Outcome and Assessment Information Set
Items to be Used at Specific Time Points

Time Point	Items Used
Start of Care	M0010-M0030, M0040-M0150, M1000-M1036, M1100-M1306, M1308, M1320-M1410, M1600-M2002, M2010, M2020-M2250
Start of care—further visits planned	
Resumption of Care	M0032, M0080-M0110, M1000-M1036, M1100-M1306, M1308, M1320-M1410, M1600-M2002, M2010, M2020-M2250
Resumption of care (after inpatient stay)	
Follow-Up	M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Recertification (follow-up) assessment Other follow-up assessment	
Transfer to an Inpatient Facility	M0080-M0100, M1041-M1056, M1500, M1510, M2004, M2015, M2300-M2410, M2430, M0903, M0906
Transferred to an inpatient facility—patient not discharged from an agency Transferred to an inpatient facility—patient discharged from agency	
Discharge from Agency — Not to an Inpatient Facility	
Death at home	M0080-M0100, M0903, M0906
Discharge from agency	M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1500-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2102, M2300-M2420, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

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

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

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 M0903*]**
☐ 9 – Discharge from agency **[*Go to M1041*]**

(M1041) Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

- ☐ 0 - No *[Go to M1051]*
- ☐ 1 - Yes

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?

- ☐ 1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
- ☐ 2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
- ☐ 3 - Yes; received from another health care provider (for example, physician, pharmacist)
- ☐ 4 - No; patient offered and declined
- ☐ 5 - No; patient assessed and determined to have medical contraindication(s)
- ☐ 6 - No; not indicated - patient does not meet age/condition guidelines for influenza vaccine
- ☐ 7 - No; inability to obtain vaccine due to declared shortage
- ☐ 8 - No; patient did not receive the vaccine due to reasons other than those listed in responses 4 – 7.

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?

- ☐ 0 - No
- ☐ 1 - Yes **[***Go to M1500 at TRN; Go to M1230 at DC* **]**

(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:

- ☐ 1 - Offered and declined
- ☐ 2 - Assessed and determined to have medical contraindication(s)
- ☐ 3 - Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine
- ☐ 4 - None of the above

SENSORY STATUS

(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 (for example, speech is nonsensical or unintelligible).
- ☐ 5 - Patient nonresponsive or unable to speak.

(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

INTEGUMENTARY STATUS

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as Unstageable? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

☐ 0 - No **[*Go to M1322*]**

☐ 1 - Yes

(M1307) The **Oldest Stage II Pressure Ulcer** that is present at discharge: (Excludes healed Stage II Pressure Ulcers)

☐ 1 - Was present at the most recent SOC/ROC assessment

☐ 2 - Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified:

__ __ /__ __ /__ __ __ __
month / day / year

☐ NA - No Stage II pressure ulcers are present at discharge

(M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:
(Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

Stage Descriptions—unhealed pressure ulcers	Number Currently Present
a. **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	___
b. **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	___
c. **Stage IV:** Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	___
d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device	___
d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	___

(M1309) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC

	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	___
b. Stage III	___
c. Stage IV	___

Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.

	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	___

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

- ☐ 0 - Newly epithelialized
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable pressure ulcer

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

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

- ☐ 1 - Stage I
- ☐ 2 - Stage II
- ☐ 3 - Stage III
- ☐ 4 - Stage IV
- ☐ NA - Patient has no pressure ulcers or no stageable pressure ulcers

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

- ☐ 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:

- ☐ 1 - One
- ☐ 2 - Two
- ☐ 3 - Three
- ☐ 4 - Four or more

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

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing

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

- ☐ 0 - No **[*At SOC/ROC, go to M1350 ; At FU//DC, 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 **[*At SOC/ROC, go to M1350 ; At FU/DC, go to M1400*]**

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

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

RESPIRATORY STATUS

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

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

CARDIAC STATUS

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the previous OASIS assessment?

- ☐ 0 - No **[*Go to M2004 at TRN; Go to M1600 at DC*]**
- ☐ 1 - Yes
- ☐ 2 - Not assessed **[*Go to M2004 at TRN; Go to M1600 at DC*]**
- ☐ NA - Patient does not have diagnosis of heart failure **[*Go to M2004 at TRN; Go to M1600 at DC*]**

(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

- ☐ 0 - No action taken
- ☐ 1 - Patient's physician (or other primary care practitioner) contacted the same day
- ☐ 2 - Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
- ☐ 3 - Implemented physician-ordered patient-specific established parameters for treatment
- ☐ 4 - Patient education or other clinical interventions
- ☐ 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

ELIMINATION STATUS

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

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment
- ☐ UK - Unknown **[*Omit "UK" option on DC*]**

(M1610) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[*Go to M1620*]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) **[*Go to M1620*]**

(M1615) When does **Urinary Incontinence** occur?

