

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

Time Point	Items Used
Discharge from Agency — Not to an Inpatient Facility	
Death at home -----	M0080-M0100, M2005, M0903, M0906
Discharge from agency -----	M0080-M0100, M1041-M1056, M1230, M1242, M1306M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906
(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?	
Enter Code <input type="checkbox"/>	0 No [Go to M1051] 1 Yes
(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?	
Enter Code <input type="checkbox"/>	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)?	
Enter Code <input type="checkbox"/>	0 No 1 Yes [Go to M1501 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:	
Enter Code <input type="checkbox"/>	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
<u>SENSORY STATUS</u>	
(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):	
Enter Code <input type="checkbox"/>	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 <u>Unable</u> 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:	
Enter Code <input type="checkbox"/>	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 2 or Higher or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code <input type="checkbox"/>	0 No [Go to M1322] 1 Yes
(M1307) The Oldest Stage 2 Pressure Ulcer that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)	
Enter Code <input type="checkbox"/>	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: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> month day year NA No Stage 2 pressure ulcers are present at discharge
(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	
	Enter Number
A1. Stage 2: 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 blister. Number of Stage 2 pressure ulcers [If 0 at FU/DC Go to M1311B1]	<input type="checkbox"/>
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
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 [If 0 at FU/DC Go to M1311C1]	<input type="checkbox"/>
B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC – – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
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 [If 0 at FU/DC Go to M1311D1]	<input type="checkbox"/>
C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC – – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers due to non-removable dressing/device [If 0 at FU/DC Go to M1311E1]	<input type="checkbox"/>
D2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
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 [If 0 at FU/DC Go to M1311F1]	<input type="checkbox"/>
E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution Number of unstageable pressure ulcers with suspected deep tissue injury in evolution [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	<input type="checkbox"/>
F2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
[Omit “A2, B2, C2, D2, E2 and F2” on SOC/ROC]	

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.

	Enter Number
a. Stage 2	<input type="text"/>
b. Stage 3	<input type="text"/>
c. Stage 4	<input type="text"/>

Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.

d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	<input type="text"/>
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	<input type="text"/>
f. Unstageable – Suspected deep tissue injury in evolution.	<input type="text"/>

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

Enter Code <input type="text"/>	0 Newly epithelialized
	1 Fully granulating
	2 Early/partial granulation
	3 Not healing
	NA No observable pressure ulcer

(M1322) Current Number of Stage 1 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. 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 <input type="text"/>	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.)

Enter Code <input type="text"/>	1 Stage 1
	2 Stage 2
	3 Stage 3
	4 Stage 4
	NA Patient has no pressure ulcers or no stageable pressure ulcers

(M1330) Does this patient have a Stasis Ulcer?

Enter Code <input type="text"/>	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 <input type="text"/>	1 One
	2 Two
	3 Three
	4 Four or more

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

Enter Code <input type="text"/>	1 Fully granulating
	2 Early/partial granulation
	3 Not healing

(M1340) Does this patient have a Surgical Wound?	
Enter Code <input type="checkbox"/>	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	
Enter Code <input type="checkbox"/>	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?	
Enter Code <input type="checkbox"/>	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

(M1501) 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 most recent SOC/ROC assessment?	
Enter Code <input type="checkbox"/>	0 No Go[to M2005 at TRN; Go to M1600 at DC] 1 Yes 2 Not assessed Go to M200[5 at TRN; Go to M1600 at DC] NA Patient does not have diagnosis of heart failure Go to M200[5 at TRN; Go to M1600 at DC]

(M1511) 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 most recent SOC/ROC 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?	
Enter Code <input type="checkbox"/>	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown [Omit "UK" option on DC]
(M1610) Urinary Incontinence or Urinary Catheter Presence:	
Enter Code <input type="checkbox"/>	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?	
Enter Code <input type="checkbox"/>	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:	
Enter Code <input type="checkbox"/>	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 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.	
Enter Code <input type="checkbox"/>	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):	
Enter Code <input type="checkbox"/>	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):	
Enter Code <input type="checkbox"/>	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.
Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches,
- 4 - 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.	
Enter Code <input type="checkbox"/>	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).

