COMPREHENSIVE ADULT NURSING ASSESSMENT
INCLUDING SOC/ROC OASIS ELEMENTS WITH PLAN OF CARE INFORMATION

(-) = Dash is a valid response. **See the OASIS D Guidance Manual for the exact instructions for each specific item.**

ITEM USES:
[A] = Administration
(Q) = Quality Measure
(PRA) = Potential Quality Measure Risk Adjustment
($) = Payment

DATE:_____

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

Follow OASIS items in sequence unless otherwise directed.

REASON FOR ASSESSMENT: ❑ Start of Care ❑ Resumption of Care

This Patient Tracking Information must be filled out at start of care and per organizational policy. It is to be maintained as part of the clinical record.

(M0010) CMS Certification Number: [A]

Branch Identification (M0014) Branch State: [A]

(M0016) Branch ID Number: [A]

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

❑ **UK - Unknown or Not Available**

Physician Name:_____ (First) ____ (MI)

_____ (Last) ____ (Suffix)

Physician Phone:_____

Physician Fax:_____

Physician Email:_____

Physician Address: (Street/Suite No.)

_____

City:_____ State:_____ ZIP Code:_____

Secondary Physician NPI #:_____

Name:_____ (First) ____ (MI)

_____ (Last) ____ (Suffix)

Phone:_____ Fax:_____

Email:_____

Address: (Street/Suite No.)

_____

City:_____ State:_____ ZIP Code:_____

Primary Care Practitioner/Practitioner's Group or other Health Care Professional responsible for providing care/services **post-discharge**

NPI #:_____ Specialty:_____

Name:_____ (First) ____ (MI)

_____ (Last) ____ (Suffix)

Phone:_____ Fax:_____

Email:_____

Address: (Street/Suite No.)

_____

City:_____ State:_____ ZIP Code:_____

(M0020) Patient ID Number: [A]

Medical Record Number if different from Patient ID Number

_____

(M0030) Start of Care Date: ($) (Q) month / day / year

(M0032) Resumption of Care Date: month / day / year (Q)

❑ **NA - Not Applicable**

❑ Physician ordered ROC date

❑ Fixed 48-hours post 24-hour hospitalization for any reason other than diagnostic tests

(M0040) Patient Name: [A]

(First) (MI)

(Last) (Suffix)

Patient Phone:_____

Patient Email:_____

Patient Address:

_____ (Street/Apt. No.)

_____ (City)

(M0050) Patient State of Residence: [A]

(M0060) Patient ZIP Code: - [A]

(M0063) Medicare Number: ❑ **NA - No Medicare**

(including suffix) [A]

(M0064) Social Security Number: ❑ **UK - Unknown or Not Available**

- - [A]

(M0065) Medicaid Number: ❑ **NA - No Medicaid**

[A]

(M0066) Birth Date: month / day / year (PRA)

EMERGENCY PREPAREDNESS

★ ★ ★ **PRIORITY CODE:**_____ ★ ★ ★

Does the patient have an Advance Directives order? ❑ **No** ❑ **Yes**

Name of Emergency Contact:_____

Relationship:_____

Phone:_____

Address:_____

City:_____ State:_____ ZIP Code:_____

Email:_____

PATIENT NAME–Last, First, Middle Initial	ID#

Patient Name_____ ID #_____

Patient's HI Claim No.:
❑ 1 - Same as **M0063** ❑ 2 - Same as **M0065**
❑ 3 - Other:_____

Certification Period:
From:_____ To:_____

Does the patient have a representative? ❑ No ❑ Yes
If yes, is the person: ❑ Court declared ❑ Patient selected
Name and Title of Representative:

_____

Representative Mailing Address:

_____

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

(M0069) Gender PRA

Enter Code ☐
1 Male
2 Female

(M0140) Race/Ethnicity: (Mark all that apply.) A
❑ 1 - American Indian or Alaska Native
❑ 2 - Asian
❑ 3 - Black or African-American
❑ 4 - Hispanic or Latino
❑ 5 - Native Hawaiian or Pacific Islander
❑ 6 - White

(M0150) Current Payment Sources for Home Care: A PRA
(Check all that apply)
❑ 0 - None; no charge for current services
❑ 1 - Medicare (traditional fee-for-service)
❑ 2 - Medicare (HMO/managed care/Advantage plan)
❑ 3 - Medicaid (traditional fee-for-service)
❑ 4 - Medicaid (HMO/managed care)
❑ 5 - Workers' compensation
❑ 6 - Title programs (for example, Title III, V, or XX)
❑ 7 - Other government (for example, TriCare, VA)
❑ 8 - Private insurance
❑ 9 - Private HMO/managed care
❑ 10 - Self-pay
❑ 11 - Other (specify):_____
❑ UK - Unknown

BRIGGS TIP

ONE CLINICIAN CONVENTION/RULE

Only one clinician may take responsibility for accurately completing a comprehensive assessment. However, for all OASIS data items integrated within the comprehensive assessment, collaboration with the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff is appropriate and would not violate the one clinician convention. When collaboration is utilized, the assessing clinician is responsible for considering available input from these other sources and selecting the appropriate OASIS item response(s) within the appropriate timeframe and consistent with data collection guidance. For items requiring patient assessment, the collaborating healthcare providers must have had direct contact with the patient.

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment A

Enter Code ☐
1 RN
2 PT
3 SLP/ST
4 OT

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

Enter Code 1 or 3 only when completing this form. Start of Care/ Resumption of Care.
When ROC, review patient tracking information and complete M0032.

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

Enter Code ☐

Start/Resumption of Care
1 Start of care–further visits planned
3 Resumption of care (after inpatient stay)

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

Transfer to an Inpatient Facility
6 Transferred to an inpatient facility–patient not discharged from agency ***[Go to M1041]***
7 Transferred to an inpatient facility–patient discharged from agency ***[Go to M1041]***

Discharge from Agency – Not to an Inpatient Facility
8 Death at home ***[Go to M2005]***
9 Discharge from agency ***[Go to M1041]***

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified. Q

☐☐/☐☐/☐☐☐☐ ***[Go to M0110, if date entered]***
month / day / year

❑ NA - No specific SOC date ordered by physician

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA. Q

☐☐/☐☐/☐☐☐☐
month / day / year

(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? $ PRA

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

*__Early__ **Episode is first or second episode in a sequence of adjacent episodes. __Later__ is the third episode and beyond in sequence of adjacent episodes. Adjacent episodes are separated by 60 days or fewer between episodes.**

Patient Name_____ ID #_____

PATIENT HISTORY AND DIAGNOSES

PHYSICIAN: Date last contacted:_____ Date last visited:_____

PRIMARY REASON FOR HOME HEALTH: (review Face-to-Face)_____

Certifying Physician's Prognosis:_____

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

1. Criteria-One: (must choose at least one)

❑ Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

AND/OR

❑ Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.

