Perfect SOC

On PC

Step 1

Search your patient, click on their name and this should bring you to the patient's chart.

If the patient is still "Pending" status , then you will see this window and need to convert the patient to "Admitted":

Choose Edit

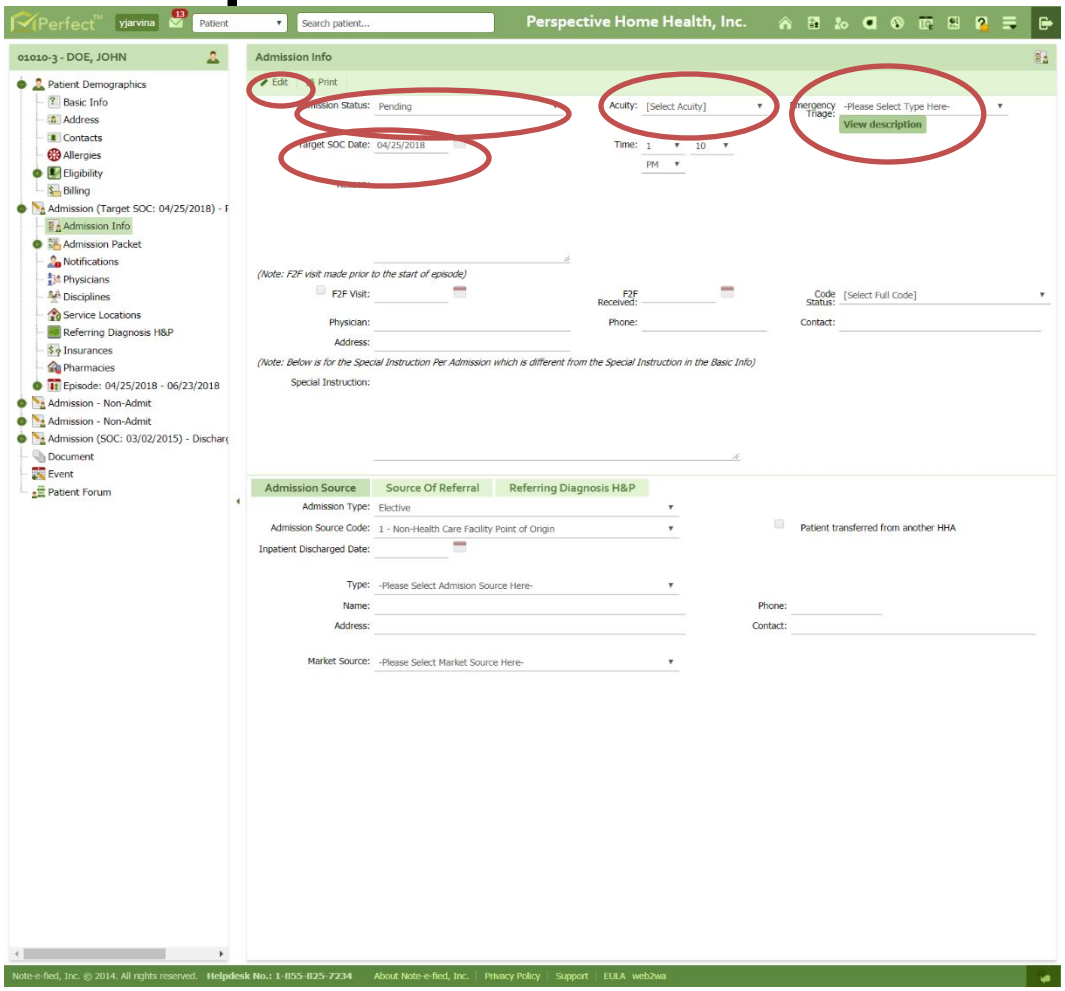
Choose Admission Status and select admit

Confirm the correct SOC date

Choose the correct Acuity Level

Choose the correct Emergency Triage

Choose Save on the top left



Step 2

Next, you will create the admission order:

Choose the “Orders” section on the left

Choose the “Add New Order”

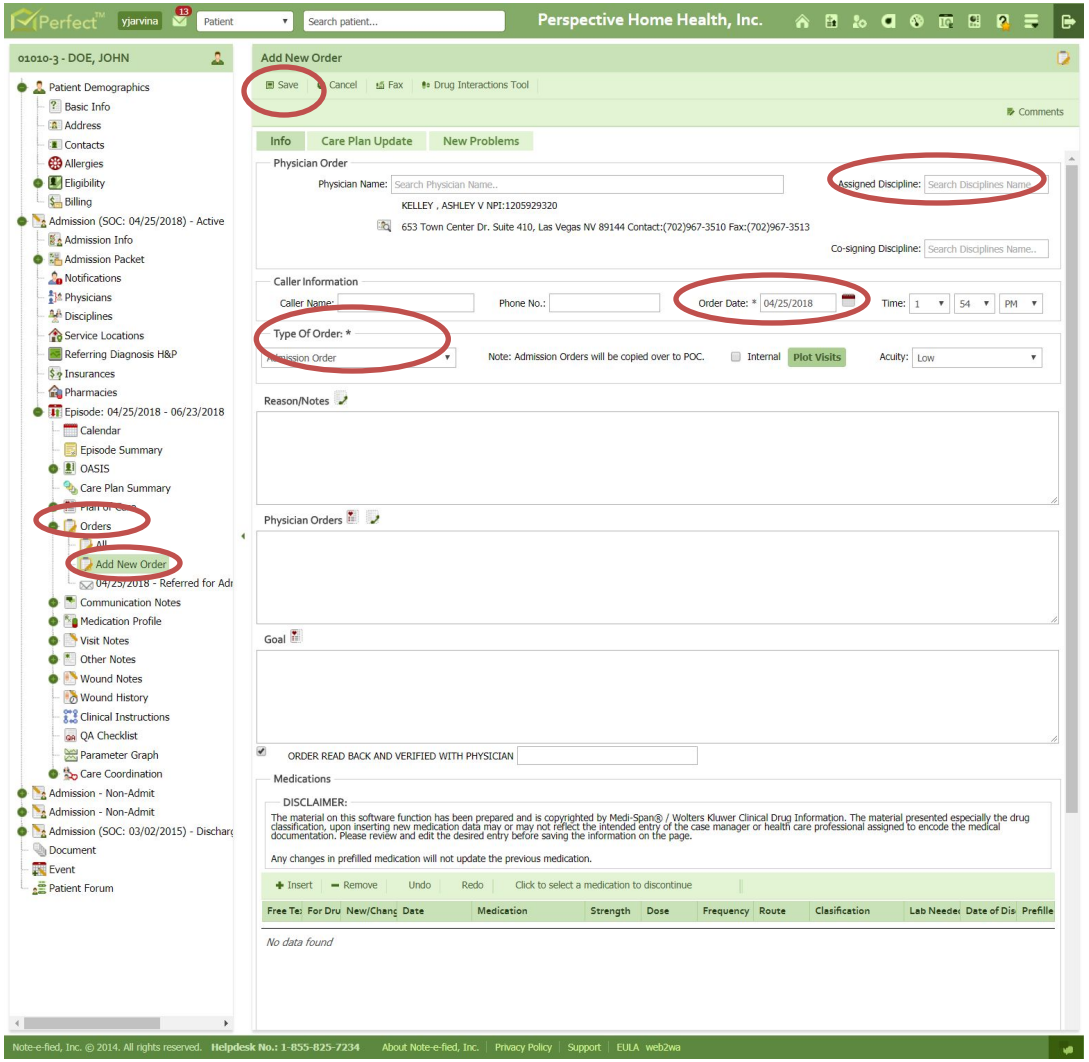
Choose “Type of Order” and select “Admission Order”

Enter your Discipline Name

Confirm the correct MD

Confirm the SOC date

Then SAVE



Step 3

Next, the admission order needs to be completed. Start by entering the Medications.

Enter medications by clicking on “Insert”
This will create a field where you can enter the medication.

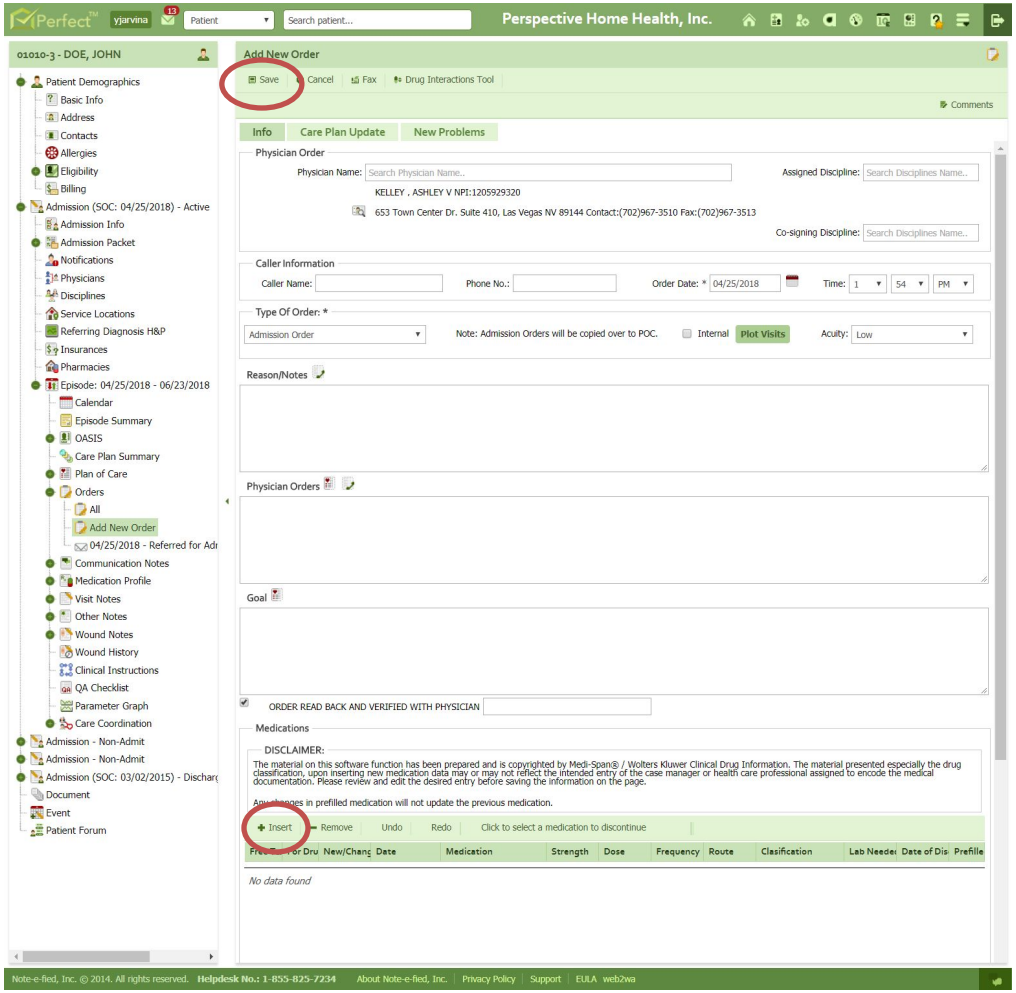
Start typing the medication name to bring forth a list of medications.

Choose the corresponding medication

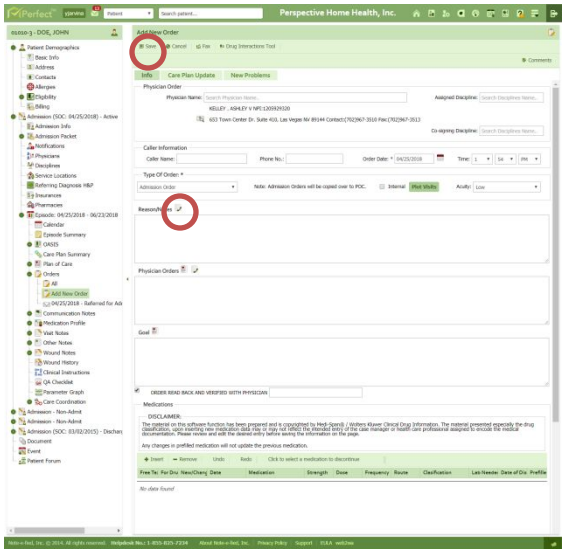
Fill in the correct Strength, Dose, Frequency, and Route

To enter the next medication, click on the “insert” again

Save often

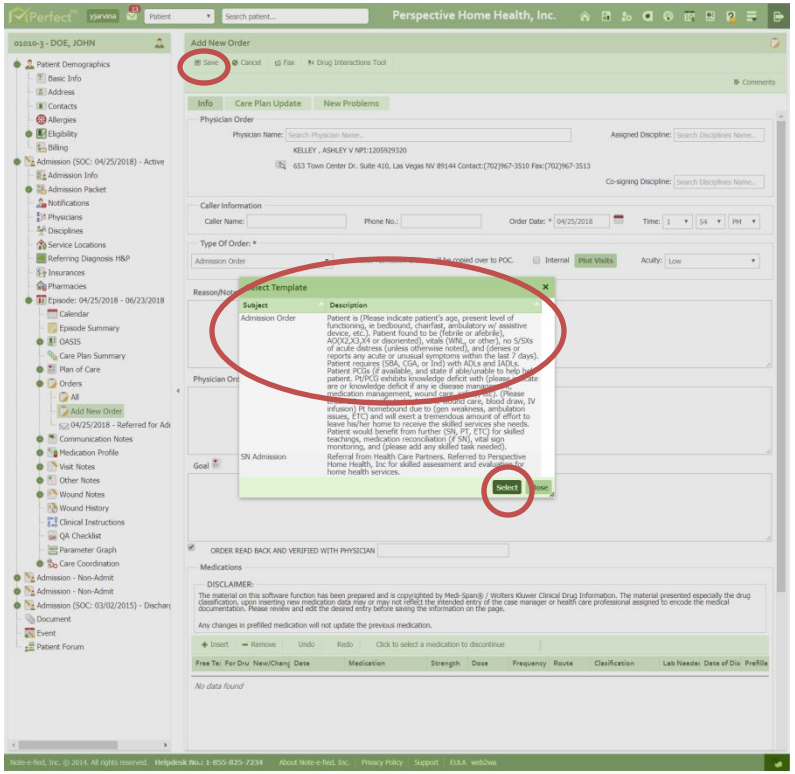


Step 4



Complete the “Reason” section.