Enter Code <input type="checkbox"/>	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:

Enter Code <input type="checkbox"/>	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:

Enter Code <input type="checkbox"/>	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 <input type="checkbox"/>	0 Able to bathe self in <u>shower</u> or <u>tub</u> 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, <u>OR</u> (b) to get in and out of the shower or tub, <u>OR</u> (c) for washing difficult to reach areas. 3 Able to participate in bathing self in shower or tub, <u>but</u> 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 <input type="checkbox"/>	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 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3 <u>Unable</u> 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.

Enter Code <input type="checkbox"/>	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 <input type="checkbox"/>	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.

Enter Code <input type="checkbox"/>	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, <u>unable</u> to ambulate but is able to wheel self independently.
	5 Chairfast, unable to ambulate and is <u>unable</u> 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.

Enter Code <input type="checkbox"/>	0 Able to independently feed self.
	1 Able to feed self independently but requires: (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision from another person; <u>OR</u> (c) a liquid, pureed or ground meat diet.
	2 <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack.
	3 Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
	4 <u>Unable</u> 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:

Enter Code <input type="checkbox"/>	0 (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; <u>OR</u> (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 <u>Unable</u> 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 <u>effectively</u> using the telephone to communicate.	
Enter Code <input type="checkbox"/>	<p>0 Able to dial numbers and answer calls appropriately and as desired.</p> <p>1 Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.</p> <p>2 Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.</p> <p>3 Able to answer the telephone only some of the time or is able to carry on only a limited conversation.</p> <p>4 <u>Unable</u> to answer the telephone at all but can listen if assisted with equipment.</p> <p>5 Totally unable to use the telephone.</p> <p>NA Patient does not have a telephone.</p>

MEDICATIONS

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

Enter Code <input type="checkbox"/>	<p>0 No</p> <p>1 Yes</p> <p>9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications</p>
--	---

(M2016) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent SOC/ROC 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?

Enter Code <input type="checkbox"/>	<p>0 No</p> <p>1 Yes</p> <p>NA Patient not taking any drugs</p>
--	---

(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.)

Enter Code <input type="checkbox"/>	<p>0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.</p> <p>1 Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart.</p> <p>2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times</p> <p>3 <u>Unable</u> to take medication unless administered by another person.</p> <p>NA No oral medications prescribed.</p>
--	---

(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.**

Enter Code <input type="checkbox"/>	<p>0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times.</p> <p>1 Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart.</p> <p>2 Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection</p> <p>3 <u>Unable</u> to take injectable medication unless administered by another person.</p> <p>NA No injectable medications prescribed.</p>
--	--

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

EMERGENT CARE

(M2301) Emergent Care: At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

Enter Code <input style="width: 30px; height: 20px;" type="text"/>	0 1 2 UK	No [Go to M2401] Yes, used hospital emergency department WITHOUT hospital admission Yes, used hospital emergency department WITH hospital admission Unknown [Go to M2401]
---	-------------------	--

(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

(M2401) Intervention Synopsis: (Check only **one** box in each row.) At the time of or at any time since the most recent SOC/ROC 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Every standardized, validated multifactor fall risk assessment conducted at or since the most recent SOC/ROC 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA 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.
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA 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.
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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?

Enter Code <input type="checkbox"/>	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.)**

Enter Code <input type="checkbox"/>	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