2. Criteria-Two:

❑ There must exist a normal inability to leave home (specify)_____

AND

❑ Leaving home must require a considerable and taxing effort.

PERTINENT HISTORY AND/OR PREVIOUS OUTCOMES: (note dates of onset, exacerbation when known)
(Reference M1000, M1005 and M1028)

❑ Hypertension ❑ Cardiac ❑ Respiratory ❑ Osteoporosis ❑ Fractures ❑ Cancer (site:_____)
❑ Infection ❑ Immunosuppressed ❑ Open Wound
❑ Surgeries:_____
❑ Other (specify):_____

IMMUNIZATIONS: Within the past 12 months: ❑ Influenza (specifically this year's flu season October 1 to March 31)
According to immunization guidelines:
❑ Pneumonia ❑ Tetanus ❑ Shingles ❑ Hepatitis C ❑ Other:_____
Needs:_____

PRIOR HOSPITALIZATIONS: ❑ No ❑ Yes Number of times:_____
Reason(s)/Date(s):_____

(M1000) From which of the following **Inpatient Facilities** was the patient discharged within the past [Q] [PRA] 14 days? **(Mark all that apply.)**

❑ 1 - Long-term nursing facility (NF)
❑ 2 - Skilled nursing facility (SNF/TCU)
❑ 3 - Short-stay acute hospital (IPPS)
❑ 4 - Long-term care hospital (LTCH)
❑ 5 - Inpatient rehabilitation hospital or unit (IRF)
❑ 6 - Psychiatric hospital or unit
❑ 7 - Other (specify) _____
❑ NA - Patient was not discharged from an inpatient facility
[Go to M1021]

(M1005) Inpatient Discharge Date (most recent):
☐☐/☐☐/☐☐☐☐ (month/day/year) ❑ UK - Unknown [A] [Q]

Patient Name_____ ID #_____

PATIENT HISTORY AND DIAGNOSES (Cont'd)

(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 = $ PRA

(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) Description	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 ICD-10-CM / Symptom Control Rating
(M1021) Primary Diagnosis	**V, W, X, Y codes NOT allowed**
a. _____ Date:_____ ❑ O ❑ E	a. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
(M1023) Other Diagnoses	**All ICD-10-CM codes allowed**
b. _____ Date:_____ ❑ O ❑ E	b. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
c. _____ Date:_____ ❑ O ❑ E	c. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
d. _____ Date:_____ ❑ O ❑ E	d. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
e. _____ Date:_____ ❑ O ❑ E	e. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4
f. _____ Date:_____ ❑ O ❑ E	f. [ ][ ][ ] [ ][ ][ ][ ] ❑0 ❑1 ❑2 ❑3 ❑4

❑ Check here if a coder or Business Associate was consulted with to complete ICD coding.

Surgical Procedure	ICD	
_____	(_____)	Date:_____
_____	(_____)	Date:_____
_____	(_____)	Date:_____

(M1028) Active Diagnoses - Comorbidities and Co-existing Conditions – Check all that apply PRA
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

❑ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
❑ 2 - Diabetes Mellitus (DM)
❑ 3 - None of the above

Patient Name_____ ID #_____

PATIENT HISTORY AND DIAGNOSES (Cont'd)

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

- ❑ 1 - Intravenous or infusion therapy (excludes TPN) $ PRA
- ❑ 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

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

- ❑ 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
- ❑ 10 - None of the above

(M1060) Height and Weight – While measuring, if the number is X.1–X.4 round down; X.5 or greater round up PRA

inches — a. Height (in inches). Record most recent height measure since the most recent SOC/ROC

pounds — b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

Reported Weight Changes:
❑ Gain ❑ Loss _____ lb. X _____ ❑ week ❑ month ❑ year

Based on general appearance, does the patient appear:
❑ Underweight ❑ Average ❑ Overweight ❑ Obese

ADVANCE DIRECTIVES

❑ Living will	❑ Education needed
❑ Do not resuscitate	❑ Copies on file
❑ Organ donor	❑ Funeral arrangements made
❑ POA	❑ Healthcare representative

❑ State specific form(s):_____

Comments:_____

VITAL SIGNS

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

Temperature:_____ ❑ Oral ❑ Axillary ❑ Rectal ❑ Tympanic

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

Respirations:_____ ❑ Regular ❑ Irregular ❑ Cheynes Stokes ❑ Death rattle ❑ Apnea periods____sec. (❑ observed ❑ reported) ❑ Accessory muscles used

❑ Non-smoker ❑ Last smoked:_____

❑ Smoker - frequency: ❑ Daily ❑ Occasional ❑ Very Occasional

If daily, (include all types of products that are smoked or vaporized) how often:_____

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? PRA

(Check one box only.)

Living Arrangement	Availability of Assistance: Around the clock	Regular daytime	Regular nighttime	Occasional/short-term assistance	No assistance available
a. Patient lives alone	❑ 01	❑ 02	❑ 03	❑ 04	❑ 05
b. Patient lives with other person(s) in the home	❑ 06	❑ 07	❑ 08	❑ 09	❑ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	❑ 11	❑ 12	❑ 13	❑ 14	❑ 15

Name of facility:_____ Phone:_____

Primary Caregiver

Patient provides their own care: ❑ Total ❑ Partial

Reported by:_____ ❑ Not reported

Does the patient feel safe providing their own care? ❑ Yes ❑ No

If no, comment:_____

Patient Name_____ ID #_____

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE

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:_____
Prior to this admission, how often did the patient receive assistance with their ADLs/IADLs, from any caregiver(s)?
❑ None received ❑ At least daily ❑ One to two times per week
❑ Three or more times per week ❑ Less often than weekly
❑ Unknown

Primary Caregiver(s) Information:

Name:_____
Relationship:_____ Phone Number:_____
Mailing address:_____
_____
Email address:_____
Name:_____
Relationship:_____ Phone Number:_____
Mailing address:_____
_____
Email address:_____
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, explain:_____
_____
_____
_____
List below the hours and days a caregiver is available to provide cares.
❑ There is no set schedule for availability

AM Hours

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

PM Hours

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Nights

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Explain any available time that a caregiver might be present:
_____
_____
_____

SENSORY STATUS

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

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.