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - Occasional stress incontinence
- ☐ 2 - During the night only
- ☐ 3 - During the day only
- ☐ 4 - During the day and night

(M1620) Bowel Incontinence Frequency:

- ☐ 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 **[***Omit "UK" option on FU, DC***]**

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.

- ☐ 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):

- ☐ 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):

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

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

- ☐ 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

(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.

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

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).

- ☐ 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:

- ☐ 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:

- ☐ 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).**

- ☐ 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- ☐ 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- ☐ 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
  (a) for intermittent supervision or encouragement or reminders, OR
  (b) to get in and out of the shower or tub, OR
  (c) for washing difficult to reach areas.
- ☐ 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- ☐ 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- ☐ 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
- ☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- ☐ 0 - Able to get to and from the toilet and transfer independently with or without a device.
- ☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- ☐ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- ☐ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- ☐ 4 - Is totally dependent in toileting.

(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.

- ☐ 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.

- ☐ 0 - Able to independently transfer.
- ☐ 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- ☐ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- ☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- ☐ 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.

- ☐ 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.

(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:

- ☐ 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
  (b) 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 (specifically: prior to this home care admission).
- ☐ 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- ☐ 2 - Unable to prepare any light meals or reheat any delivered meals.

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

- ☐ 0 - Able to dial numbers and answer calls appropriately and as desired.
- ☐ 1 - Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- ☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- ☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- ☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- ☐ 5 - Totally unable to use the telephone.
- ☐ NA - Patient does not have a telephone.

MEDICATIONS

(M2004) Medication Intervention: If there were any clinically significant medication issues at the time of, or at any time since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day to resolve any identified clinically significant medication issues, including reconciliation?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No clinically significant medication issues identified at the time of or at any time since the previous OASIS assessment

(M2015) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient not taking any drugs

(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.)**

- ☐ 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.**

- ☐ 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.

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. (Check only **one** box in each row.)

Type of Assistance	No assistance needed – patient is independent or does not have needs in this area	Non-agency caregiver(s) currently provide assistance	Non-agency caregiver(s) need training/ supportive services to provide assistance	Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but no non-agency caregiver(s) available
a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	☐0	☐1	☐2	☐3	☐4
b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances)	☐0	☐1	☐2	☐3	☐4
c. **Medication administration** (for example, oral, inhaled or injectable)	☐0	☐1	☐2	☐3	☐4
d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program)	☐0	☐1	☐2	☐3	☐4
e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	☐0	☐1	☐2	☐3	☐4
f. **Supervision and safety** (for example, due to cognitive impairment)	☐0	☐1	☐2	☐3	☐4
g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments)	☐0	☐1	☐2	☐3	☐4

EMERGENT CARE

(M2300) Emergent Care: At the time of or at any time since the previous OASIS assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

- ☐ 0 - No **[*Go to M2400*]**
- ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
- ☐ 2 - Yes, used hospital emergency department WITH hospital admission
- ☐ UK - Unknown **[*Go to M2400*]**

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall
- ☐ 3 - Respiratory infection (for example, pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (for example, fluid overload)
- ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
- ☐ 7 - Myocardial infarction or chest pain
- ☐ 8 - Other heart disease
- ☐ 9 - Stroke (CVA) or TIA
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 11 - GI bleeding, obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection or complication
- ☐ 15 - Wound infection or deterioration
- ☐ 16 - Uncontrolled pain
- ☐ 17 - Acute mental/behavioral health problem
- ☐ 18 - Deep vein thrombosis, pulmonary embolus
- ☐ 19 - Other than above reasons
- ☐ UK - Reason unknown

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2400) Intervention Synopsis: (Check only **one** box in each row.) At the time of or at any time since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	☐0	☐1	☐NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the last OASIS assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the last OASIS 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.
d. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Every standardized, validated pain assessment conducted at or since the last OASIS assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

(M2410) To which **Inpatient Facility** has the patient been admitted?

- ☐ 1 - Hospital **[*Go to M2430*]**
- ☐ 2 - Rehabilitation facility **[*Go to M0903*]**
- ☐ 3 - Nursing home **[*Go to M0903*]**
- ☐ 4 - Hospice **[*Go to M0903*]**
- ☐ NA - No inpatient facility admission **[*Omit "NA" option on TRN*]**

(M2420) Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer.)**

- ☐ 1 - Patient remained in the community (without formal assistive services)
- ☐ 2 - Patient remained in the community (with formal assistive services)
- ☐ 3 - Patient transferred to a non-institutional hospice
- ☐ 4 - Unknown because patient moved to a geographic location not served by this agency
- ☐ UK - Other unknown **[*Go to M0903*]**

(M0903) Date of Last (Most Recent) Home Visit:

__ __ /__ __ / __ __ __ __
month / day / year

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

___ __ /__ __ / __ __ __ __
month / day / year