Choose the template icon located next t the “Reason/Notes”



Choose the “Admission Order” patient encounter template and click select.

Complete the narrative.

Feel free to amend the template to fit your patient.

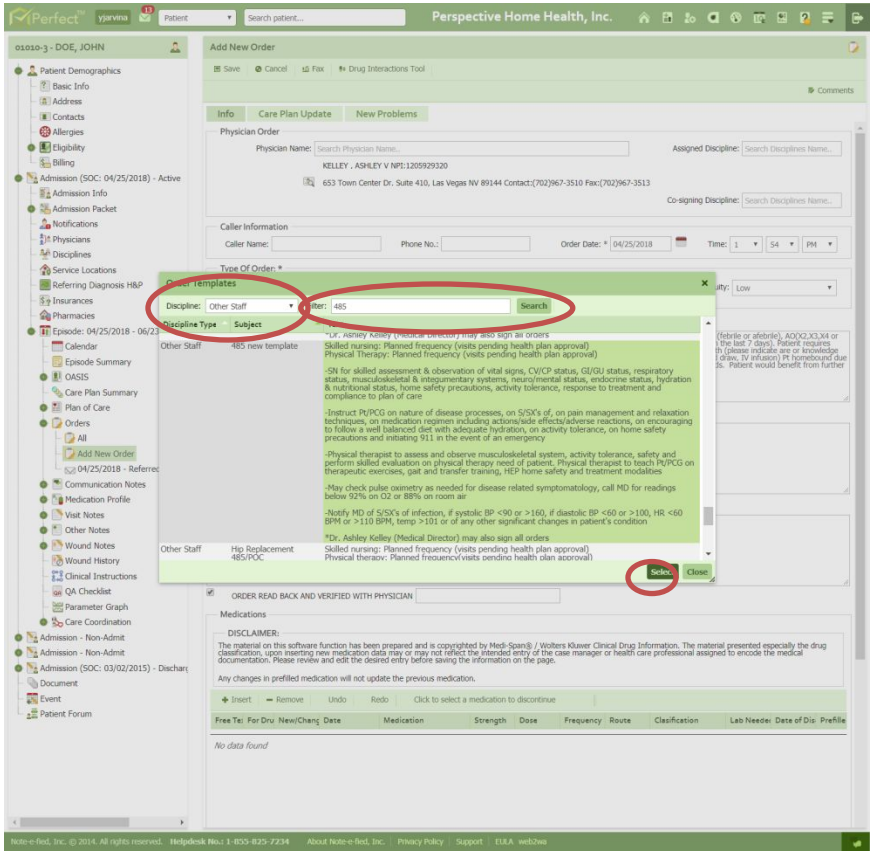
Your narrative should “paint” a clear picture of the Pt’s status, problems, skilled needs, and proposed solutions.

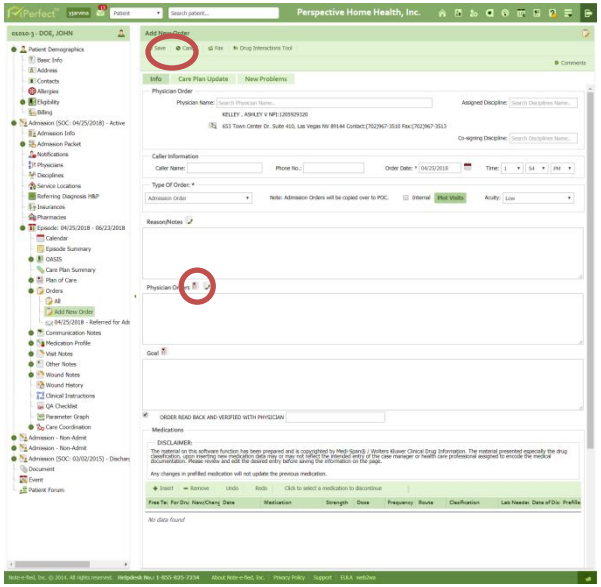
Save often

Step 5

Next, complete the “Physician Orders” section.

Choose by clicking the template icon with the ‘heart’





For disciple, choose “Other Staff”

In filter, fist look for “485 new template”

Choose the 485 new template and click select

Then continue adding the diagnosis teachings by clicking repeating the earlier steps on this page.

Under filter, start typing in the diagnosis (ie ulcer, hypertension etc)

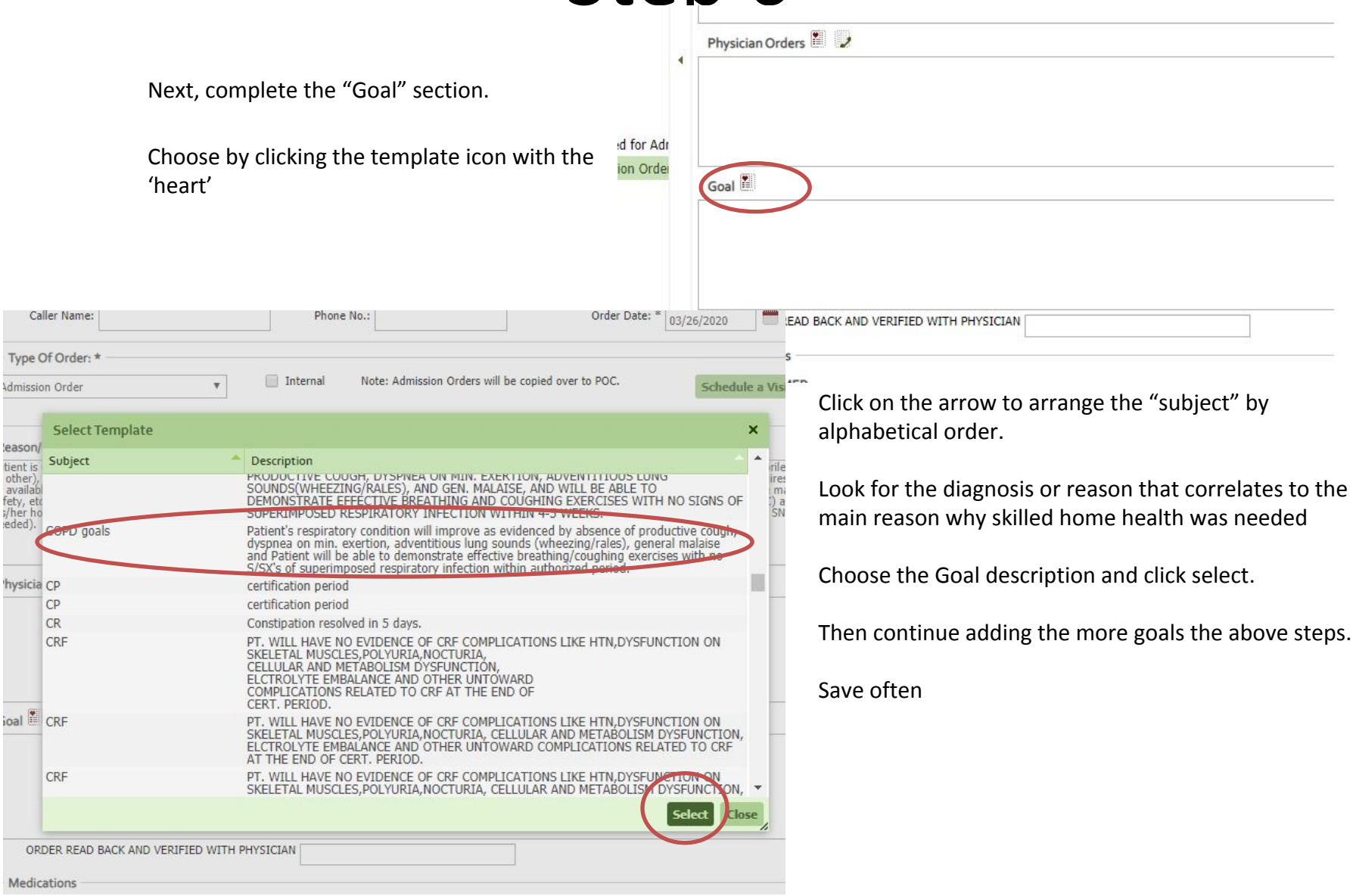
Choose the diagnosis and click select

Save often

Step 6

Next, complete the “Goal” section.

Choose by clicking the template icon with the ‘heart’



Click on the arrow to arrange the “subject” by alphabetical order.

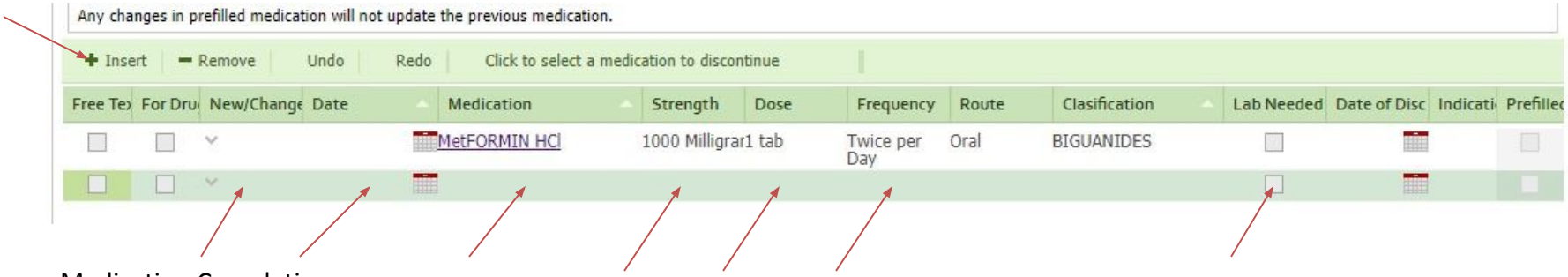
Look for the diagnosis or reason that correlates to the main reason why skilled home health was needed

Choose the Goal description and click select.

Then continue adding the more goals the above steps.

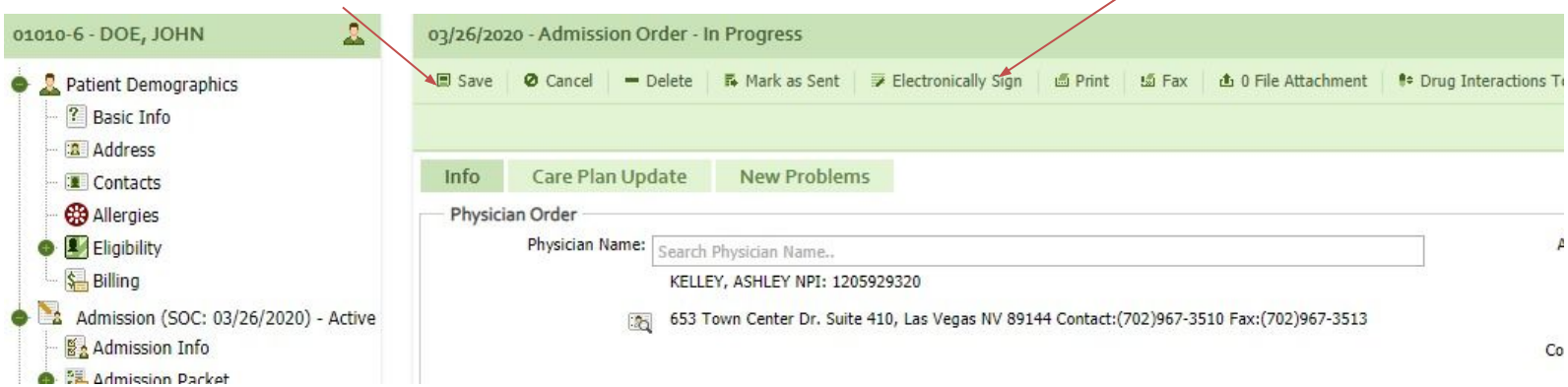
Save often

Step 7



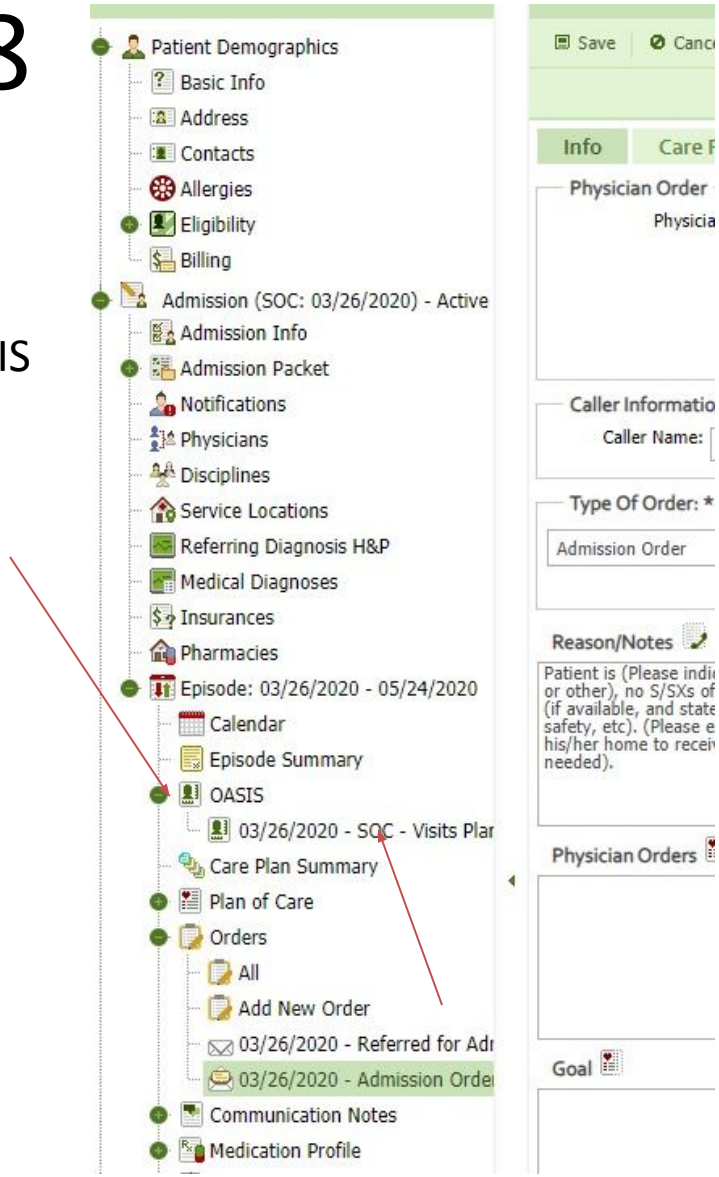
Medication Completion:

- Choose “Insert”
- Enter the “Date” of the prescription
- Start typing in the name of the medication under “Medication”
- Enter appropriate strength, dose, and frequency
- (Please note on Medications that have a finite prescribed period (ie Antibiotics), please enter length of the medication (ie x 4 days, 10-days, etc)
- Check “Lab Needed” box if labs are needed to monitor the medication.
- “Save” often
- When done, “Electronically Sign”



Step 8

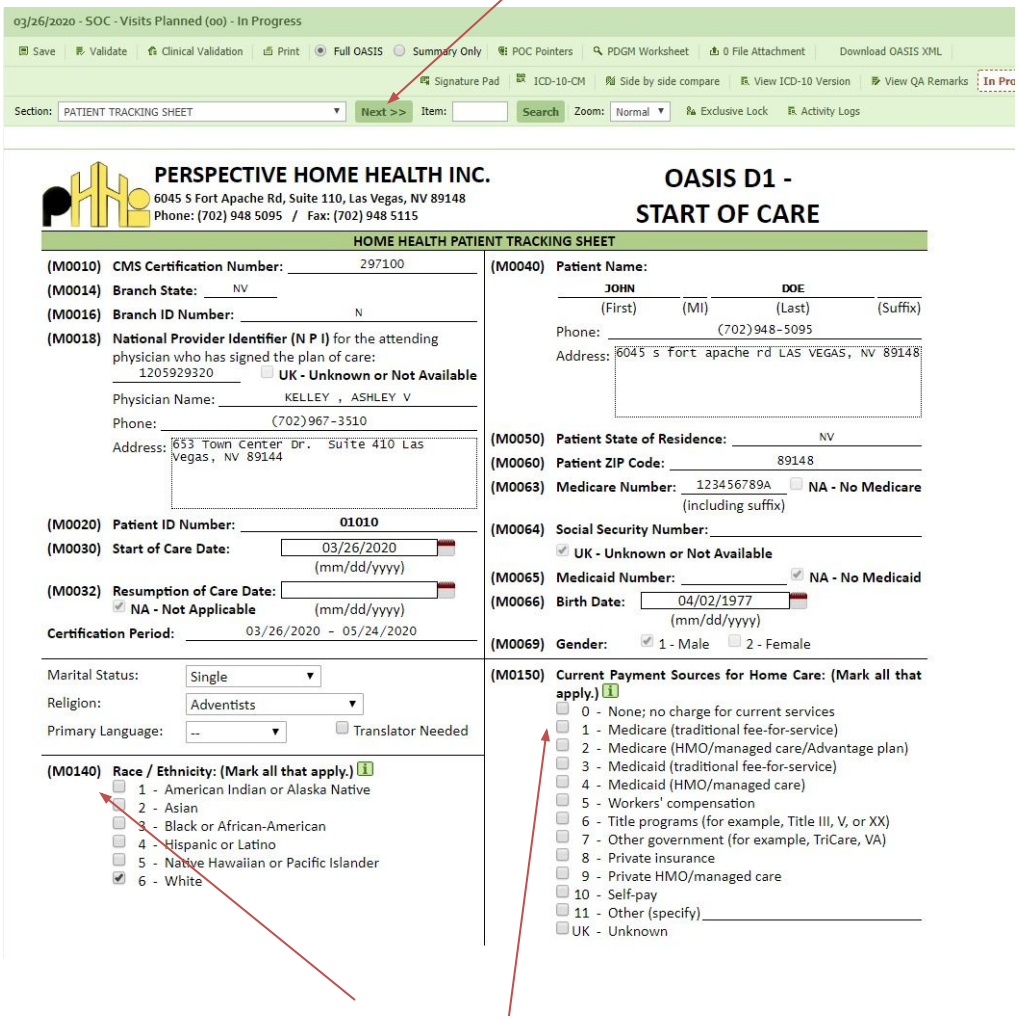
- OASIS Completion
- Choose the OASIS section and chose SOC OASIS



Step 8 (cont)

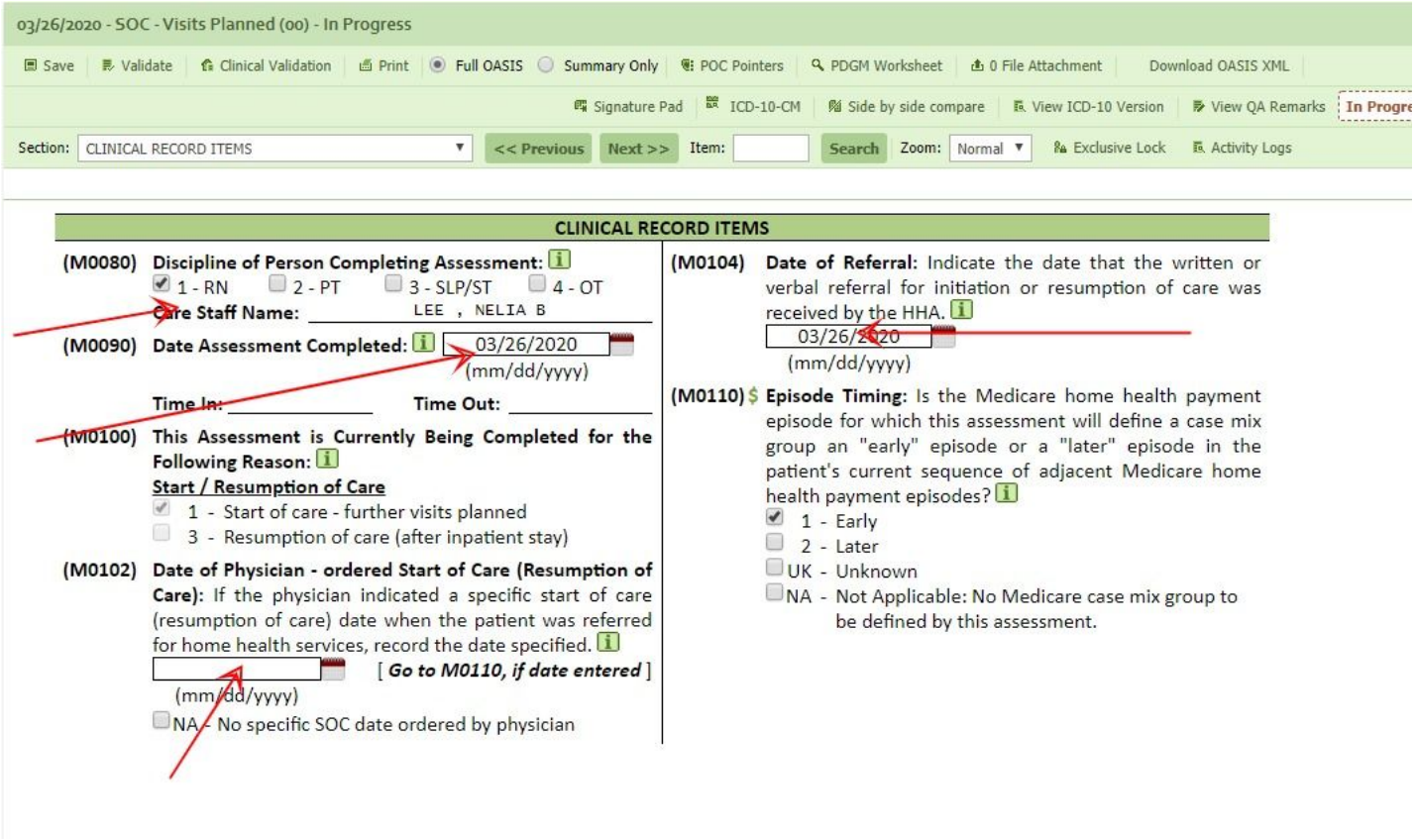
Select the appropriate Race and Payment source

Select next to continue



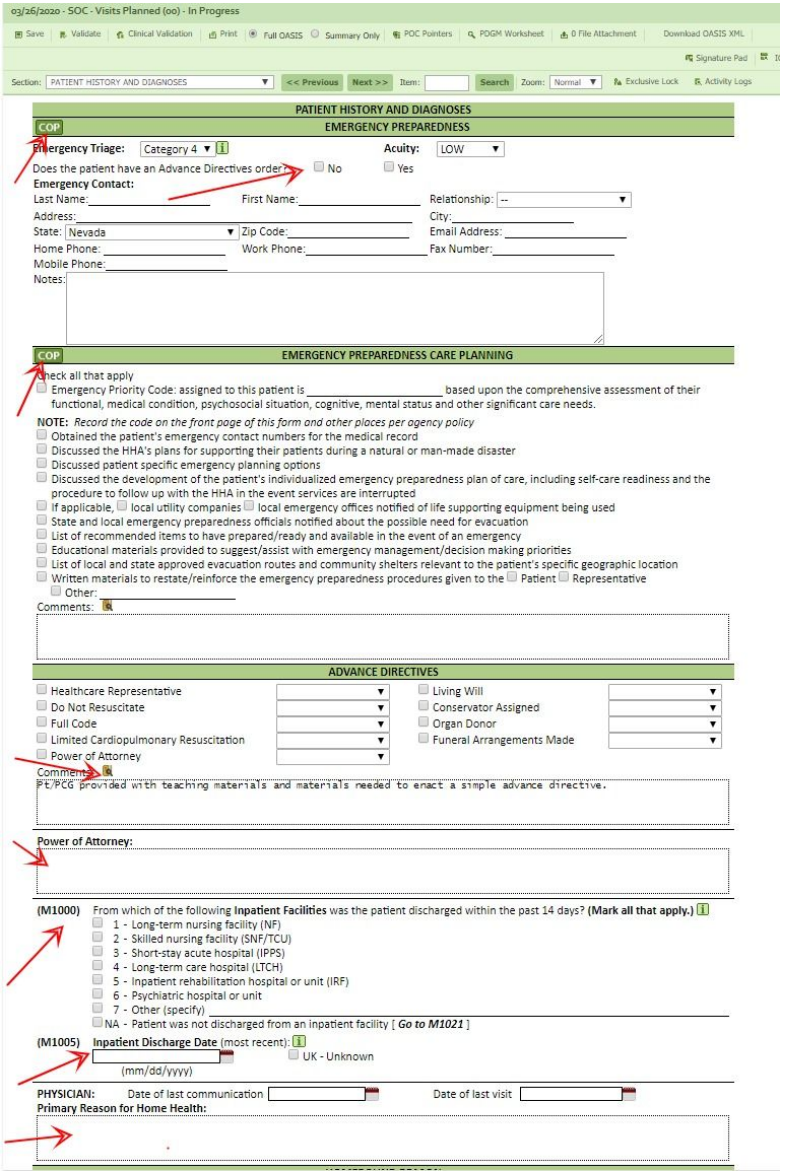
Step 8 (cont)

- Choose disciple type
- Enter staff name
- Confirm referral date or specified SOC date
- Choose “Next” when done