❑ **No Problem** ❑ PERRLA
❑ Pupils unequal ❑ Glasses
❑ Glaucoma: ❑ R ❑ L ❑ Cataract(s): ❑ R ❑ L
❑ Scleral icterus/yellowing ❑ Contacts: ❑ R ❑ L
❑ Blurred vision: ❑ R ❑ L ❑ Ptosis: ❑ R ❑ L
❑ Prosthesis: ❑ R ❑ L ❑ Blind: ❑ R ❑ L
❑ Other:_____
❑ Infections:_____
❑ Cataract surgery: (Right) Date:_____ (Left) Date:_____
How does the impaired vision interfere/impact their function/safety? (explain):_____
_____

NOSE

❑ **No Problem**
❑ Congestion ❑ Epistaxis ❑ Loss of smell ❑ Sinus problem
❑ Other (specify):_____
_____
_____

THROAT

❑ **No Problem**
❑ Dysphagia ❑ Hoarseness ❑ Lesion(s) ❑ Sore throat
❑ Other (specify):_____
_____
_____

MOUTH

❑ **No Problem**
❑ Dentures: ❑ Upper ❑ Lower ❑ Partial ❑ Mass(es) ❑ Tumor(s)
❑ Gingivitis ❑ Ulceration(s) ❑ Toothache ❑ Lesion(s)
❑ Other (specify):_____
_____
_____

EARS

Ability to hear (with hearing aid or hearing appliance if normally used):
❑ Adequate: hears normal conversation without difficulty
❑ Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly
❑ Severely Impaired: absence of useful hearing
❑ Unable to assess hearing

❑ **No Problem**
❑ HOH: ❑ R ❑ L ❑ Deaf: ❑ R ❑ L ❑ Hearing aid: ❑ R ❑ L
❑ Vertigo ❑ Tinnitus: ❑ R ❑ L
❑ Other (specify):_____
_____
_____

Patient Name_____ ID #_____

SPEECH/ORAL (VERBAL) EXPRESSION

Understanding of verbal content in patient's own language (with hearing aid or device if used):

❑ Understands: clear comprehension without cues or repetitions
❑ Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand
❑ Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
❑ Rarely/Never Understands
❑ Unable to assess understanding

Speech and oral (verbal) expression of language (in patient's own language):

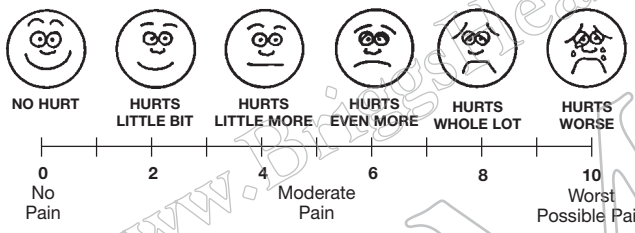
❑ Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment
❑ Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance)
❑ Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences
❑ Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases
❑ Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is non sensical or unintelligible)
❑ Patient nonresponsive or unable to speak

PAIN

Check box to indicate which pain assessment was used.
❑ Wong-Baker ❑ PAINAD

Intensity: (using scales below)

Wong-Baker FACES Pain Rating Scale



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

**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.

❑ 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:_____

Non-verbals demonstrated: (Cont'd)

❑ Self-assessment ❑ Implications:_____

How does the pain interfere/impact the patient's safety? ❑ N/A (explain):

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.)			

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, Frowning.	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 Document updated 1.10.2013.

Patient Name_____ ID #_____

PAIN (Cont'd)

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

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

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
Comment:_____

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)_____
❑ Secondary bleed: ❑ GI ❑ GU ❑ GYN ❑ Unknown ❑ Hemophilia
❑ Other:_____

❑ Diabetes: ❑ Type 1 ❑ Type 2 Date of onset:_____
❑ Diabetic diet ❑ Oral medication ❑ Injectable medication
❑ Medication name, dose/frequency (specify):_____

On medication since:_____
Administered by: ❑ Self ❑ Caregiver ❑ Nurse ❑ Family
❑ Other:_____
❑ Hyperglycemia: ❑ Glycosuria ❑ Polyuria ❑ Polydipsia
❑ Hypoglycemia: ❑ Sweats ❑ Polyphagia ❑ Weak ❑ Faint ❑ Stupor
A1C _____% ❑ Patient reported
❑ Lab slip Date:_____

ENDOCRINE/HEMATOLOGY (Cont'd)

BS _____mg/dL Date:_____ Time:_____
❑ FBS ❑ Before meal ❑ Postprandial ❑ Random ❑ HS
❑ Blood sugar ranges:_____
❑ Patient ❑ Caregiver ❑ Family Report
Monitored by: ❑ Self ❑ Caregiver ❑ Family ❑ Nurse
❑ Other:_____
Frequency of monitoring:_____
Competency with use of Glucometer:_____
❑ **Disease Management Problems (explain):**

INTEGUMENTARY STATUS

❑ **No Problem**

Disorder(s) of skin, hair, nails (details):_____

Check all applicable conditions listed below:
Turgor: ❑ Good ❑ Poor
❑ Itch ❑ Rash ❑ Dry ❑ Scaling ❑ Redness ❑ Bruises
❑ Ecchymosis ❑ Pallor ❑ Jaundice
❑ Other (specify):_____

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* 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 ulcers; the significance of these factors is yet to be elucidated.*

(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 Stage 2 pressure ulcers/injuries)

Enter Code ☐

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

Ⓠ PRA

Complete Braden Scale form per organizational guideline (Briggs #3166). OASIS Scoring Instructions (see page 10 of 29).

Patient Name_____ ID #_____

INTEGUMENTARY STATUS (Cont'd)

Definitions:

- **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.

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage $ Q PRA H — Enter Number

A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with 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 ☐

(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 ☐ — $ PRA

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.) $ Q

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?** $ PRA

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 ☐ — $ PRA

1 One
2 Two
3 Three
4 Four or more

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

Enter Code ☐ — $ Q PRA

1 Fully granulating
2 Early/partial granulation
3 Not healing

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

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 ☐ — $ Q PRA

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

DEFINITIONS

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.

Patient Name_____ ID #_____

INTEGUMENTARY STATUS (Cont'd)

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.

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.

Patient Name______________________________ ID #______________

INTEGUMENTARY STATUS (Cont'd)

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

Wound care done during this visit: ❑ Yes ❑ No Location(s) wound site:______________

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

Technique: ❑ Sterile ❑ Clean

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

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

Patient tolerated procedure well: ❑ Yes ❑ No

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: ❑ Yes ❑ No

Integument findings:______________

____

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

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

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

Complete LEAP Diabetic Foot Screening (Briggs form 3484P) per organizational guideline

Comments:______________

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:

____

____

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* ❑ Venous stasis ulcer	❑ Arterial ❑ Diabetic foot ulcer ❑ Malignancy ❑ Mechanical/Trauma ❑ Pressure ulcer ❑ Surgical* ❑ Venous stasis ulcer	❑ Arterial ❑ Diabetic foot ulcer ❑ Malignancy ❑ Mechanical/Trauma ❑ Pressure ulcer ❑ Surgical* ❑ Venous stasis ulcer	❑ Arterial ❑ Diabetic foot ulcer ❑ Malignancy ❑ Mechanical/Trauma ❑ Pressure ulcer ❑ Surgical* ❑ Venous stasis ulcer	❑ Arterial ❑ Diabetic foot ulcer ❑ Malignancy ❑ Mechanical/Trauma ❑ Pressure ulcer ❑ Surgical* ❑ Venous stasis ulcer
Size (cm) (LxWxD)					
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)**					
Date Healed					
Odor					
Surrounding Skin					
Edema					
Appearance of the Wound Bed					
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