Patient Identifiers: Facial Recognition Patient Address

Professional Nursing Service

D.O.B. Initial Visit ___/___/___

Skilled Nursing Visit Report

Patient Name _____

Allergies _____

Temp	Ap Pulse	Radial Pulse	Resp	HT	WT

B/P	Lying	Sitting	Standing
R			
L			

Nursing Diagnosis: _____

NURSING ASSESSMENT OF SIGNS & SYMPTOMS: Check Responses

MENTAL PSYCHO SOCIAL	MEDICATION REVIEW	CV	GI/GU/NUTRITION	WOUND ASSESSMENT
<input type="checkbox"/> Alert <input type="checkbox"/> Oriented X ___/3 <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Agitated <input type="checkbox"/> Confused <input type="checkbox"/> Forgetful <input type="checkbox"/> Delusional <input type="checkbox"/> Disoriented <input type="checkbox"/> Hallucination <input type="checkbox"/> Paranoia <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Knowledge Deficit/Coping <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Evidence of Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Drug or <input type="checkbox"/> ETOH use <input type="checkbox"/> No Problem Assessed	<input type="checkbox"/> No Changes <input type="checkbox"/> Changes on back NEUROLOGICAL MUSCOLO-SKELETAL <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Tactile Speech: <input type="checkbox"/> Slurred <input type="checkbox"/> Garbled Aphasia: <input type="checkbox"/> Rec. <input type="checkbox"/> Exp. Hand Grasp <input type="checkbox"/> = <input type="checkbox"/> ≠ Pedal Push <input type="checkbox"/> = <input type="checkbox"/> ≠ Pupillary Reaction: Rt: _____ Lt: _____ <input type="checkbox"/> HA <input type="checkbox"/> Syncope <input type="checkbox"/> Vertigo <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Spasms <input type="checkbox"/> Seizures <input type="checkbox"/> Balance Poor <input type="checkbox"/> Unsteady Gait <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> WC <input type="checkbox"/> Weakness <input type="checkbox"/> Endurance <input type="checkbox"/> Bed <input type="checkbox"/> Chair Bound <input type="checkbox"/> No Problem Assessed	<input type="checkbox"/> Chest Pain / <input type="checkbox"/> Murmur Peripheral Pulses / 4 site _____ <input type="checkbox"/> Neck Vein Distention CAP refill: = <input type="checkbox"/> >3 sec <input type="checkbox"/> <3 sec Edema: <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> +4 <input type="checkbox"/> RUE <input type="checkbox"/> RLE <input type="checkbox"/> LUE <input type="checkbox"/> LLE Other: <input type="checkbox"/> No Problem Assessed CP <input type="checkbox"/> SOB <input type="checkbox"/> Dyspnea <input type="checkbox"/> DOE <input type="checkbox"/> Orthopnea <input type="checkbox"/> O2 _____ lpm/ _____ % pox <input type="checkbox"/> Cough <input type="checkbox"/> Prod <input type="checkbox"/> Non-prod <input type="checkbox"/> Cyanosis <input type="checkbox"/> Pallor Breath Sounds: <input type="checkbox"/> CTA <input type="checkbox"/> Crackles <input type="checkbox"/> Wheeze <input type="checkbox"/> Rhonchi <input type="checkbox"/> Absent <input type="checkbox"/> Diminished <input type="checkbox"/> Clear Location: <input type="checkbox"/> No Problem Assessed	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Reflux <input type="checkbox"/> Epigastric Distress Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Tube feed <input type="checkbox"/> NPO Dietary Compliance Fluid Intake _____ 24hrs Meals QD _____ BS x _____ Quads <input type="checkbox"/> Normal <input type="checkbox"/> Hypo <input type="checkbox"/> Hyperactive <input type="checkbox"/> Diarrhea <input type="checkbox"/> Incontinence <input type="checkbox"/> Colostomy <input type="checkbox"/> Flatulence LBM _____ <input type="checkbox"/> Constipation <input type="checkbox"/> Impaction <input type="checkbox"/> G-tube <input type="checkbox"/> NG-tube <input type="checkbox"/> J-tube Abdomen: Girth _____ <input type="checkbox"/> Tenderness <input type="checkbox"/> Distention Urinary Output _____ 24hrs <input type="checkbox"/> Pain <input type="checkbox"/> Burning <input type="checkbox"/> Hematuria <input type="checkbox"/> Distention <input type="checkbox"/> Retention <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Incont Catheter: <input type="checkbox"/> Foley <input type="checkbox"/> Suprapubic Blood Glucose _____ <input type="checkbox"/> Random <input type="checkbox"/> FBS <input type="checkbox"/> Trends <input type="checkbox"/> No Problem Assessed	Location: L _____ cm W _____ cm D _____ cm (weekly) Pressure Stage: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Stasis <input type="checkbox"/> Arterial <input type="checkbox"/> Surgical Drainage Amt: _____ Purulent: <input type="checkbox"/> Yellow <input type="checkbox"/> Tan <input type="checkbox"/> Green Type: <input type="checkbox"/> Serous <input type="checkbox"/> Ser.Sang <input type="checkbox"/> Frank Tunnel _____ cm _____ o'clock Odor: <input type="checkbox"/> Yes <input type="checkbox"/> No Wound Bed: Surrounding Tissue: Wound Care: <input type="checkbox"/> Cleanse / <input type="checkbox"/> Irrigate Apply _____ Pack _____ Cover _____ Wrap _____ Secure _____ Other: Wound #2: <input type="checkbox"/> see narrative <input type="checkbox"/> No Wounds
ENVIRONMENT/SAFETY Hazards: <input type="checkbox"/> Fire <input type="checkbox"/> Mobility <input type="checkbox"/> Oxygen <input type="checkbox"/> Sharps <input type="checkbox"/> Lifeline Use <input type="checkbox"/> Impaired Phone Access <input type="checkbox"/> No Problem Assessed	PAIN <input type="checkbox"/> None / <input type="checkbox"/> Chronic / <input type="checkbox"/> Acute Scale 0-10: _____ Location: _____ Character: _____ Pain Management <input type="checkbox"/> see narrative Tx. <input type="checkbox"/> Effective / <input type="checkbox"/> Ineffective	SKIN <input type="checkbox"/> Pale <input type="checkbox"/> Jaundice <input type="checkbox"/> Flush <input type="checkbox"/> Mottled <input type="checkbox"/> Clammy <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Dry <input type="checkbox"/> Hot <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold Turgor: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Elastic <input type="checkbox"/> Rash <input type="checkbox"/> Itch <input type="checkbox"/> Open area <input type="checkbox"/> WNL <input type="checkbox"/> Other:		