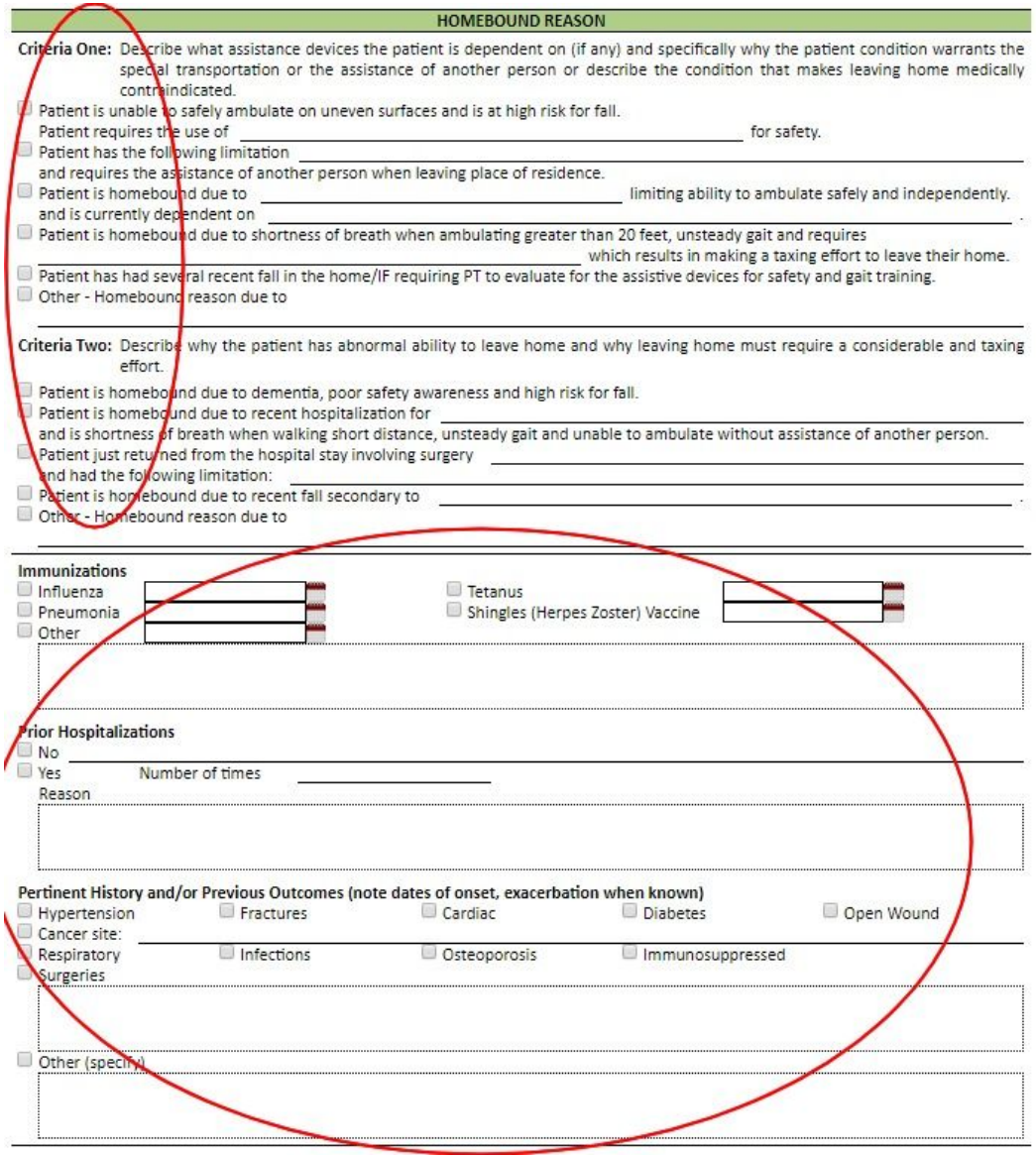
Step 8 (cont)

- Complete all fields appropriately, and pay close attention to all fields labelled with “COP” (Conditions of Participation)
- ALL “COP” fields needs to be completed thoroughly
- Advance Directive information is needed, indicate if none
- If no advance directive, may place “Pt/PCG was educated on advance directives and was provided with educational materials and materials needed to enact a simple advance directive.”
- List POA
- Inpatient DC date must be entered if Pt was DC’d from an inpatient facility within 14-days of the SOC date.
- Primary reason for Home Health. ie “The patient was referred to skilled home health care for a skilled evaluation on home safety, medication management, knowledge deficit, to check vital signs, to provide wound care, to provide therapy, and to provide skilled teachings on observed knowledge deficits.”



Step 8 (cont)

- Complete homebound status and patient medical history.



HOMEBOUND REASON

Criteria One: Describe what assistance devices the patient is dependent on (if any) and specifically why the patient condition warrants the special transportation or the assistance of another person or describe the condition that makes leaving home medically contraindicated.

- ☐ Patient is unable to safely ambulate on uneven surfaces and is at high risk for fall.
  Patient requires the use of _____ for safety.
- ☐ Patient has the following limitation _____
  and requires the assistance of another person when leaving place of residence.
- ☐ Patient is homebound due to _____ limiting ability to ambulate safely and independently.
  and is currently dependent on _____ .
- ☐ Patient is homebound due to shortness of breath when ambulating greater than 20 feet, unsteady gait and requires _____ which results in making a taxing effort to leave their home.
- ☐ Patient has had several recent fall in the home/IF requiring PT to evaluate for the assistive devices for safety and gait training.
- ☐ Other - Homebound reason due to _____

Criteria Two: Describe why the patient has abnormal ability to leave home and why leaving home must require a considerable and taxing effort.

- ☐ Patient is homebound due to dementia, poor safety awareness and high risk for fall.
- ☐ Patient is homebound due to recent hospitalization for _____
  and is shortness of breath when walking short distance, unsteady gait and unable to ambulate without assistance of another person.
- ☐ Patient just returned from the hospital stay involving surgery _____
  and had the following limitation: _____
- ☐ Patient is homebound due to recent fall secondary to _____ .
- ☐ Other - Homebound reason due to _____

Immunizations

- ☐ Influenza
- ☐ Pneumonia
- ☐ Other
- ☐ Tetanus
- ☐ Shingles (Herpes Zoster) Vaccine

Prior Hospitalizations

- ☐ No _____
- ☐ Yes Number of times _____

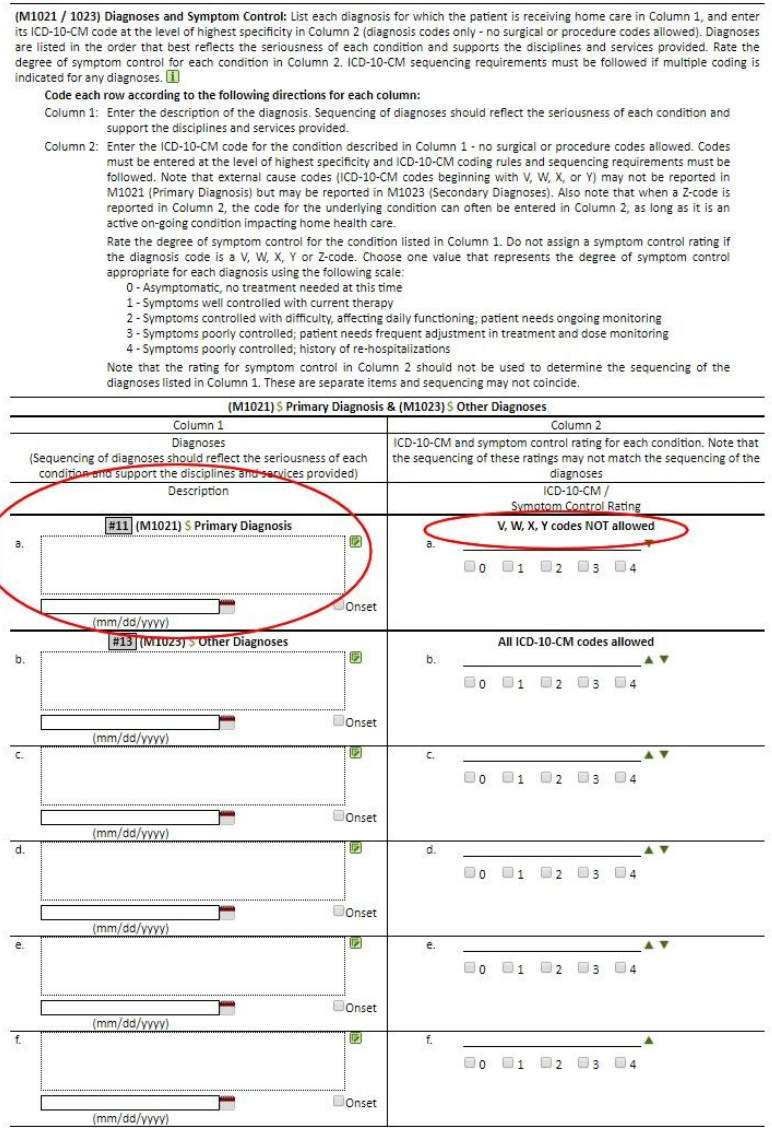
Reason

Pertinent History and/or Previous Outcomes (note dates of onset, exacerbation when known)

- ☐ Hypertension ☐ Fractures ☐ Cardiac ☐ Diabetes ☐ Open Wound
- ☐ Cancer site: _____
- ☐ Respiratory ☐ Infections ☐ Osteoporosis ☐ Immunosuppressed
- ☐ Surgeries
- ☐ Other (specify)

Step 8 (cont)

- Enter diagnosis. May enter by description or by code.



(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 code 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

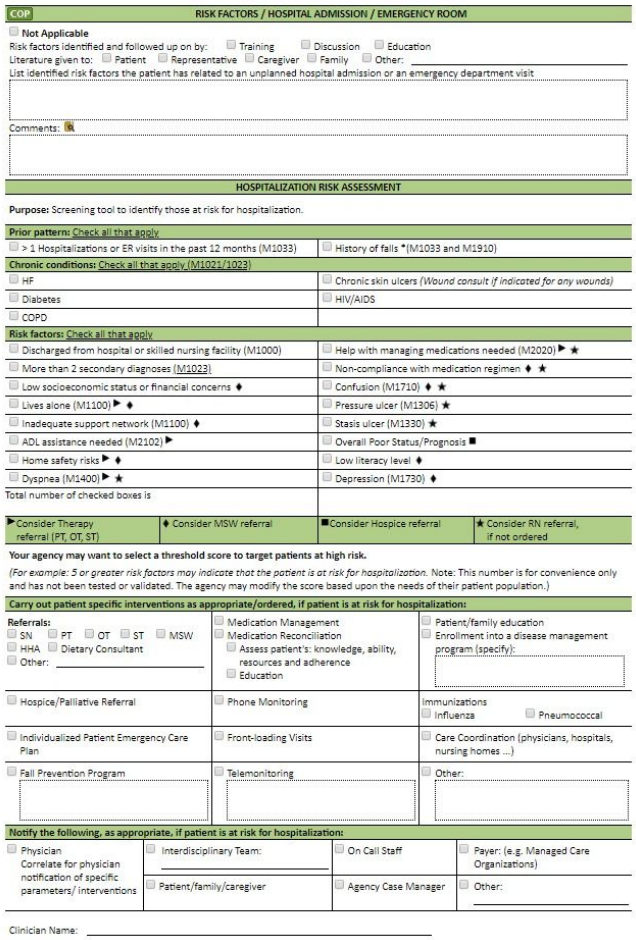
Note that the rating for symptom control in Column 2 should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.

(M1021) $ 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
#11 (M1021) $ Primary Diagnosis a. Onset (mm/dd/yyyy)	V, W, X, Y codes NOT allowed a. 0 1 2 3 4
#13 (M1023) $ Other Diagnoses b. Onset (mm/dd/yyyy)	All ICD-10-CM codes allowed b. 0 1 2 3 4
c. Onset (mm/dd/yyyy)	c. 0 1 2 3 4
d. Onset (mm/dd/yyyy)	d. 0 1 2 3 4
e. Onset (mm/dd/yyyy)	e. 0 1 2 3 4
f. Onset (mm/dd/yyyy)	f. 0 1 2 3 4

Step 8 (cont)

- Continue to complete all "(MXXXX) questions



COP **RISK FACTORS / HOSPITAL ADMISSION / EMERGENCY ROOM**

☐ **Not Applicable**

Risk factors identified and followed up on by: ☐ Training ☐ Discussion ☐ Education

Literature given to: ☐ Patient ☐ Representative ☐ Caregiver ☐ Family ☐ Other: _____

List identified risk factors the patient has related to an unplanned hospital admission or an emergency department visit

Comments:

HOSPITALIZATION RISK ASSESSMENT

Purpose: Screening tool to identify those at risk for hospitalization.

Prior pattern: Check all that apply	
☐ > 1 Hospitalizations or ER visits in the past 12 months (M1033)	☐ History of falls *(M1033 and M1910)
Chronic conditions: Check all that apply (M1021/1023)	
☐ HF	☐ Chronic skin ulcers *(Wound consult if indicated for any wounds)*
☐ Diabetes	☐ HIV/AIDS
☐ COPD	
Risk factors: Check all that apply	
☐ Discharged from hospital or skilled nursing facility (M1000)	☐ Help with managing medications needed (M2020) ▶ ★
☐ More than 2 secondary diagnoses (M1023)	☐ Non-compliance with medication regimen ♦ ★
☐ Low socioeconomic status or financial concerns ♦	☐ Confusion (M1710) ♦ ★
☐ Lives alone (M1100) ▶ ♦	☐ Pressure ulcer (M1306) ★
☐ Inadequate support network (M1100) ♦	☐ Stasis ulcer (M1330) ★
☐ ADL assistance needed (M2102) ▶	☐ Overall Poor Status/Prognosis ■
☐ Home safety risks ▶ ♦	☐ Low literacy level ♦
☐ Dyspnea (M1400) ▶ ★	☐ Depression (M1730) ♦
Total number of checked boxes is	

▶ Consider Therapy referral (PT, OT, ST) | ♦ Consider MSW referral | ■ Consider Hospice referral | ★ Consider RN referral, if not ordered

Your agency may want to select a threshold score to target patients at high risk.