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_____

Respiratory Treatments utilized at home:
❑ Oxygen (intermittent or continuous)
❑ Ventilator (continually or at night)
❑ Continuous / ❑ Bi-level positive airway pressure
O_2 @ _____ LPM via ❑ cannula ❑ mask ❑ trach O_2 saturation _____%
Trach size/type_____
Who manages? ❑ Self ❑ 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 ❑ Murmur
❑ Pacemaker: Date:_____ Last date checked:_____
Type:_____
❑ **Chest Pain:** ❑ Anginal ❑ Postural ❑ Localized ❑ Substernal
❑ Radiating ❑ Dull ❑ Ache ❑ Sharp ❑ Vise-like
Associated with: ❑ Shortness of breath ❑ Activity ❑ Sweats
Frequency/duration:_____
How relieved:_____

_____

❑ Palpitations ❑ Fatigue
❑ **Edema:** ❑ Pedal ❑ Right ❑ Left ❑ Sacral
❑ Dependent:_____
❑ Pitting ❑ +1 ❑ +2 ❑ +3 ❑ +4 ❑ Non-pitting
Site:_____
❑ Cramps ❑ Claudication
Capillary refill: ❑ Less than 3 seconds ❑ Greater than 3 seconds
❑ **Disease Management Problems (explain):**_____

_____

_____

RESPIRATORY STATUS

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

Enter Code ☐

0 Patient is not short of breath $ O PRA
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**

NUTRITIONAL STATUS

❑ **No Problem**
❑ NAS ❑ NPO ❑ Controlled Carbohydrate ❑ Other:_____

Nutritional requirements (diet)

_____

❑ Increase fluids:_____amt. ❑ Restrict fluids:_____amt.

Appetite: ❑ Good ❑ Fair ❑ Poor ❑ Anorexic ❑ Nausea
❑ Vomiting: Frequency:_____ Amount:_____
❑ Heartburn (food intolerance) ❑ Other:_____
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)
❑ Therapeutic diet – (e.g., low salt, low cholesterol, gluten free, diabetic)
❑ 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	

INTERPRETATION OF ASSESSMENT

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 and plan:_____

_____

_____

ENTERAL FEEDINGS - ACCESS DEVICE

❑ **N/A** ❑ **No Problem**
❑ Nasogastric ❑ Gastrostomy ❑ Jejunostomy
❑ Other (specify):_____
❑ Pump: (type/specify):_____
❑ Bolus ❑ Continuous
Feedings: Type (amt./rate):_____
Flush Protocol: (amt./specify):_____
Performed by: ❑ Self ❑ RN ❑ Caregiver ❑ Family
❑ Other:_____
Dressing/Site care: (specify):_____

_____

Interventions/Instructions/Comments:_____

_____

_____

_____

Patient Name_____ ID #_____

ELIMINATION STATUS

Urinary Elimination: ❑ **No Problem**

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

(Check all applicable items)

❑ Urgency ❑ Frequency ❑ Retention ❑ Burning ❑ Pain
❑ Hesitancy ❑ Nocturia ❑ Hematuria ❑ Oliguria ❑ Anuria

Color: ❑ Yellow/straw ❑ Amber ❑ Brown/gray ❑ Blood-tinged
❑ Other:_____

Clarity: ❑ Clear ❑ Cloudy ❑ Sediment ❑ Mucous

Odor: ❑ Yes ❑ No ❑ Observed ❑ Reported

If the patient has incontinence, when does urinary incontinence occur?
❑ Timed-voiding defers incontinence
❑ Occasional stress incontinence
❑ During the night only
❑ During the day only
❑ During the day and night

❑ Incontinence products/other:_____

Urinary Catheter: Type:_____ Date last changed:_____
❑ Foley inserted (date)_____ with _____ French
Inflated balloon with _____mL ❑ without difficulty ❑ Suprapubic
Irrigation solution: Type (specify):_____
Amount_____mL Frequency_____ Returns_____
Patient tolerated procedure well ❑ Yes ❑ No

❑ Urostomy site (describe skin around stoma):_____

Ostomy care managed by: ❑ Self ❑ Caregiver ❑ Family

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

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

Enter Code ☐
0 No
1 Yes
NA Patient on prophylactic treatment
UK Unknown

(M1610) Urinary Incontinence or Urinary Catheter Presence: $ PRA

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)

Bowel Elimination: ❑ **No Problem**

Disorder(s) of GI system (type)_____

❑ Flatulence ❑ Constipation ❑ Fecal impaction ❑ Diarrhea
❑ Rectal bleeding ❑ Hemorrhoids ❑ Last BM:_____

❑ Bowel sounds: active_____
absent_____
hypoactive_____
hyperactive_____

RU | LU
RL | LL

❑ Frequency of stools_____
Bowel regimen/program:_____
❑ Laxative ❑ Enema use: ❑ Daily ❑ Weekly ❑ Monthly ❑ PRN
❑ Other:_____
❑ Involuntary incontinence (details if applicable):_____

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

Ostomy care managed by: ❑ Self ❑ Caregiver ❑ Family
❑ Other:_____

(M1620) Bowel Incontinence Frequency: $ Q PRA

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
UK Unknown

(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.

ABDOMEN

❑ **No Problem**

❑ Tenderness ❑ Pain ❑ Distention ❑ Hard ❑ Soft ❑ Ascites
❑ Abdominal girth _____ cm
❑ Other:_____

GENITALIA

❑ **No Problem**

❑ Discharge/Drainage: (describe):_____
❑ Lesions ❑ Blisters ❑ Masses ❑ Cysts
❑ Inflammation ❑ Surgical alteration
❑ Prostate problem: ❑ BPH ❑ TURP Date:_____
❑ Self-testicular exam Freq._____ Date last exam:_____
❑ Menopause ❑ Hysterectomy Date:_____
Date last PAP:_____ Results:_____
❑ Breast self-exam Freq._____ Date last exam:_____
❑ Nipple discharge: ❑ R Date:_____ ❑ L Date:_____
❑ Mastectomy: ❑ R Date:_____ ❑ L Date:_____
❑ Other (specify):_____

Patient Name_____ ID #_____

NEURO / EMOTIONAL / BEHAVIORAL STATUS

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

Enter Code ☐

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

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

Enter Code ☐

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

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

Enter Code ☐

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

❑ **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:_____
(Type):_____

❑ Hemiplegia: ❑ Right ❑ Left
❑ Paraplegia ❑ Quadriplegia ❑ Tetraplegia

How does the patient's condition affect functional ability and safety?