Teaching _____

Response to teaching _____

SERVICES PROVIDED	INSTRUCT	GOALS
Skilled Assessment	Medication Effects / Side Effects	Verbalizes knowledge of Medication Regime
Urinary Catheter Care	Pain Management Techniques (Pharm / NonPharm)	Verbalizes Two Pain Management Techniques
Wound Care / Dressing	Diet / Fluid Intake	Knowledge of Appropriate Nutrition / Hydration
Venipuncture / Central Line / Port Access	Falls Prevention / Ambulation Safety	Demonstrates Safe Ambulation / Transfers
Bowel / Bladder Training	Universal Precautions / Infection Control	Demonstrates Infection Control
Medication Box/Dispenser Fill	Disease Process	Verbalizes Two Disease Management Skills
Administration Med:	Emergency Protocols / 911	Knowledge of Emergency Phone Numbers
Labs:	Diabetic Management	Participates in POC Development / Modification
	Smoking Cessation	Exhibits Goal Directed Behavior

Medical Necessity for visit: _____

Narrative: _____

Plan: _____

Communications with Physician / Discipline _____

Supervision: Aide _____ LPN _____ PT _____ OT _____ ST _____ SW _____

Orders/Instructions followed Care plan appropriate / revised Pt / CG satisfied with care Staff present

RN / LPN Signature _____ Date _____ Time In _____ Time Out _____

Signature of Patient and/or Caregiver _____

Physician: _____

Nurse: _____

Patient Name: _____

Payor Source: _____

Physician Giving D/C Order: _____

Dicipline	S.O.C	Last Visit	Notification of Discharge (Check all that Apply)	
SN:			Team Leader	Physician
HHA:			Therapist	Patient
PT:			DME	Other:
OT:			Pharmacy/Infusion co.	UHHC
ST:			MSW	
MSW:			Scheduling	