(For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization. Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)

Carry out patient specific interventions as appropriate/ordered, if patient is at risk for hospitalization:

Referrals: ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ HHA ☐ Dietary Consultant ☐ Other: _____	☐ Medication Management ☐ Medication Reconciliation ☐ Assess patient's: knowledge, ability, resources and adherence ☐ Education	☐ Patient/family education ☐ Enrollment into a disease management program (specify):
☐ Hospice/Palliative Referral	☐ Phone Monitoring	Immunizations ☐ Influenza ☐ Pneumococcal
☐ Individualized Patient Emergency Care Plan	☐ Front-loading Visits	☐ Care Coordination (physicians, hospitals, nursing homes ...)
☐ Fall Prevention Program	☐ Telemonitoring	☐ Other:

Notify the following, as appropriate, if patient is at risk for hospitalization:

☐ Physician Correlate for physician notification of specific parameters/ interventions	☐ Interdisciplinary Team: _____	☐ On Call Staff	☐ Payer: (e.g. Managed Care Organizations)
	☐ Patient/family/caregiver	☐ Agency Case Manager	☐ Other: _____

Clinician Name: _____

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

1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐ Yes ☐ No ☐ Not assessed (no information)

2 - Diabetes Mellitus (DM)
☐ Yes ☐ No ☐ Not assessed (no information)

3 - None of the above
☐ Yes ☐ No ☐ Not assessed (no information)

(M1030) $ **Therapies** the patient receives at home: **(Mark all that apply.)**
☐ 1 - Intravenous or infusion therapy (excludes TPN)
☐ 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.)**
☐ 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

Complete hospitalization risk

Height and weight are mandatory
Complete Safety Measures and Prognosis

Clinician Name: _____

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

_____ 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.)

_____ **BMI**

#15 SAFETY MEASURES

☐ 1 - Bleeding precautions	☐ 4 - Fall precautions	☐ 7 - Elevate head of bed	☐ 10 - Lock w/c with transfers
☐ 2 - O2 precautions	☐ 5 - Aspiration precautions	☐ 8 - 24 hr. supervision	☐ 11 - Infection control measures
☐ 3 - Seizure precautions	☐ 6 - Siderails up	☐ 9 - Clear pathways	☐ 12 - Walker/cane

☐ 13 - Other: _____

#20 PROGNOSIS

☐ 1 - Poor ☐ 2 - Guarded ☐ 3 - Fair ☐ 4 - Good ☐ 5 - Excellent

Step 8 (cont)

Living arrangement and PCG information needed

LIVING ARRANGEMENTS

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

Phone Number _____ Relationship _____

List name/relationship of other caregiver(s):

Name: _____ Contact #: _____ Relationship: _____

Name: _____ Contact #: _____ Relationship: _____

Able to safely care for patient ☐ Yes ☐ No

HOME SAFETY ASSESSMENT

- ☐ Architectural Barriers
- ☐ Medications are properly stored
- ☐ No telephone
- ☐ Cluttered surroundings / Obstructed Paths
- ☐ Inadequate railing / grab bars
- ☐ Unsafe oxygen use / storage
- ☐ No fire extinguisher
- ☐ Inadequate electricity / cooling / heating
- ☐ Inadequate supply of water
- ☐ Inadequate sanitation / plumbing
- ☐ Inadequate smoke detectors on all levels of home
- ☐ Unsafe storage of equipments
- ☐ No emergency exit plan
- ☐ Rodent / insect infestation
- ☐ Unsafe electrical wiring
- ☐ Nonworking stove / refrigerator
- ☐ Exposed flammables
- ☐ Inadequate Lighting
- ☐ Other:

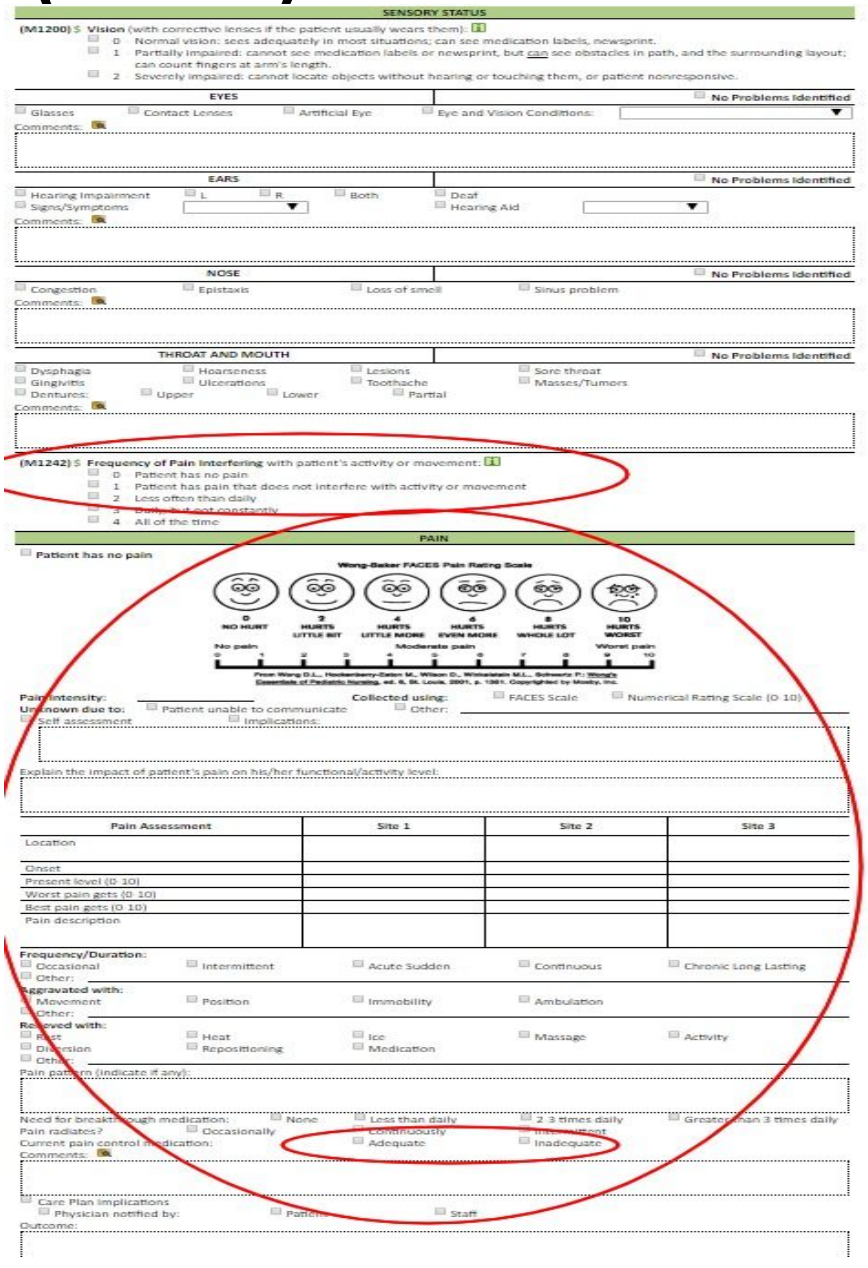
Step 8 (cont)

Complete the sensory status, make sure responses are based on both subjective and objective observation.

M1242 Question asks if and how often does the pain interfere with activities. NOT whether there is pain or not.

Complete the “PAIN” portion even if response to M1242 is “1-4”

Don’t forget to indicate if the current pain measures is/are adequate

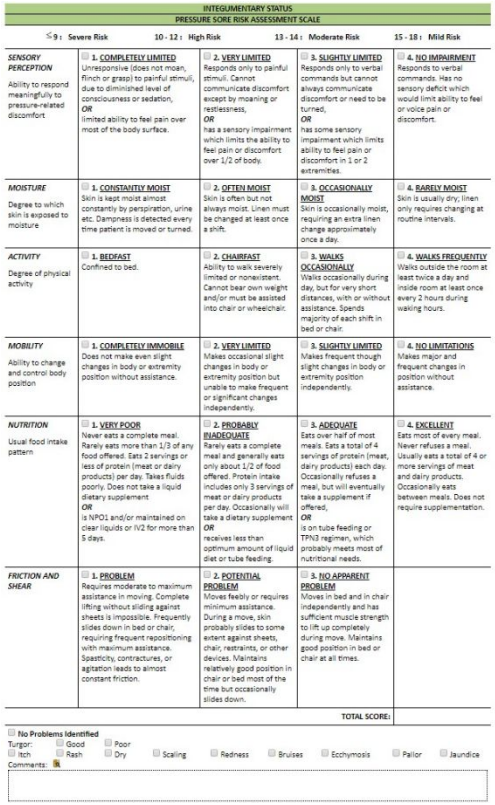


Step 8 (cont)

Complete the endocrine/hematology portion if applies to the patient.

Complete the portion even if we are not treating the patient for any endocrine or hematology ailments.

Choose next when done



INTEGUMENTARY STATUS

PRESSURE SORE RISK ASSESSMENT SCALE

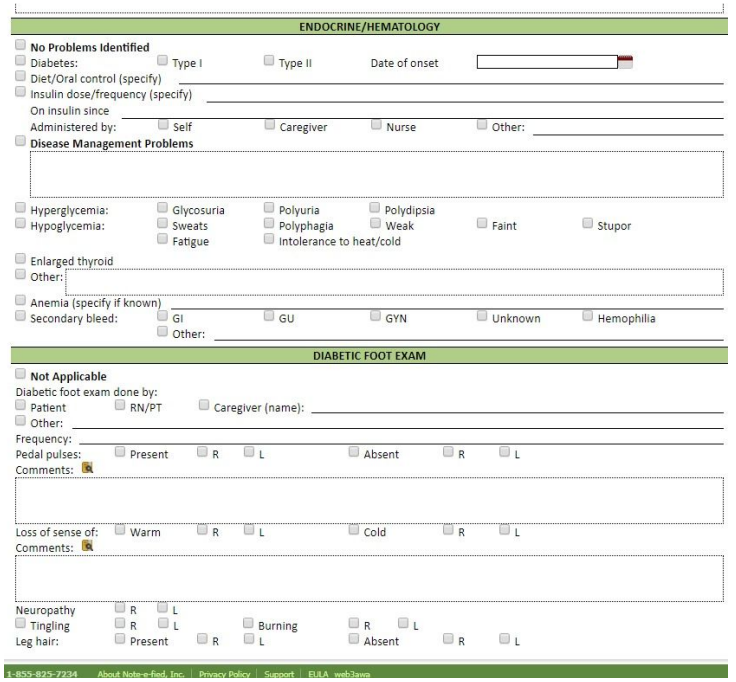
≤9 : Severe Risk	10 - 12 : High Risk	13 - 14 : Moderate Risk	15 - 18 : Mild Risk
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	☐ **1. COMPLETELY LIMITED** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation, ***OR*** limited ability to feel pain over most of the body surface.	☐ **2. VERY LIMITED** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, ***OR*** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	☐ **3. SLIGHTLY LIMITED** Responds only to verbal commands but cannot always communicate discomfort or need to be turned, ***OR*** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	☐ **4. NO IMPAIRMENT** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
MOISTURE Degree to which skin is exposed to moisture	☐ **1. CONSTANTLY MOIST** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	☐ **2. OFTEN MOIST** Skin is often but not always moist. Linen must be changed at least once a shift.	☐ **3. OCCASIONALLY MOIST** Skin is occasionally moist, requiring an extra linen change approximately once a day.	☐ **4. RARELY MOIST** Skin is usually dry; linen only requires changing at routine intervals.
ACTIVITY Degree of physical activity	☐ **1. BEDFAST** Confined to bed.	☐ **2. CHAIRFAST** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	☐ **3. WALKS OCCASIONALLY** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	☐ **4. WALKS FREQUENTLY** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
MOBILITY Ability to change and control body position	☐ **1. COMPLETELY IMMOBILE** Does not make even slight changes in body or extremity position without assistance.	☐ **2. VERY LIMITED** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	☐ **3. SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position independently.	☐ **4. NO LIMITATIONS** Makes major and frequent changes in position without assistance.
NUTRITION Usual food intake pattern	☐ **1. VERY POOR** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement ***OR*** is NPO1 and/or maintained on clear liquids or IV2 for more than 5 days.	☐ **2. PROBABLY INADEQUATE** Rarely eats a complete meal and generally eats only about 1/2 of food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement ***OR*** receives less than optimum amount of liquid diet or tube feeding.	☐ **3. ADEQUATE** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally refuses a meal, but will eventually take a supplement if offered, ***OR*** is on tube feeding or TPN3 regimen, which probably meets most of nutritional needs.	☐ **4. EXCELLENT** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
FRICTION AND SHEAR	☐ **1. PROBLEM** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	☐ **2. POTENTIAL PROBLEM** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	☐ **3. NO APPARENT PROBLEM** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	
			TOTAL SCORE:	

☐ **No Problems Identified**

Turgor: ☐ Good ☐ Poor

☐ Itch ☐ Rash ☐ Dry ☐ Scaling ☐ Redness ☐ Bruises ☐ Ecchymosis ☐ Pallor ☐ Jaundice

Comments:



ENDOCRINE/HEMATOLOGY

☐ **No Problems Identified**

☐ Diabetes: ☐ Type I ☐ Type II Date of onset

☐ Diet/Oral control (specify)

☐ Insulin dose/frequency (specify)

On insulin since

Administered by: ☐ Self ☐ Caregiver ☐ Nurse ☐ Other:

☐ **Disease Management Problems**

☐ Hyperglycemia: ☐ Glycosuria ☐ Polyuria ☐ Polydipsia

☐ Hypoglycemia: ☐ Sweats ☐ Polyphagia ☐ Weak ☐ Faint ☐ Stupor

☐ Fatigue ☐ Intolerance to heat/cold

☐ Enlarged thyroid

☐ Other:

☐ Anemia (specify if known)

☐ Secondary bleed: ☐ GI ☐ GU ☐ GYN ☐ Unknown ☐ Hemophilia

☐ Other:

DIABETIC FOOT EXAM

☐ **Not Applicable**

Diabetic foot exam done by:

☐ Patient ☐ RN/PT ☐ Caregiver (name):

☐ Other:

Frequency:

Pedal pulses: ☐ Present ☐ R ☐ L ☐ Absent ☐ R ☐ L

Comments:

Loss of sense of: ☐ Warm ☐ R ☐ L ☐ Cold ☐ R ☐ L

Comments:

Neuropathy ☐ R ☐ L

☐ Tingling ☐ R ☐ L ☐ Burning ☐ R ☐ L

Leg hair: ☐ Present ☐ R ☐ L ☐ Absent ☐ R ☐ L

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Start completing the integumentary status page.