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

Enter Code ☐

Q PRA

0 No
1 Yes, patient was screened using the PHQ-2©* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 - 14 days	NA Unable to respond
a) Little interest or pleasure in doing things	❑ 0	❑ 1	❑ 2	❑ 3	❑ NA
b) Feeling down, depressed, or hopeless?	❑ 0	❑ 1	❑ 2	❑ 3	❑ NA

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

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

❑ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
❑ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
❑ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
❑ 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
❑ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
❑ 6 - Delusional, hallucinatory, or paranoid behavior
❑ 7 - None of the above behaviors demonstrated

Patient Name_____ ID #_____

NEURO/EMOTIONAL/BEHAVIORAL STATUS (Cont'd)

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

Enter Code ☐

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

Consider the Confusion Assessment Method (CAM) for further cognitive assessment

MENTAL STATUS

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. Consider including information collected by items M1700-1750 and M2102 in your description.

_____

Has there been a sudden/acute change in their mental status?
❑ 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

Primary language:_____
❑ Language barrier ❑ Needs interpreter
❑ Sign language (type):_____
❑ Learning barrier: ❑ Mental ❑ Psychosocial ❑ Physical ❑ Functional
❑ Unable to: ❑ Read ❑ Write Educational level:_____
❑ Spiritual ❑ Cultural implications that impact care
Explain:_____
_____
Spiritual resource:_____
Phone No._____
Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widower
Number of children _____ Ages and gender:_____
_____
Do children live near the patient? ❑ Yes ❑ No

PSYCHOSOCIAL (Cont'd)

Did the patient drive a vehicle before this admission? ❑ Yes ❑ No ❑ Patient does not have a vehicle
If yes, do they want to drive again post-discharge? ❑ Yes ❑ No ❑ Unknown
Did the patient have job before this admission? ❑ Yes ❑ No
If yes, do they want to return to work post-discharge? ❑ Yes ❑ No ❑ Unknown
Sleep: ❑ Adequate ❑ Inadequate Rest: ❑ Adequate ❑ Inadequate
Frequency of naps:_____
Number of hours slept per night:_____
Explain:_____
_____
_____

Feelings/emotions the patient reports when asked:
❑ Angry ❑ Fear ❑ Sadness ❑ Discouraged ❑ Lonely ❑ Depressed
❑ Helpless ❑ Content ❑ Happy ❑ Hopeful ❑ Motivated
❑ Other:_____
❑ N/A - No answer given
❑ 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; ❑ Potential ❑ Actual
❑ Verbal ❑ Emotional ❑ Physical ❑ Financial
MSW referral made: ❑ Yes ❑ No
Other intervention:_____
_____
_____

Comments:_____

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 #_____

BRIGGS TIP

Licensed clinicians can establish a patient's discharge goal(s) at the time of SOC/ROC based on the patient's prior medical condition, SOC/ROC assessment, self-care and mobility status, discussions with the patient and family, professional judgment, the profession's practice standards, expected treatments, patient motivation to improve, anticipated length of stay, and the discharge plan. Goals should be established as part of the patient's care plan.

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

GG0100. Prior Functioning: Everyday Activities: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury. (PRA)

Coding:

3. **Independent** - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Patient needed partial assistance from another person to complete activities.
1. **Dependent** - A helper completed the activities for the patient.
8. **Unknown**
9. **Not Applicable**

↓ Enter Codes in Boxes

☐	**A. Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
☐	**B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	**C. Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	**D. Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury. (PRA)

↓ Check all that apply

☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair and/or scooter**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

FUNCTIONAL LIMITATIONS

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

MUSCULOSKELETAL

❑ **No Problem**

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

❑ Fracture (location):_____
❑ Swollen, painful joints (specify):_____
❑ Contracture(s) Location:_____
Hand grips: ❑ Equal ❑ Unequal ❑ Strong ❑ Weak (specify):_____

Dominant side: ❑ R ❑ L
❑ Motor changes: ❑ Fine ❑ Gross (specify):_____

❑ Weakness: ❑ UE ❑ LE (details):_____

❑ Atrophy_____ ❑ Poor conditioning
❑ Decreased ROM_____ ❑ Paresthesia_____
❑ Shuffling ❑ Wide-based gait
❑ Amputation: ❑ BK ❑ AK ❑ UE; ❑ R ❑ L (specify):_____

❑ Other (specify):_____

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

Patient Name_____ ID #_____

FALL RISK ASSESSMENT

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 A 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**	

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(M1910) Has this patient had a multi-factor **Falls Risk Assessment** using a standardized, validated assessment tool? Q PRA

Enter Code ☐
0 No
1 Yes, and it does not indicate a risk for falls
2 Yes, and it does indicate a risk for falls

Plan/Comments:_____

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). Q PRA

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: $ Q PRA

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: $ Q PRA

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. $ Q PRA
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. $ Q PRA
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.

Patient Name_____ ID #_____

ADL/IADLs (Cont'd)

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

Enter Code ☐

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

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

Enter Code ☐

0 Able to independently transfer. $ Q PRA
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. $ Q PRA

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.

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

Enter Code ☐

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

Patient's current ability to plan and safely prepare light meals (for example, cereal, sandwich):
- ❑ Able to independently plan, prepare and reheat light meals
- ❑ Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past
- ❑ Unable to prepare light meals due to physical, cognitive, or mental limitations
- ❑ Unable to prepare or reheat any light meals

Patient's current ability to use the telephone safely:
- ❑ Able to dial numbers and answer calls appropriately
- ❑ Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers
- ❑ Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls
- ❑ Able to answer the telephone some of the time or is able to carry on a limited conversation
- ❑ Unable to answer the telephone at all but can listen if assisted with equipment
- ❑ Totally unable to use the telephone
- ❑ Patient does not have a telephone

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

M1910 is on page 17 of 29

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):_____
- ❑ Other (specify):_____
- ❑ Other (specify):_____

ALLERGIES

Allergies: ❑ None known
❑ Aspirin ❑ Penicillin ❑ Sulfa ❑ Pollen ❑ Eggs
❑ Milk products ❑ Insect bites
❑ Other:_____

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

GG0130. Self-Care (Q)

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

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**

1. SOC/ROC Performance	2. Discharge Goal	
↓ 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. (Q) (PRA)
		B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them. (Q) (PRA)
		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. (Q) (PRA)
		E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower (PRA)
		F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. (PRA)
		G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. (PRA)
		H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. (PRA)

Patient Name_____ ID #_____

GG0170. Mobility (O)

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

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**

1. SOC/ROC Performance	2. Discharge Goal		
↓ 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.	PRA
		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.	Q PRA
		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.	Q PRA
		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.	Q PRA
		E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).	Q PRA
		F. Toilet transfer: The ability to get on and off a toilet or commode.	Q PRA
		G. Car Transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.	PRA
		I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb)*	PRA
		J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.	Q PRA
		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.	Q PRA
		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.	PRA
		M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*	PRA
		N. 4 steps: The ability to to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*	PRA
		O. 12 steps: The ability to go up and down 12 steps with or without a rail.	PRA
		P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.	PRA
		Q. Does patient use wheelchair/scooter? **0. No** → Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1. **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns.	Q PRA
		R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.	Q PRA
		RR1. Indicate the type of wheelchair or scooter used. **1. Manual** **2. Motorized**	Q PRA
		S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.	Q PRA
		SS1. Indicate the type of wheelchair or scooter used. **1. Manual** **2. Motorized**	Q PRA

