OASIS ITEM

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

☐ 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.

ITEM INTENT

Identifies the patient's ability to see and visually manage (function) safely within his/her environment, wearing corrective lenses if these are usually worn.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- "Nonresponsive" means that the patient is not able to respond.
- As specified within the OASIS question, only assess functional vision with corrective lenses if the patient usually wears corrective lenses.
- A magnifying glass (as might be used to read newsprint) is not an example of corrective lenses.
- Reading glasses (including "grocery store" reading glasses) are considered to be corrective lenses.
- Assessment strategies: In the health history interview, ask the patient about vision problems (e.g., cataracts) and whether or not the patient uses glasses. Observe ability to locate signature line on consent form, to count fingers at arm's length and ability to differentiate between medications, especially if medications are self-administered. Be sensitive to requests to read, as patient may not be able to read though vision is adequate.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information (e.g., history and physical)

OASIS ITEM

(M1210) Ability to hear (with hearing aid or hearing appliance if normally used):

- ☐ 0 - Adequate: hears normal conversation without difficulty.
- ☐ 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- ☐ 2 - Severely Impaired: absence of useful hearing.
- ☐ UK - Unable to assess hearing.

ITEM INTENT

Identifies the patient's ability to hear spoken language and other sounds (e.g., alarms).

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Hearing is evaluated with the patient wearing hearing aids or devices if he/she usually uses them.
- Select the "UK" response if the patient is not able to respond or if it is otherwise impossible to assess hearing (e.g., severe dementia, schizophrenia, unconscious).
- If evaluating ability to hear with hearing aids, be sure that the devices are in place, turned on, and that the hearing aids are working (i.e., batteries are functional).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information (e.g., history and physical)

OASIS ITEM

(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):

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

ITEM INTENT

Identifies the patient's functional ability to comprehend spoken words and instructions in the patient's primary language. Both hearing and cognitive abilities may impact a patient's ability to understand verbal content.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- The "UK" response should be selected if the patient is not able to respond or if it is otherwise impossible to assess understanding of spoken words and instructions.
- For patients whose primary language differs from the clinician's, an interpreter may be necessary.
- If a patient can comprehend lip reading, they have the ability to understand verbal content, even if they are deaf.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information (e.g., history and physical)
- Interpreter

OASIS ITEM

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

☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).

☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.

☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.

☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).

☐ 5 - Patient nonresponsive or unable to speak.

ITEM INTENT

Identifies the patient's physical and cognitive ability to communicate with words in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Augmented speech (e.g., a trained esophageal speaker, use of an electrolarynx) **is** considered verbal expression of language.
- Presence of a tracheostomy requires further evaluation of the patient's ability to speak. Can the trach be covered to allow speech? If so, to what extent can the patient express him/herself?
- Select Response 5 for a patient who communicates entirely nonverbally (e.g., by sign language or writing) or is unable to speak.
- "Nonresponsive" means that the patient is not able to respond.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information (e.g., history and physical)
- Interpreter

OASIS ITEM

(M1240) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

- ☐ 0 - No standardized assessment conducted
- ☐ 1 - Yes, and it does not indicate severe pain
- ☐ 2 - Yes, and it indicates severe pain

ITEM INTENT

Identifies if a standardized pain assessment is conducted and whether a clinically significant level of pain is present, as determined by the assessment tool used. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- A standardized tool is one that 1) has been scientifically tested on a population with characteristics similar to that of the patient being assessed and shown to be effective in identifying level of pain; and 2) includes a standard response scale (e.g., a scale where patients rate pain from 0-10). The standardized tool must be appropriately administered as indicated in the instructions and must be relevant for the patient's ability to respond. Severe pain is defined according to the scoring system for the standardized tool being used. CMS does not endorse a specific tool.
- If the standardized tool does not define levels of "severe" pain, then the agency or care provider should use the level(s) of pain identified in the standardized tool that best reflect the concept of "severe."
- Select Response 0 if such a tool was not used to assess pain.
- Select Response 1 or 2 based on the pain reported at the time the standardized tool was administered, per the tool's instructions.
- In order to select Response 1 or 2, the pain assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the allowed time frame (i.e., within five days of SOC, within two days of discharge from the inpatient facility at ROC).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physical assessment
- Clinical record
- A variety of standardized pain assessment approaches have been tested and are available for provider use in patient assessment. These approaches include visual analog scales, the Wong-Baker FACES Pain Rating Scale, numerical scales, and the Memorial Pain Assessment Card. Links to these and other assessment tools can be found in Chapter 5 of this manual.

Guidance for this item updated 12/2010

OASIS ITEM

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

- ☐ 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

ITEM INTENT

Identifies frequency with which pain interferes with patient's activities, with treatments if prescribed.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Responses are arranged in order of least to most interference with activity or movement.
- Pain interferes with activity when the pain results in the activity being performed less often than otherwise desired, requires the patient to have additional assistance in performing the activity, or causes the activity to take longer to complete. Include all activities (e.g., sleeping, recreational activities, watching television), not just ADLs.
- When reviewing patient's medications, the presence of medication for pain or joint disease provides an opportunity to explore the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement. Be careful not to overlook seemingly unimportant activities (for example, the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk). Evaluating the patient's ability to perform ADLs and IADLs can provide additional information about such pain. Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual pain scales (e.g., FACES). The patient's treatment for pain (whether pharmacologic or nonpharmacologic) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation of nonverbal indications of pain
- Physical assessment
- Referral information (e.g., history and physical)
- Standardized pain assessment tools. Links to these tools can be found in Chapter 5 of this manual.

Guidance for this item updated 12/2010