Step 8 (cont)

- Continue completing the integumentary section.

Definitions.

- **Newly epithelialized:**
  - Wound bed completely covered with new epithelium; and
  - no exudate; and
  - no avascular tissue (eschar and/or slough); and
  - no signs or symptoms of infection.
- **Fully granulating:**
  - Wound bed filled with granulation tissue to the level of the surrounding skin; and
  - no dead space; and
  - no avascular tissue (eschar and/or slough); and
  - no signs or symptoms of infection; and
  - wound edges are open.
- **Early/partial granulation:**
  - Wound bed covered with ≥ 25% of granulation tissue; and
  - wound bed covered with < 25% of avascular tissue (eschar and/or slough); and
  - no signs or symptoms of infection; and
  - wound are edges open.
- **Not healing:**
  - Wound with ≥ 25% avascular tissue (eschar and/or slough); or
  - signs/symptoms of infection; or
  - clean but nongranulating wound bed; or
  - closed/hyperkeratotic wound edges; or
  - persistent failure to improve despite appropriate and comprehensive wound management.
- **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.*

This guidance applies to surgical wounds closed by either primary intention (specifically, approximated incisions) or secondary intention (specifically, open surgical wounds).

(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 pressure ulcers/injuries)
- 0 - No [***Go to M1322***]
- 1 - Yes

(M1311) $ Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a 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/injuries 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**	_____

Pressure Ulcer Stages (NPUAP):

Category/Stage I: Non-blanchable erythema. Intact skin with nonblanchable 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. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk).

Category/Stage II: Partial thickness skin loss. 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 serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury.

Category/Stage III: Full thickness skin loss. Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Category/Stage IV: Full thickness tissue loss. Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable: Depth unknown. Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover and should not be removed.

Suspected Deep Tissue Injury: Depth unknown. 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. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

(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.
- 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.)
- 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?**
- 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 [***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***]

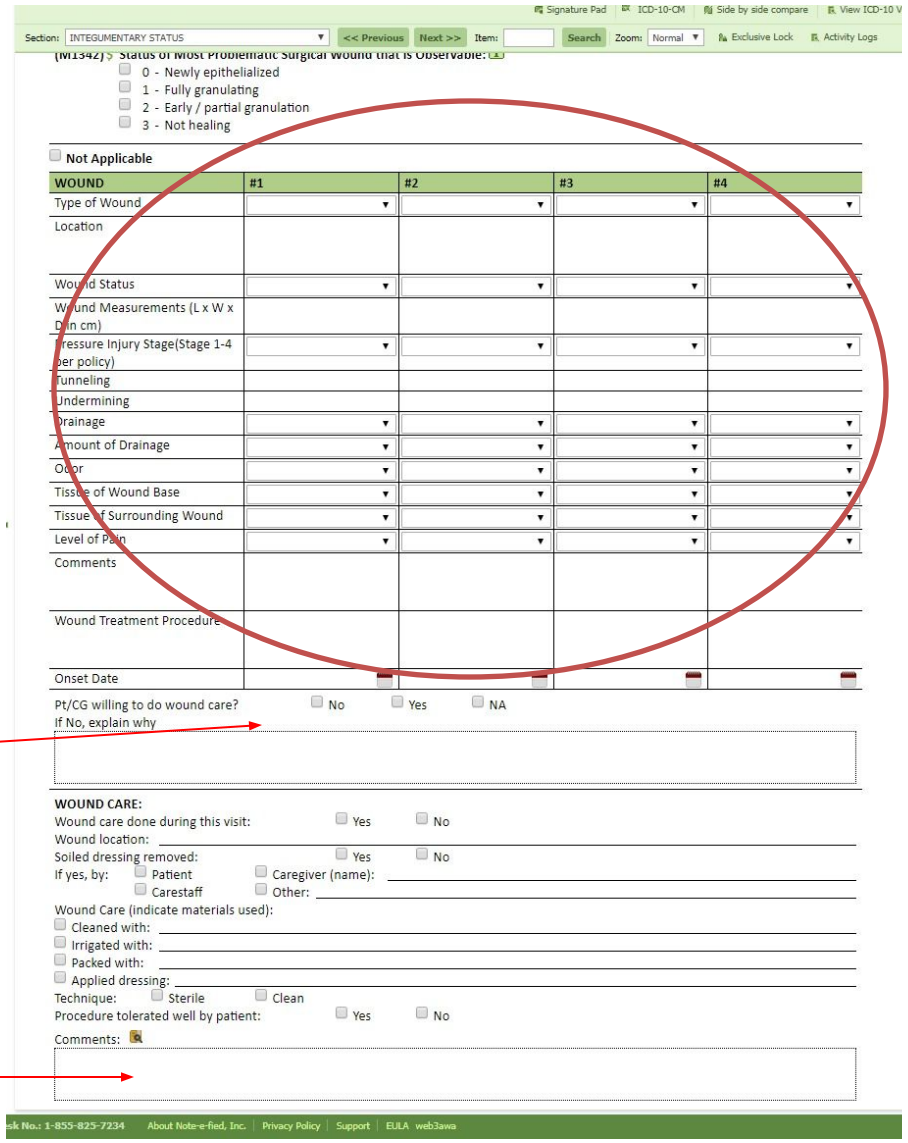
(M1342) $ Status of Most Problematic Surgical Wound that is Observable:
- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early / partial granulation
- 3 - Not healing

Step 8 (cont)

Complete the wound information thoroughly

Indicate why or why can't the Pt/PCG do the wound care but also mention potential to learn wound care

Indicate if the patient is going to a wound care clinic, has WoundTech seeing the patient and/or if SN is not needed for wound care under comments.



Step 8 (cont)

Continue to answer the Respiratory Status

VITAL SIGNS are mandatory

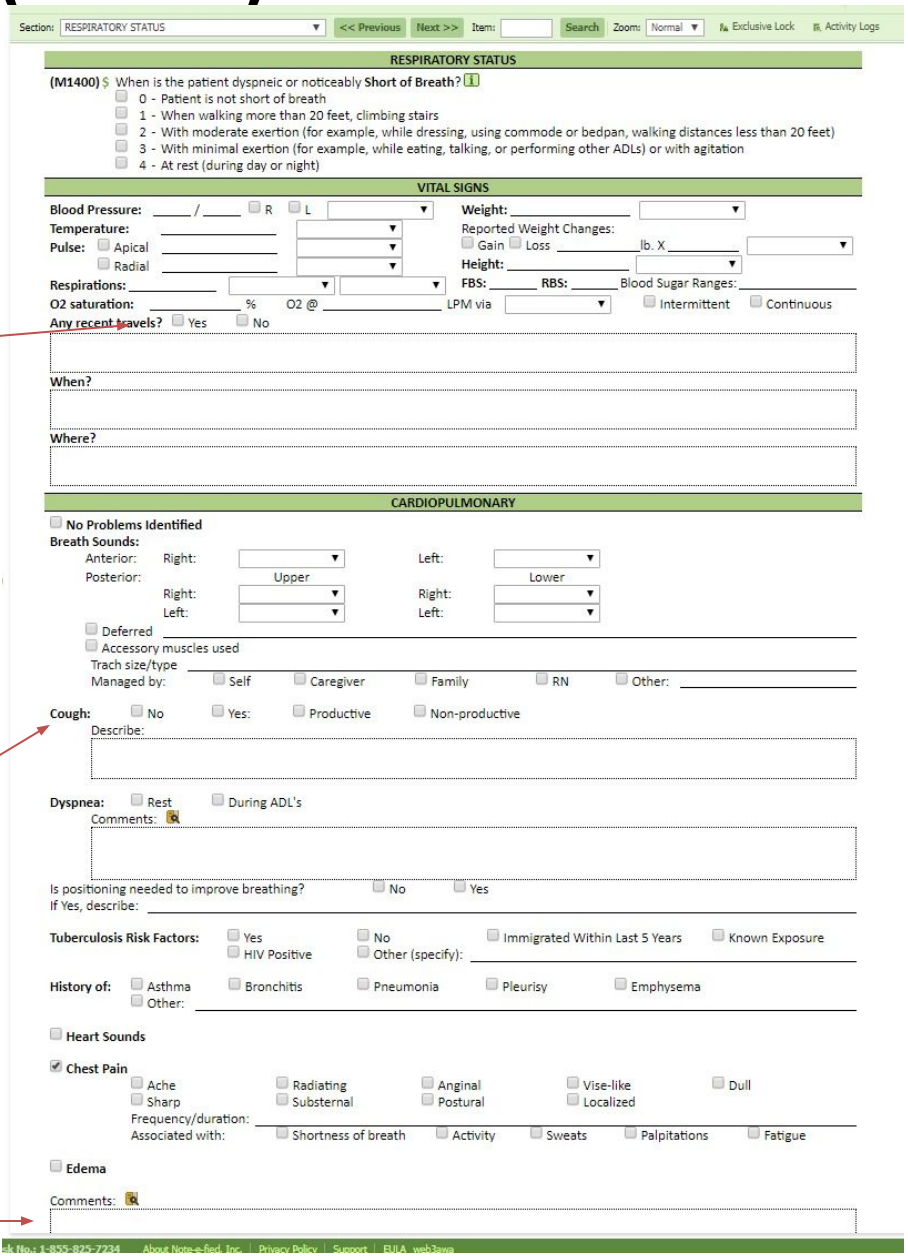
Complete the CARDIOPULMONARY section

Please be consistent with your responses

Note the new COVID-19 screening question when asked about travel information

COVID-19 questioning mandate answering the presence of cough question

Please indicate on the bottom portion on other pertinent responses to COVID-19 questions.



Step 8 (cont)

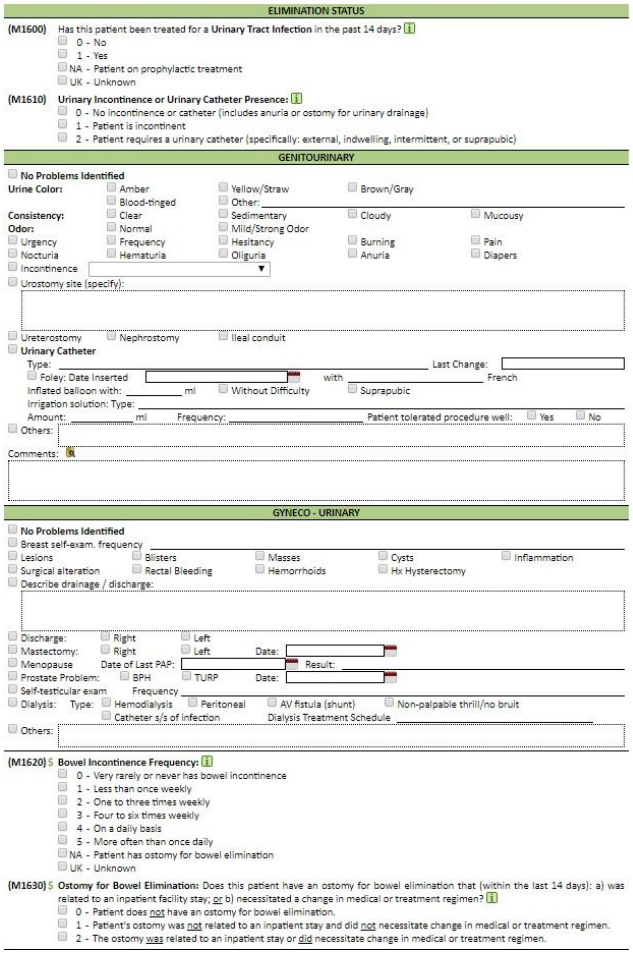
Complete the GI section and Nutritional sections.

Mention if Patient is on dialysis and which days they go to dialysis center

Note Last Bowel Movement and frequency of elimination

Indicate appropriate diet

Complete enteral feedings if present; even if we are not providing enteral feeding care.