Patient Name_____ ID #_____

MEDICATIONS

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues? Q PRA H

Enter Code ☐

0 No - No issues found during review **[*Go to M2010*]**
1 Yes - Issues found during review
9 NA - Patient is not taking any medications **[*Go to M2102*]**

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues? Q H

Enter Code ☐

0 No
1 Yes

(M2010) Patient/Caregiver High-Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

Enter Code ☐

0 No
1 Yes
NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

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

Enter Code ☐

0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
1 Able to take medication(s) at the correct times if:
(a) individual dosages are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.
2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
3 Unable to take medication unless administered by another person.
NA No oral medications prescribed.

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

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

If no, was MSW referral made? ❑ Yes ❑ No/comment:_____

_____

_____

_____

_____

_____

INFUSION

❑ **N/A**

❑ **Peripheral line** ❑ **Midline catheter** ❑ **Central line**

Type/brand:_____

Size/gauge/length:_____

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

Insertion site:_____ Insertion date:_____

Lumens: ❑ Single ❑ Double ❑ Triple

Flush solution/frequency:_____

Patent: ❑ Yes ❑ No

Injection cap change frequency:_____

Dressing change during visit: ❑ Yes ❑ No

Dressing change frequency:_____

❑ Sterile ❑ Clean

Performed by: ❑ Self ❑ RN ❑ Caregiver ❑ Family

❑ Other:_____

Site/skin condition:_____

External catheter length_____cm

Other:_____

_____

PICC Specific:

Circumference of arm _____ cm

X-ray verification: ❑ Yes ❑ No

IVAD Port Specific:

Reservoir: ❑ Single ❑ Double

Huber gauge/length:_____

Accessed: ❑ No ❑ Yes, date:_____

Epidural/Intrathecal Access:

Site/skin condition:_____

_____

Infusion solution (type/volume/rate):_____

❑ Pump: (type, specify):_____

Administered by: ❑ Self ❑ Caregiver ❑ RN ❑ Family

❑ Other:_____

Purpose of Intravenous Access:_____

❑ Antibiotic therapy ❑ Pain control ❑ Lab draws

❑ Chemotherapy ❑ Maintain venous access

❑ Hydration ❑ Parenteral nutrition

❑ Other:_____

_____

❑ Medication(s) administered:

(name of drug):_____

Dose:_____ Route:_____

Frequency:_____

Duration of therapy:_____

❑ Medication(s) administered:

(name of drug):_____

Dose:_____ Route:_____

Frequency:_____

Duration of therapy:_____

❑ Infusion care provided during visit: ❑ Yes ❑ No

Interventions/Instructions/Comments:_____

_____

_____

_____

Patient Name_____ ID #_____

CARE MANAGEMENT

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code ☐

f. **Supervision and safety** (for example, due to cognitive impairment) Q PRA

0 No assistance needed –patient is independent or does not have needs in this area

1 Non-agency caregiver(s) currently provide assistance

2 Non-agency caregiver(s) need training/supportive services to provide assistance

3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

4 Assistance needed, but no non-agency caregiver(s) available

CARE PREFERENCES/PATIENT'S PERSONAL GOALS

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 personal goal(s) the patient would like to achieve from this home health admission? For example, in the future they would like to shop at the mall, shop for their own food or go to a family wedding etc. ❑ No ❑ Yes

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

❑ 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.

❑ Other:_____

❑ Other:_____

CARE PREFERENCES/PATIENT'S PERSONAL GOALS (Cont'd)

Resumption of Care: ❑ No change(s) ❑ Goal(s) changed

List all the patient's goal(s) and indicate if **E**-Existing, **N**-New, **M**-Modified existing or **D**-Discontinued

Note: *The IMPACT Act requires HHAs to take into account patient goal(s) and preferences in discharge and transfer planning. This process starts upon admission/resumption of care.*

REFUSED CARES

Did the ❑ Patient ❑ Representative ❑ Other:_____ refuse ❑ care(s) ❑ service(s) in advance? ❑ No ❑ Yes

If yes, explain:_____

Could the ❑ care(s) ❑ service(s) they refused significantly affect the recommended plan of care? ❑ No ❑ Yes

If yes, explain how:_____

STRENGTHS/LIMITATIONS

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

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

Patient Name_____ ID #_____

STRENGTHS/LIMITATIONS (Cont'd)

List the patient's limitations that might challenge progress toward their goal(s), both personal and the HHA measurable goal. For example, limited nutritional or financial resources, unsafe environment, multiple animals sharing the living space, etc.

How might the patient's limitation(s) affect their safety and/or progress?

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.*

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE

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:_____

HOME ENVIRONMENT SAFETY

Safety hazards in the home:

Unsound structure	❑ Yes	❑ No
Inadequate heating/cooling/electricity	❑ Yes	❑ No
Inadequate sanitation/plumbing	❑ Yes	❑ No
Inadequate refrigeration	❑ Yes	❑ No
Unsafe gas/electrical appliances or outlets	❑ Yes	❑ No
Inadequate running water	❑ Yes	❑ No
Unsafe storage of supplies/equipment	❑ Yes	❑ No
No telephone available and/or unable to use phone	❑ Yes	❑ No
Insects/rodents	❑ Yes	❑ No
Medications stored safely	❑ Yes	❑ No
Grab bar(s) in bathroom/tub/shower	❑ Yes	❑ No

Emergency planning/fire safety:

Fire extinguisher	❑ Yes	❑ No
Smoke detectors on all levels of home	❑ Yes	❑ No
Tested and functioning	❑ Yes	❑ No

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE (Cont'd)

Emergency planning/fire safety (Cont'd):

More than one exit	❑ Yes	❑ No
Plan for exit	❑ Yes	❑ No
Plan for power failure	❑ Yes	❑ No
CO detector	❑ Yes	❑ No

Oxygen use:

Signs posted	❑ Yes	❑ No
Handles smoking/flammables safely	❑ Yes	❑ No
Oxygen back-up: ❑ Available ❑ Knows how to use		
Electrical/fire safety	❑ Yes	❑ No
Is there a need for a Fall Risk Plan?	❑ Yes	❑ No
Safety plan(s) indicated?	❑ Yes	❑ No

Comments:

Instructions/Materials Provided (Check all applicable items)

- ❑ Rights and responsibilities
- ❑ State hotline number
- ❑ Advance directives
- ❑ Do not resuscitate (DNR)
- ❑ HIPAA Notice of Privacy Practices
- ❑ OASIS Privacy Notice
- ❑ Emergency planning in the event service is disrupted
- ❑ Agency phone number/after hours number
- ❑ When to contact physician and/or agency
- ❑ Standard precautions/handwashing
- ❑ Basic home safety
- ❑ Disease (specify):_____
- ❑ Medication regimen/administration
- ❑ Administrator's contact information
- ❑ Copy of Rights & Responsibilities and transfer/discharge policies to Representative (HHA has 4 business days)
- ❑ Other:_____

EMERGENCY PREPAREDNESS CARE PLANNING

Complete this section per agency policy for applicable activities completed during this visit. (check all that apply)

- ❑ Emergency Priority Code assigned to this patient is _____ based upon the comprehensive assessment of their functional, medical condition, psychosocial situation, cognitive, mental status and any significant care needs.

