair or a manual one.

40

M0700

Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, or on a variety of surfaces.

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Improvement in Management of Oral Medications

Step 1 Assessment

- Request the patient to walk to where their medications are stored
- Request the patient read a medication bottle label
- Request the patient unscrew the medication bottle cap
- Question patient about medication dose, schedule, actions, and side effects
- Question patient about how medications are obtained (physically and financially)

41

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Step 2 Care planning and 485 development

- Arrange for medication set-up if appropriate
 - Provide a pill box
 - Medication diary
- Referral to MSW for financial assistance for medications
- Referral to PT/OT for lower/upper body strengthening as appropriate

Step 3 Patient Education

- Educate patient/caregiver in safe and reliable medication management

42

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M0780

Management of Oral Medications: Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

Do you consider medications given through a gastrostomy tube (M0780) oral medications?

Item M0780 is assessing the patient's ability to take all oral medicines. The route of admission for medications given/taken by G-tube is "per G-tube", not "po". Therefore, medications whose route is listed as per G-tube are NOT oral medications.

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M0780

**My patient sets up her own pill planner.
How would I answer M0780?**

If your patient is able to take the correct medication in the correct dosage at the correct time as a result of this **set up**, then you would consider her independent and response zero would apply.

**I have had several patients who use a list of medications to self-administer their meds.
Would this be considered a drug diary or chart?**

Yes, this is considered a drug diary or chart. The statement for response 1c (“someone” develops a drug diary or chart) pertains to anyone developing the aid. What you need to assess is whether the patient must use this list to take the medications at the correct times. If he/she does require the list, then response 1 is the appropriate choice.

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M0780

Some assisted living facilities require that facility staff administer medications to residents. If the patient appears able to take oral medications independently, how would the clinician answer M0780.

M0780 refers to the patient's ability to take the correct oral medication(s) and proper dosage(s) at the correct times. Your assessment of the patient's vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, will allow you to evaluate this ability, despite the facility's requirement. You would certainly want to document the requirement in the clinical record.

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Improvement in Pain Interfering with Activity

Step 1 Assessment

- Request the patient to walk if appropriate.
Ask the following questions:
 - When is the pain most severe?
 - Which activities of daily living does pain interfere with?
 - How frequently does pain interfere with this activity?
- Assess patient's level of pain using a pain scale every visit
 - Numeric
 - Wong-Baker
 - Nonverbal observations include: facial expressions, monitoring heart rate, respiratory rate, pallor, pupil size, perspiration, irritability, etc.
- Question patient about how medications are obtained (physically and financially)

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Step 2 Care planning and 485 development

- Establish an acceptable pain goal with patient
 - Interventions available should include both pharmacological and non-pharmacological options
- Referral to PT/OT for therapeutic modalities and energy conservation as appropriate
- Referral to MSW for financial assistance for pain medications
- Consult with physician if pain medication ineffective

Step 3 Patient Education

- Educate patient/caregiver in effective pharmacological and nonpharmacological methods

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Wong-Baker FACES Pain Rating Scale



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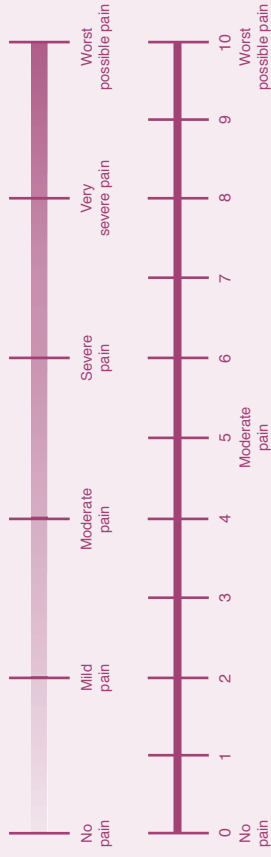
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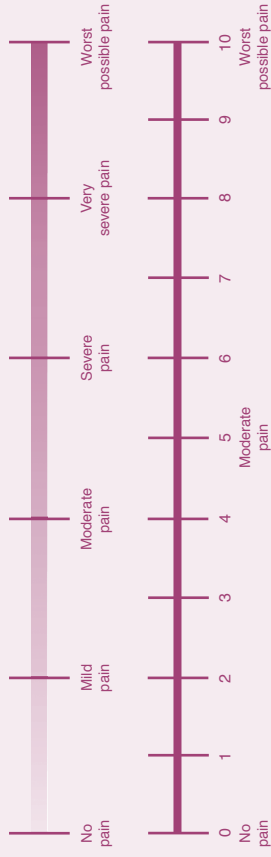
Pain Assessment Ruler



McGill Pain Intensity Subscale

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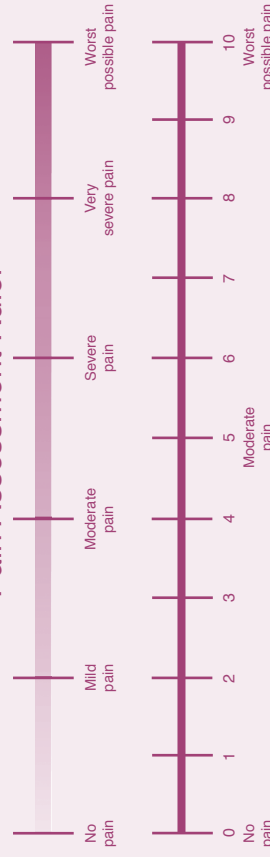
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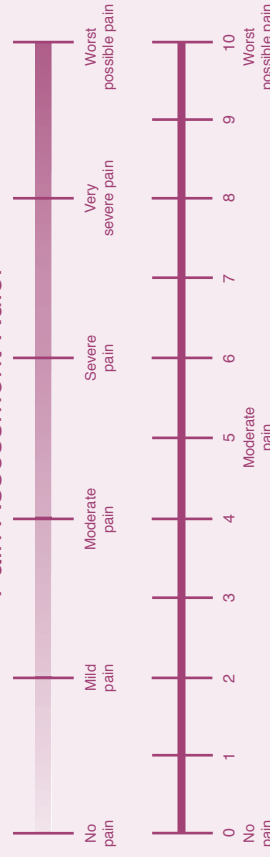
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Frequency of pain interfering with patient's activity or movement:

How can you assess pain in a nonverbal patient? A nonresponsive patient?

Nonverbal or nonresponsive patients experience pain, and careful observation establishes its presence and an estimation of its severity. The clinician should observe facial expression (frowning, gritting teeth), note changes in pulse rate, respiratory rate, perspiration, pallor, pupil size, or irritability. A nonverbal (but responsive) patient can also utilize a visual analog scale to describe the pain being experienced.

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Publication No. AZ-8SOW-1B-102506-01.
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