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

(M1610) **Urinary Incontinence or Urinary Catheter Presence:**
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)

GENITOURINARY

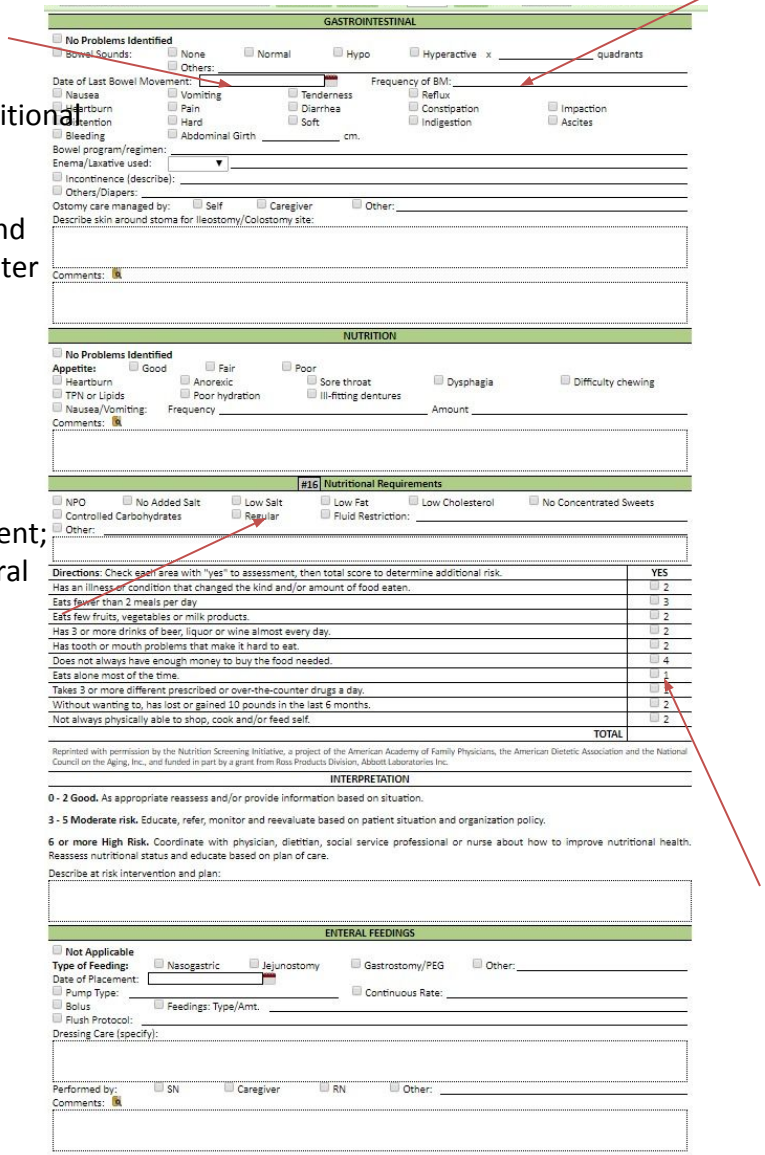
No Problems Identified
Urine Color: Amber, Blood-tinged, Yellow/Straw, Other:, Brown/Gray
Consistency: Clear, Sedimentary, Cloudy, Mucousy
Odor: Normal, Mild/Strong Odor
Urgency, Frequency, Hesitancy, Burning, Pain
Nocturia, Hematuria, Oliguria, Anuria, Diapers
Incontinence
Urostomy site (specify):
Ureterostomy, Nephrostomy, Ileal conduit
Urinary Catheter
Type: Last Change:
Foley: Date Inserted with French
Inflated balloon with: ml Without Difficulty Suprapubic
Irrigation solution: Type:
Amount: ml Frequency: Patient tolerated procedure well: Yes No
Others:
Comments:

GYNECO - URINARY

No Problems Identified
Breast self-exam. frequency
Lesions, Blisters, Masses, Cysts, Inflammation
Surgical alteration, Rectal Bleeding, Hemorrhoids, Hx Hysterectomy
Describe drainage / discharge:
Discharge: Right Left
Mastectomy: Right Left Date:
Menopause Date of Last PAP: Result:
Prostate Problem: BPH TURP Date:
Self-testicular exam Frequency
Dialysis: Type: Hemodialysis, Peritoneal, AV fistula (shunt), Non-palpable thrill/no bruit
Catheter s/s of infection Dialysis Treatment Schedule
Others:

(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

(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?
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.



GASTROINTESTINAL

No Problems Identified
Bowel Sounds: None, Normal, Hypo, Hyperactive x quadrants
Others:
Date of Last Bowel Movement: Frequency of BM:
Nausea, Vomiting, Tenderness, Reflux
Heartburn, Pain, Diarrhea, Constipation, Impaction
Distention, Hard, Soft, Indigestion, Ascites
Bleeding, Abdominal Girth cm.
Bowel program/regimen:
Enema/Laxative used:
Incontinence (describe):
Others/Diapers:
Ostomy care managed by: Self, Caregiver, Other:
Describe skin around stoma for Ileostomy/Colostomy site:
Comments:

NUTRITION

No Problems Identified
Appetite: Good, Fair, Poor
Heartburn, Anorexic, Sore throat, Dysphagia, Difficulty chewing
TPN or Lipids, Poor hydration, Ill-fitting dentures
Nausea/Vomiting: Frequency Amount
Comments:

#16 Nutritional Requirements

NPO, No Added Salt, Low Salt, Low Fat, Low Cholesterol, No Concentrated Sweets
Controlled Carbohydrates, Regular, Fluid Restriction:
Other:

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	

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INTERPRETATION

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

Not Applicable
Type of Feeding: Nasogastric, Jejunostomy, Gastrostomy/PEG, Other:
Date of Placement:
Pump Type: Continuous Rate:
Bolus Feedings: Type/Amt.
Flush Protocol:
Dressing Care (specify):
Performed by: SN, Caregiver, RN, Other:
Comments:

Step 8 (cont)

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

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

- 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	N/A 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.)**

- 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

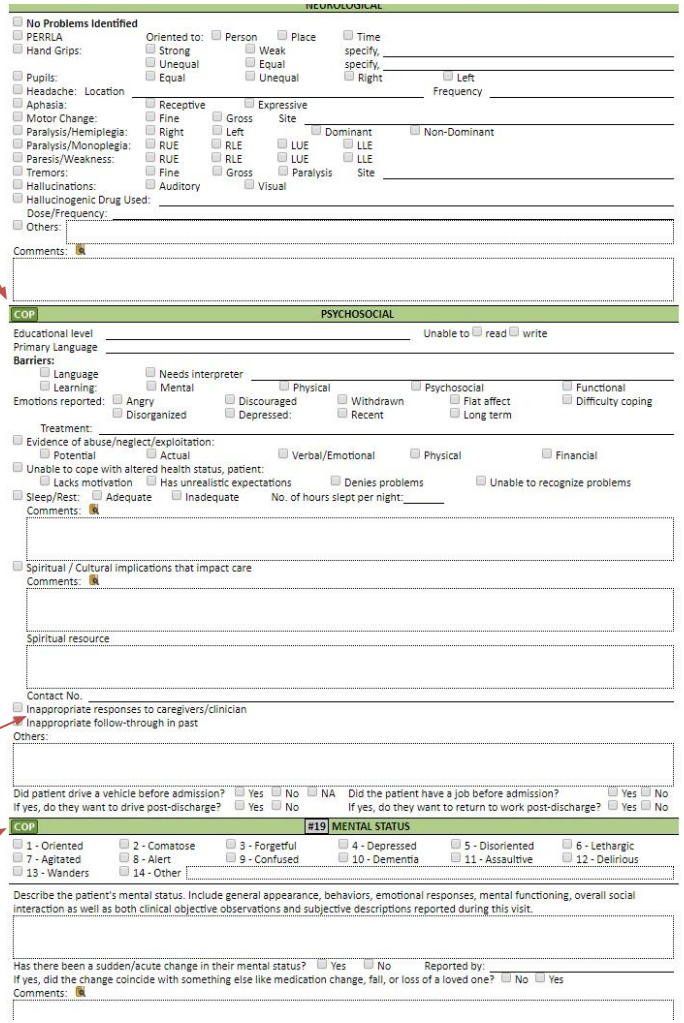
(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed): Any physical, verbal, or other disruptive / dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- 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

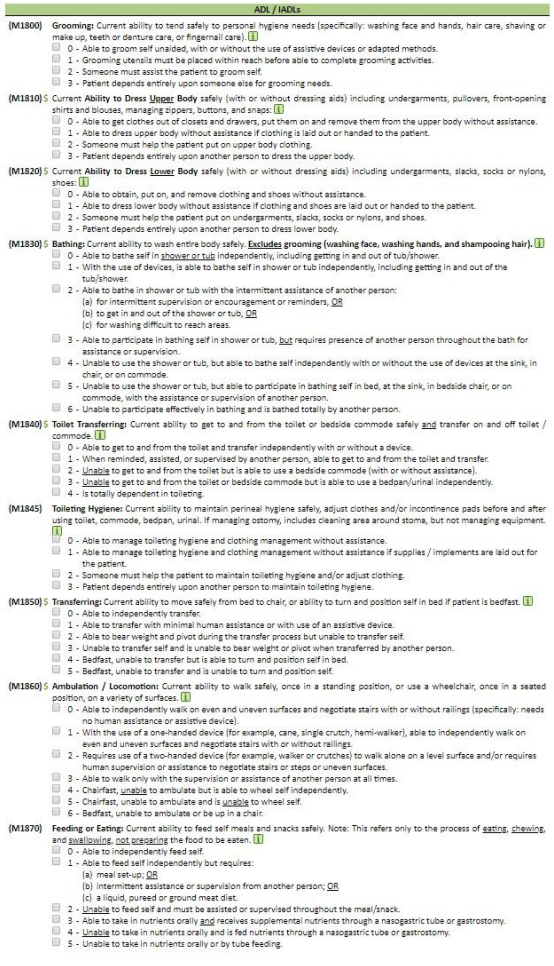
Complete NEURO section

If patient has indicator of being slightly none compliant, make sure to check # 2 in M1740 and indicate "Inappropriate follow-through in past

Complete "COP" sections



Step 8 (cont)



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.

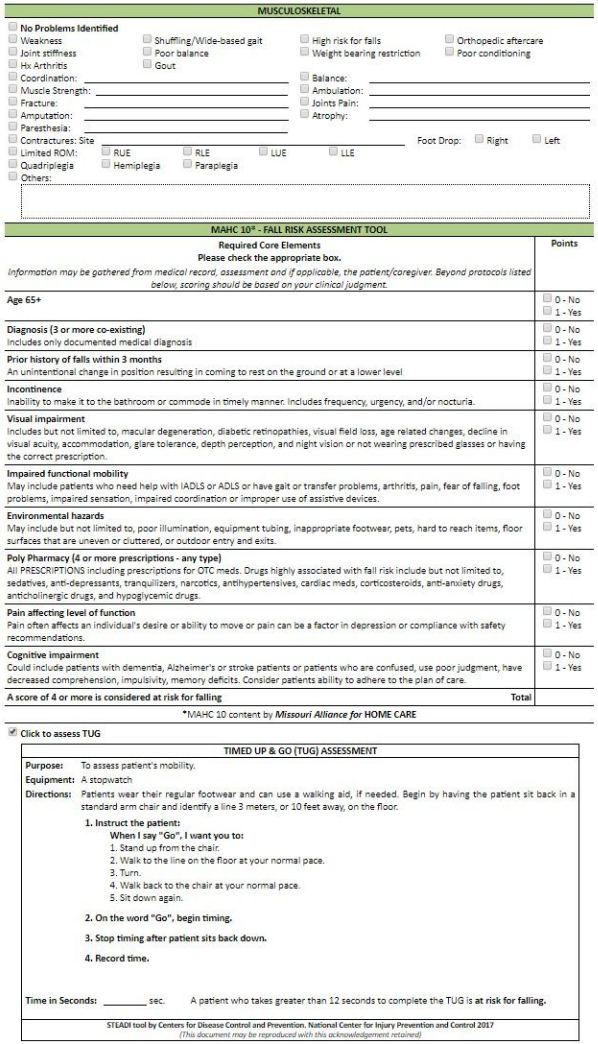
(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet / commode.
- 0 - Able to get to and from the toilet and transfer independently with or without a device.
- 1 - When reminded, assisted, or supervised by another person, 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.



MUSCULOSKELETAL

No Problems Identified

Weakness; Shuffling/Wide-based gait; High risk for falls; Orthopedic aftercare
Joint stiffness; Poor balance; Weight bearing restriction; Poor conditioning
Hx Arthritis; Gout
Coordination: ____ Balance: ____
Muscle Strength: ____ Ambulation: ____
Fracture: ____ Joints Pain: ____
Amputation: ____ Atrophy: ____
Paresthesia: ____
Contractures: Site ____ Foot Drop: Right Left
Limited ROM: RUE RLE LUE LLE
Quadriplegia Hemiplegia Paraplegia
Others:

MAHC 10® - FALL RISK ASSESSMENT TOOL

Required Core Elements
Please check the appropriate box.
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+	0 - No; 1 - Yes
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis	0 - No; 1 - Yes
Prior history of falls within 3 months An unintentional change in position resulting in coming to rest on the ground or at a lower level	0 - No; 1 - Yes
Incontinence Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.	0 - No; 1 - Yes
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.	0 - No; 1 - Yes
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.	0 - No; 1 - Yes
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.	0 - No; 1 - Yes
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.	0 - No; 1 - Yes
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.	0 - No; 1 - Yes
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 patients ability to adhere to the plan of care.	0 - No; 1 - Yes
A score of 4 or more is considered at risk for falling **Total**	

*MAHC 10 content by ***Missouri Alliance for* HOME CARE**

Click to assess TUG

TIMED UP & GO (TUG) ASSESSMENT

Purpose: To assess patient's mobility.
Equipment: A stopwatch
Directions: Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

1. Instruct the patient:
When I say "Go", I want you to:
1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

2. On the word "Go", begin timing.

3. Stop timing after patient sits back down.

4. Record time.

Time in Seconds: _____ sec. A patient who takes greater than 12 seconds to complete the TUG is **at risk for falling.**

STEADI tool by Centers for Disease Control and Prevention. National Center for Injury Prevention and Control 2017
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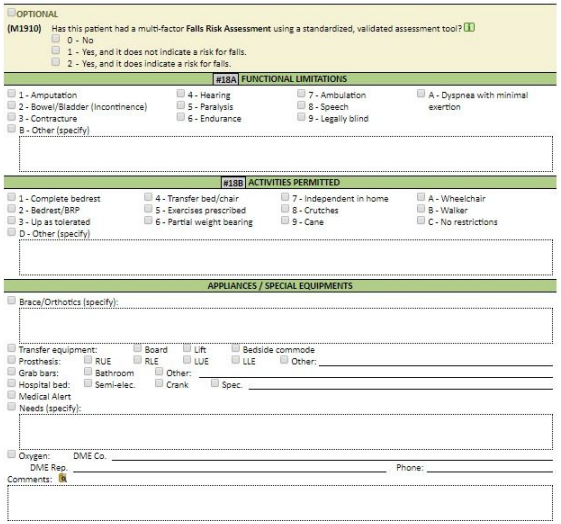


OPTIONAL

(M1910) Has this patient had a multi-factor **Falls Risk Assessment** using a standardized, validated assessment tool?
- 0 - No
- 1 - Yes, and it does not indicate a risk for falls.
- 2 - Yes, and it does indicate a risk for falls.