(**Note**: Record the code on the front page of this form and other places per agency policy)

- ❑ Obtained the patient's emergency contact number(s) for the medical record

Patient Name_____ ID #_____

EMERGENCY PREPAREDNESS CARE PLANNING (Cont'd)

❑ Discussed the HHA's plans for supporting their patients during a natural or man-made disaster

❑ Discussed patient specific emergency planning options

❑ Discussed the development of the patient's individualized emergency preparedness plan of care, including self-care readiness and the procedure to follow up with the HHA in the event services are interrupted

❑ If applicable, ❑ local utility companies ❑ local emergency offices notified of life supporting equipment being used

❑ State and local emergency preparedness officials notified about the possible need for evacuation

❑ List of recommended items to have prepared/ready and available in the event of an emergency

❑ Educational materials provided to suggest/assist with emergency management/decision making priorities

❑ List of local and state approved evacuation routes and community shelters relevant to the patient's specific geographic location

❑ Written materials to restate/reinforce the emergency preparedness procedures given to the ❑ Patient ❑ Representative (if any) ❑ Caregiver ❑ Other:_____

Comments:_____

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.

$ PRA

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:_____

List identified risk factors the patient has related to an unplanned hospital admission or an emergency department visit (e.g., smoking, alcohol, unsteady gait, etc.). (Reference 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)

❑ Patient ❑ Caregiver ❑ Representative ❑ Family knowledgeable and able to verbalize and/or demonstrate independence with:

Wound care: ❑ Yes ❑ No ❑ N/A

Diabetic ❑ Foot exam ❑ Care: ❑ Yes ❑ No ❑ N/A

Insulin administration: ❑ Yes ❑ No ❑ N/A

Glucometer use: ❑ Yes ❑ No ❑ N/A

Nutritional management: ❑ Yes ❑ No ❑ N/A

❑ Oral ❑ Injected ❑ Infused ❑ Inhaled medication(s) administration: ❑ Yes ❑ No ❑ N/A

Pain management: ❑ Yes ❑ No ❑ N/A

Oxygen use: ❑ Yes ❑ No ❑ N/A

Use of medical devices: ❑ Yes ❑ No ❑ N/A

Catheter care: ❑ Yes ❑ No ❑ N/A

Trach care: ❑ Yes ❑ No ❑ N/A

Ostomy care: ❑ Yes ❑ No ❑ N/A

Other care(s):_____

❑ Patient ❑ Caregiver ❑ Representative ❑ Family needs further ❑ education ❑ training with:_____

❑ Caregiver ❑ Representative ❑ Family present at time of visit: ❑ Yes ❑ No ❑ Patient ❑ Caregiver ❑ Representative ❑ Family educated this visit for (specify):_____

❑ Patient ❑ Caregiver ❑ Representative ❑ Family appears to understand all information given: ❑ Yes ❑ No

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

Comment(s):_____

Patient Name_____ ID #_____

REHABILITATION POTENTIAL FOR ANTICIPATED DISCHARGE PLANNING

❑ 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 the patient's condition is likely to undergo functional improvement and benefit from rehabilitative care
❑ Discussed discharge plan with: ❑ Patient ❑ Representative ❑ Other:_____

SUMMARY CHECKLIST

CARE PLAN: Collaboration with: ❑ Patient ❑ Caregiver ❑ Representative ❑ Family involvement
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
CARE COORDINATION: ❑ Certifying Physician ❑ 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
Comments:_____
Verbal Order obtained: ❑ No ❑ Yes, specify date:_____

DME/MEDICAL SUPPLIES

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_____

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

FOLEY 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

Patient Name_____ ID #_____

PROFESSIONAL SERVICES WORKSHEET

Utilize this section to assist with completion of plan of care (optional)

SN - FREQUENCY/DURATION_____
- ❑ Skilled Observation for_____
- ❑ Evaluate Cardiopulmonary Status
- ❑ Evaluate Nutrition/Hydration/Elimination
- ❑ Evaluate for S/S of Infections
- ❑ Teach Disease Process
- ❑ Teach S/S of Infection and Standard Precautions
- ❑ Teach Diet
- ❑ Teach Home Safety/Falls Prevention
- ❑ Other_____
- ❑ PRN Visits for_____
- ❑ Psychiatric Nursing for_____

MEDICATIONS
- ❑ Medication Teaching
- ❑ Evaluate Med Effects/Compliance
- ❑ Set up Meds Every ____ ❑ Days ❑ Weeks
- ❑ Administer Medication(s) (name, dose, route, frequency)_____
- ❑ Administer Medication(s) (name, dose, route, frequency)_____
- ❑ Administer Medication(s) (name, dose, route, frequency)_____

IV
- ❑ Administer IV Medication (name, dose, route, frequency and duration)_____
- ❑ Teach IV Administration_____

FLUSHING PROTOCOL/ FREQUENCY (specify)
- ❑ Administer Flush(es) _____
  - ___mL normal saline
  - ___mL normal saline
  - ___mL sterile water
  - ___mL heparin ___unit/mL
  - ___mL heparin ___unit/mL
- ❑ Teach S/S of IV Complications
- ❑ Teach IV Site Care
- ❑ Teach Infusion Pump
- ❑ Teach Complete Parenteral Nutrition
- ❑ Site Care (specify)_____
- ❑ Line Protocol (specify)_____
- ❑ ___PRN Visits for IV Complications
- ❑ Anaphylaxis Protocol (specify orders)
- ❑ Other_____

RESPIRATORY
- ❑ O_2 at _____ liters per minute
- ❑ Pulse Oximetry: Every Visit
- ❑ Pulse Oximetry: PRN Dyspnea
- ❑ Teach Oxygen Use/Precautions
- ❑ Teach Trach Care ❑ Administer Trach Care
- ❑ Other_____

INTEGUMENTARY
- ❑ Wound Care (specify each site)_____
- ❑ Evaluate Wound/Pressure Ulcer for Healing
- ❑ Measure Wound(s) Weekly
- ❑ Teach Wound Care/Dressing
- ❑ Other_____