REASON FOR DISCHARGE (√)	
(01) Goals Met/Condition Stable	(09) Moved from Service Area
(02) Hospitalized	(10) Change in Reimbursement Source
(03) Expired	(11) Lack of Progress
(04) Entered Long Term Care (LTC)/ECF or Rehab	(12) Not Homebound
(05) MD/Pt./Family Request/Refusal	(12) Non-Compliance
(06) Unsafe Condition/Environment	(12) Assisted Living
(07) Refer to Other Agency or Hospice	(12) Other:
(08) No Source of Reimbursement	

OVERALL STATUS OF PATIENT AT DISCHARGE: () Improved () Unimproved () Deteriorated

Psycho/Social Status: () Alert () Forgetful () Agitated () Impaired Perception () Impaired Judgment
() Oriented () Disoriented () Depressed () Lethargic

DISPOSITION (√)	
(01) Home (A) Self-Care/ Independent (B) Caregiver/Needs Assistance	(05) Expired – Unexpected
(02) Hospital (Scheduled)	(06) LTC – ECF
(03) Hospital (Emergency Adm.)	(07) Rehab
(04) Expired -Expected	(08) Hospice and/or Psych

SUMMARY OF CARE
(+) Yes/Receptive (-) No/Non-Receptive (NA) Not Applicable

	Skilled Svc Provided	Instruction Provided	Materials Given	Response	Comments
Disease Process					
Safety/Emergency Measures					
IV Dressing Change/Assess site					
Medication Therapy () IV () PO () Topical () Injections () Enteral					
Nutrition/Hydration () TPN () Parenteral () Enteral					
Wound Care					
Skin Assessment					
PT					
OT					
ST					
MSW					
Psychiatric Nursing					
Maternal / Child					
HHA					
Other:					

Advanced Directies: Healthcare POA Living Will DNR

Community Referrals: _____

Patient to follow-up with Dr. _____ RN Signature: _____ Date: _____

Summary of Care Provided/Reason for Hospitalization: _____



PROFESSIONAL NURSING SERVICE

Discharge Instructions

Patient Name: _____

HEALTH MANAGEMENT INSTRUCTIONS

It has been our pleasure to serve you. Please follow the discharge instructions listed below. If you have any questions, you may reach us at 330-929-5512, Monday – Friday, 8 am – 5 pm.

- Make an appointment with your physician:
 - o Dr _____ Phone _____
- Maintain an updated medication list and bring to all physician appointments, have this list available at all times in the event of an emergency situation.
- Follow your prescribed diet _____.
- Continue prescribed exercises/activity.
- Maintain a safe environment.
- Out patient lab work
 - o Home lab technician phone _____
 - o Type of lab work ordered _____
- Reorder supplies from _____ Phone _____
- Services remaining (circle) SN PT OT ST MSW AIDE NONE

HEALTH INSTRUCTIONS

- Daily weights.
- Check blood sugars.
- Report signs and symptoms of infection to your Doctor immediately.
- Report new or worsening symptoms or pain to your Doctor.
- Take your medications as prescribed. Refill prescriptions promptly.
- Other: _____

Patient Signature _____

Nurse Signature _____

PROFESSIONAL NURSING SERVICE

Discharge Instructions

Patient Name: _____

HEALTH MANAGEMENT INSTRUCTIONS

It has been our pleasure to serve you. Please follow the discharge instructions listed below. If you have any questions, you may reach us at 330-929-5512, Monday – Friday, 8 am – 5 pm.

- Make an appointment with your physician:
 - Dr _____ Phone _____
- Maintain an updated medication list and bring to all physician appointments, have this list available at all times in the event of an emergency situation.
- Follow your prescribed diet _____.
- Continue prescribed exercises/activity.
- Maintain a safe environment.
- Out patient lab work
 - Home lab technician phone _____
 - Type of lab work ordered _____
- Reorder supplies from _____ Phone _____
- Services remaining (circle) SN PT OT ST MSW AIDE NONE

HEALTH INSTRUCTIONS

- Daily weights.
- Check blood sugars.
- Report signs and symptoms of infection to your Doctor immediately.
- Report new or worsening symptoms or pain to your Doctor.
- Take your medications as prescribed. Refill prescriptions promptly.
- Other: _____

Patient Signature _____

Nurse Signature _____