ELIMINATION
- ❑ Foley _____ French inflated balloon with _____mL changed every_____
- ❑ Suprapubic Cath Insertion every_____ with size _____Fr. balloon_____
- ❑ Teach Care of Indwelling Catheter
- ❑ Teach Self - Cath ❑ Teach Ostomy Care
- ❑ Teach Bowel Regime
- ❑ Other_____

GASTROINTESTINAL
- ❑ Teach N/G Tube Feeding
- ❑ Teach G-Tube Feeding
- ❑ Other_____

DIABETES
- ❑ Administer Medication
- ❑ Prepare Insulin Syringes
- ❑ Blood Glucose Monitoring PRN or _____
- ❑ Teach Diabetic Care
- ❑ Other_____

LABORATORY
- ❑ Venipuncture for_____ Frequency _____
- ❑ Other_____

PT - FREQUENCY/DURATION_____
- ❑ Evaluation and Treatment
- ❑ Pulse Oximetry PRN
- ❑ Home Safety/Falls Prevention
- ❑ Therapeutic Exercise
- ❑ Transfer Training
- ❑ Gait Training
- ❑ Establish Home Exercise Program
- ❑ Modality (specify frequency, duration, (amount) _____
- ❑ Prosthetic Training
- ❑ Muscle Re-Education
- ❑ Other_____

OT - FREQUENCY/DURATION_____
- ❑ Evaluation and Treatment
- ❑ Pulse Oximetry PRN
- ❑ Home Safety/Falls Prevention
- ❑ Adaptive Equipment
- ❑ Therapeutic Exercise
- ❑ Muscle Re-Education
- ❑ Establish Home Exercise Program
- ❑ Homemaker Training
- ❑ Modality (specify frequency, duration, (amount)_____
- ❑ Other_____

SLP - FREQUENCY/DURATION _____
- ❑ Evaluation and Treatment
- ❑ Voice Disorder Treatment
- ❑ Speech Articulation Disorder Treatment
- ❑ Dysphagia Treatment
- ❑ Receptive Skills
- ❑ Expressive Skills
- ❑ Cognitive Skills
- ❑ Other_____

HOME HEALTH AIDE - FREQUENCY/ DURATION_____
- ❑ Personal Care for ADL Assistance
- ❑ Other (specific task for HHA) _____

HOMEMAKER - FREQUENCY/DURATION_____
- ❑ Other_____

MSW - FREQUENCY/DURATION_____
- ❑ Evaluate and Treat
- ❑ Evaluate Family Situation
- ❑ Evaluate/Refer to Community Resources
- ❑ Evaluate Financial Status
- ❑ Other_____

Patient Name_____ ID #_____

DIRECTIONS: Use this **OPTIONAL** worksheet to identify specific interventions that focused on specific problems that were both included on the physician-ordered home health Plan of Care AND implemented as part of care provided at the time of or at any time since the most recent SOC/ROC assessment. "Included in the physician-ordered Plan of Care" means that the patient condition was discussed and there was agreement as to the Plan of Care between the home health agency staff and the patient's physician. To support Best Practice*, list any standardized/validated tool(s) used even when the tool indicated that an intervention was NOT needed.

PLAN OF CARE SYNOPSIS – BRIGGS TRANSFER/DISCHARGE LOOK BACK WORKSHEET

Continue to track this information until transfer or discharge to answer M2401

Plan/Intervention	Discussed current findings with Physician (Check only one in each row below)			Not Applicable	Intervention(s) included in Plan of Care AND implemented as ordered (currently OR at any time since the SOC/ROC). List any standardized/validated tool(s) that were used	Date Order Received for POC	Date Completed or D/C
	No	**Yes**	**N/A -** Based on condition(s) below ▼				
Diabetic* foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	❑	❑	❑	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee)			
Falls prevention* interventions	❑	❑	❑	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls			
Depression* intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	❑	❑	❑	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used			
Pain* monitoring and mitigation	❑	❑	❑	Every standardized, validated pain assessment (appropriate to the patient's ability to communicate the severity of pain) conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain			
Pressure ulcer(s)* prevention	❑	❑	❑	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers. If no standardized tool(s) were used clinical factors were included (e.g., mobility, incontinence and/or nutrition etc.)			
Pressure ulcer treatment based on principles of moist wound healing	❑	❑	❑	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated			
Parameters to notify physician with vital sign changes	❑	❑	❑	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference			

Patient Name_____ ID #_____

REHABILITATION/POTENTIAL GOALS WORKSHEET

Check goal(s) and insert information. Check box to indicate short or long term goal(s).

DISCIPLINE GOALS AND DATE WILL BE ACHIEVED

Nursing:

❑ Demonstrates compliance with medication
by _____ (date) ❑ Short ❑ Long

❑ Stabilization of cardiovascular pulmonary condition
by _____ (date) ❑ Short ❑ Long

❑ Demonstrates competence in following medical regimen
by _____ (date) ❑ Short ❑ Long

❑ Verbalizes pain controlled at acceptable level
by _____ (date) ❑ Short ❑ Long

❑ Demonstrates independence in _____
by _____ (date) ❑ Short ❑ Long

❑ Verbalizes ❑ Demonstrates independence with care
by _____ (date) ❑ Short ❑ Long

❑ Wound healing without complications
by _____ (date) ❑ Short ❑ Long

❑ Expect daily SN visits to end
by _____ (date) ❑ Short ❑ Long

❑ Other_____
by _____ (date) ❑ Short ❑ Long

Physical Therapy:

❑ Demonstrates ability to follow home exercise program
by _____ (date) ❑ Short ❑ Long

❑ Other_____
by _____ (date) ❑ Short ❑ Long

Occupational Therapy:

❑ Demonstrates ability to follow home exercise program by
_____ (date) ❑ Short ❑ Long

❑ Other_____
by _____ (date) ❑ Short ❑ Long

Speech Therapy:

❑ Demonstrate swallowing skills in ❑ Formal ❑ Informal dysphagia evaluation exercise program by _____ (date)
❑ Short ❑ Long

❑ Completes speech therapy program
by _____ (date) ❑ Short ❑ Long

❑ Other_____
by _____ (date) ❑ Short ❑ Long

Aide:

❑ Assumes responsibility for personal care needs
by _____ (date) ❑ Short ❑ Long

❑ Other_____
by _____ (date) ❑ Short ❑ Long

Medical Social Services:

❑ Verbalize information about community resources and how to obtain assistance by _____ (date) ❑ Short ❑ Long

❑ Other_____
by _____ (date) ❑ Short ❑ Long

Comments:_____

SIGNATURES/DATES

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

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

OASIS INFORMATION

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

Patient Name_____ ID #_____

ASSESSMENT SUMMARY (Include skilled care provided this visit and analysis of findings)

Reason for Admission:_____ Homebound Reason:_____

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

_____ _____
Agency Name *Phone Number*