#18A FUNCTIONAL LIMITATIONS

1 - Amputation; 4 - Hearing; 7 - Ambulation; A - Dyspnea with minimal exertion
2 - Bowel/Bladder (Incontinence); 5 - Paralysis; 8 - Speech
3 - Contracture; 6 - Endurance; 9 - Legally blind
B - Other (specify)

#18B ACTIVITIES PERMITTED

1 - Complete bedrest; 4 - Transfer bed/chair; 7 - Independent in home; A - Wheelchair
2 - Bedrest/BRP; 5 - Exercises prescribed; 8 - Crutches; B - Walker
3 - Up as tolerated; 6 - Partial weight bearing; 9 - Cane; C - No restrictions
D - Other (specify)

APPLIANCES / SPECIAL EQUIPMENTS

Brace/Orthotics (specify):
Transfer equipment: Board Lift Bedside commode
Prosthesis: RUE RLE LUE LLE Other: ____
Grab bars: Bathroom Other: ____
Hospital bed: Semi-elec. Crank Spec. ____
Medical Alert
Needs (specify):
Oxygen: DME Co. ____
DME Rep. ____ Phone: ____
Comments:

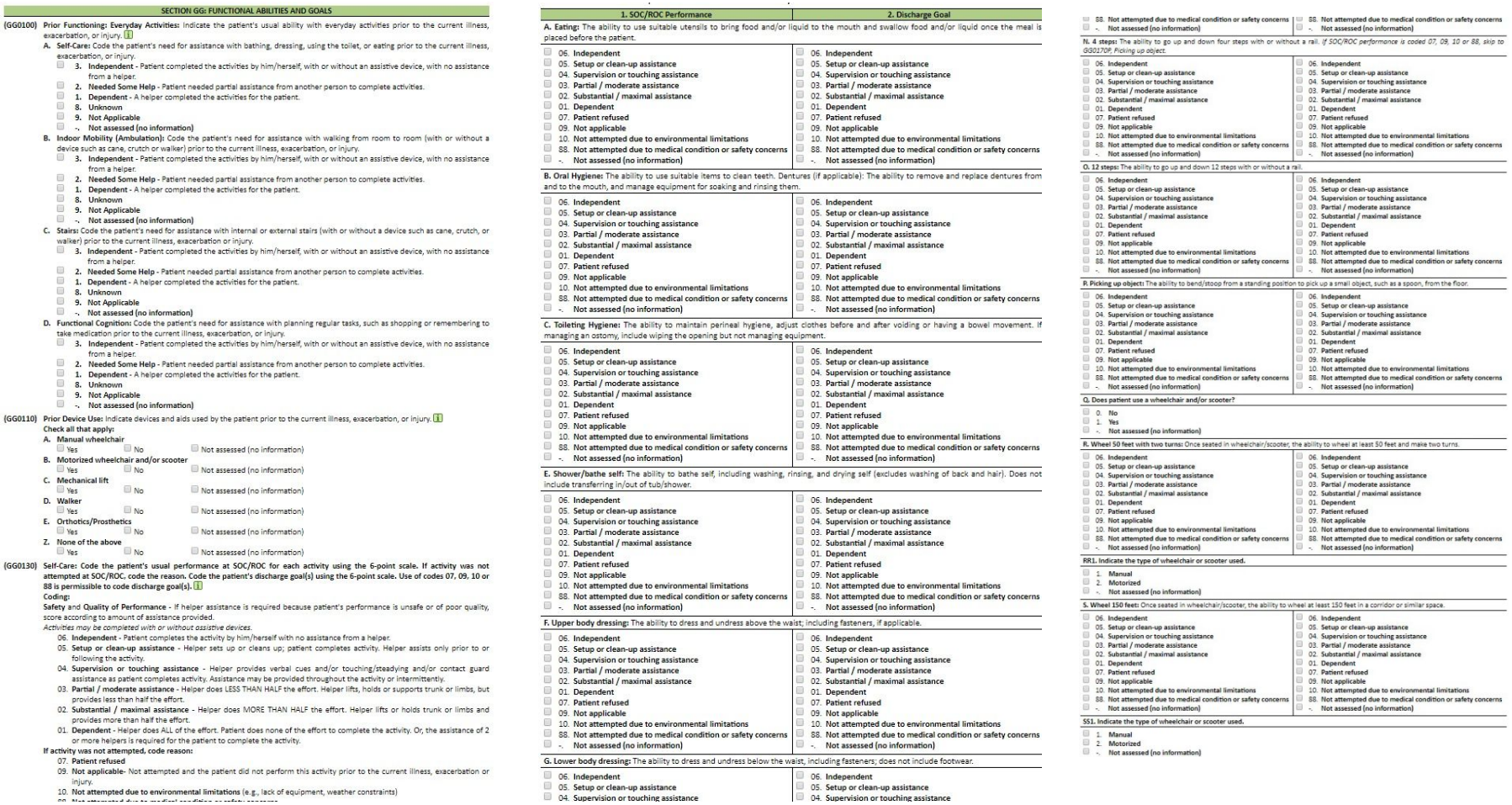
Complete ADL/IADLs section using both subjective and objective observation.

"Can patients be safer?"

Please think "within the past 7-days" when answering questions

Must indicate Functional Limitation and Activities Permitted

Step 8 (cont)



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.

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.
- 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**
- -. **Not assessed (no information)**

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.
- 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**
- -. **Not assessed (no information)**

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.
- 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**
- -. **Not assessed (no information)**

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.
- 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**
- -. **Not assessed (no information)**

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

Check all that apply:

	Yes	No	Not assessed (no information)
A. Manual wheelchair			
B. Motorized wheelchair and/or scooter			
C. Mechanical lift			
D. Walker			
E. Orthotics/Prosthetics			
Z. None of the above			

(GG0130) Self-Care: 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)

1. SOC/ROC Performance	2. Discharge Goal
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.	
06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance
03. Partial / moderate assistance	03. Partial / moderate assistance
02. Substantial / maximal assistance	02. Substantial / maximal assistance
01. Dependent	01. Dependent
07. Patient refused	07. Patient refused
09. Not applicable	09. Not applicable
10. Not attempted due to environmental limitations	10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)
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.	
06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance
03. Partial / moderate assistance	03. Partial / moderate assistance
02. Substantial / maximal assistance	02. Substantial / maximal assistance
01. Dependent	01. Dependent
07. Patient refused	07. Patient refused
09. Not applicable	09. Not applicable
10. Not attempted due to environmental limitations	10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)
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.	
06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance
03. Partial / moderate assistance	03. Partial / moderate assistance
02. Substantial / maximal assistance	02. Substantial / maximal assistance
01. Dependent	01. Dependent
07. Patient refused	07. Patient refused
09. Not applicable	09. Not applicable
10. Not attempted due to environmental limitations	10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)
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.	
06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance
03. Partial / moderate assistance	03. Partial / moderate assistance
02. Substantial / maximal assistance	02. Substantial / maximal assistance
01. Dependent	01. Dependent
07. Patient refused	07. Patient refused
09. Not applicable	09. Not applicable
10. Not attempted due to environmental limitations	10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)
F. Upper body dressing: The ability to dress and undress above the waist, including fasteners, if applicable.	
06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance
03. Partial / moderate assistance	03. Partial / moderate assistance
02. Substantial / maximal assistance	02. Substantial / maximal assistance
01. Dependent	01. Dependent
07. Patient refused	07. Patient refused
09. Not applicable	09. Not applicable
10. Not attempted due to environmental limitations	10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)
G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.	
06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance

88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)

N. 4 steps: The ability 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 GG0170F, Picking up object.*

06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance
03. Partial / moderate assistance	03. Partial / moderate assistance
02. Substantial / maximal assistance	02. Substantial / maximal assistance
01. Dependent	01. Dependent
07. Patient refused	07. Patient refused
09. Not applicable	09. Not applicable
10. Not attempted due to environmental limitations	10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)

O. 12 steps: The ability to go up and down 12 steps with or without a rail.

06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance
03. Partial / moderate assistance	03. Partial / moderate assistance
02. Substantial / maximal assistance	02. Substantial / maximal assistance
01. Dependent	01. Dependent
07. Patient refused	07. Patient refused
09. Not applicable	09. Not applicable
10. Not attempted due to environmental limitations	10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)

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.

06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance
03. Partial / moderate assistance	03. Partial / moderate assistance
02. Substantial / maximal assistance	02. Substantial / maximal assistance
01. Dependent	01. Dependent
07. Patient refused	07. Patient refused
09. Not applicable	09. Not applicable
10. Not attempted due to environmental limitations	10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)

Q. Does patient use a wheelchair and/or scooter?
- 0. No
- 1. Yes
- -. Not assessed (no information)

R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance
03. Partial / moderate assistance	03. Partial / moderate assistance
02. Substantial / maximal assistance	02. Substantial / maximal assistance
01. Dependent	01. Dependent
07. Patient refused	07. Patient refused
09. Not applicable	09. Not applicable
10. Not attempted due to environmental limitations	10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)

RR1. Indicate the type of wheelchair or scooter used.
- 1. Manual
- 2. Motorized
- -. Not assessed (no information)

S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

06. Independent	06. Independent
05. Setup or clean-up assistance	05. Setup or clean-up assistance
04. Supervision or touching assistance	04. Supervision or touching assistance
03. Partial / moderate assistance	03. Partial / moderate assistance
02. Substantial / maximal assistance	02. Substantial / maximal assistance
01. Dependent	01. Dependent
07. Patient refused	07. Patient refused
09. Not applicable	09. Not applicable
10. Not attempted due to environmental limitations	10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns	88. Not attempted due to medical condition or safety concerns
-. Not assessed (no information)	-. Not assessed (no information)

SS1. Indicate the type of wheelchair or scooter used.
- 1. Manual
- 2. Motorized
- -. Not assessed (no information)

Under Functional Status, please assess the tasks if possible. If not, use subjective and objective observation to answer.

Please refrain from answering “Not assessed”.

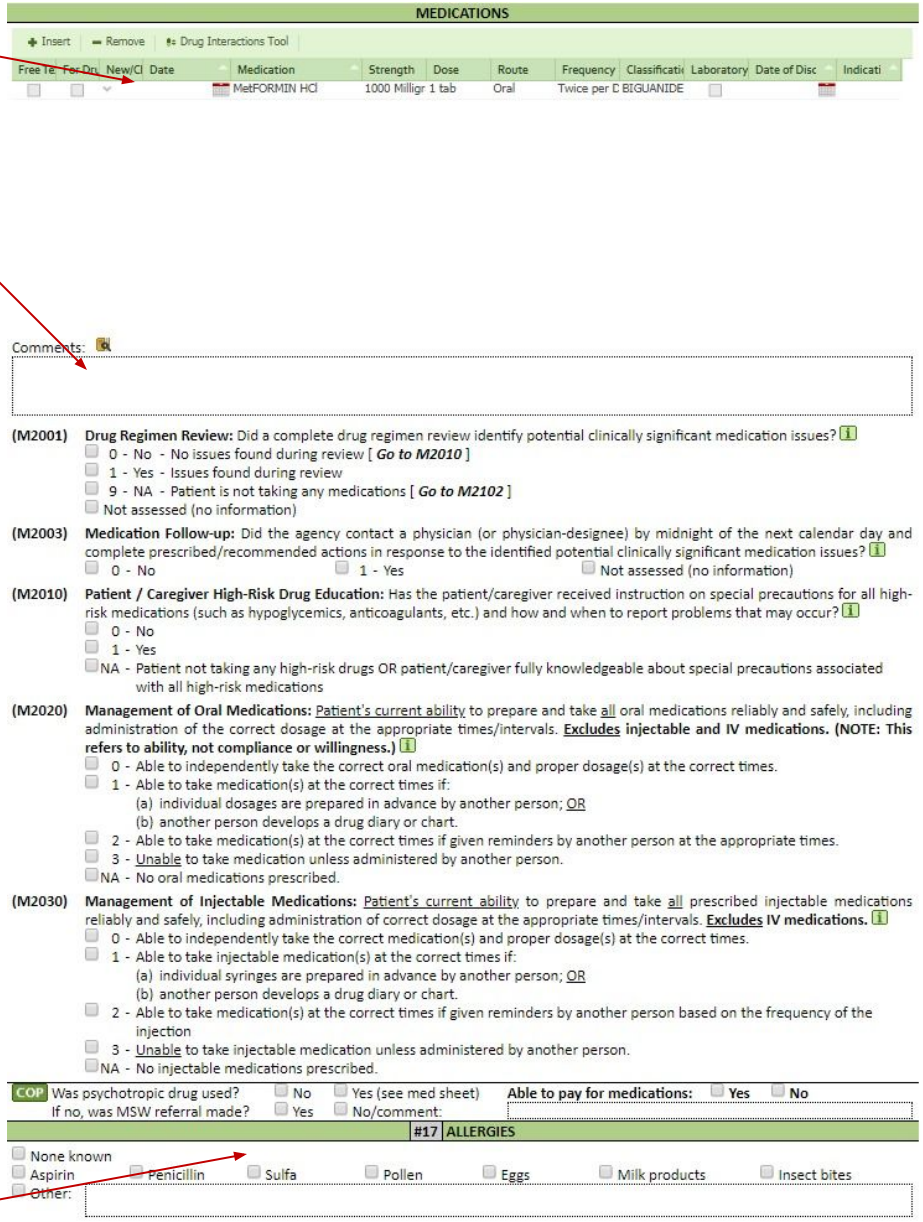
Step 8 (cont)

Medications should populate under Medication section if it was properly entered in the Admission Order

Please indicate under comments on Patient compliance/none compliance, etc with medication

If patient has IV ABX, please indicate route (PIV, PIC, Port-A-Cath), where IV is located, capacity for Pt/PCG to learn and take over IV, and/or if specialty pharmacy nurse is managing IV instead of us

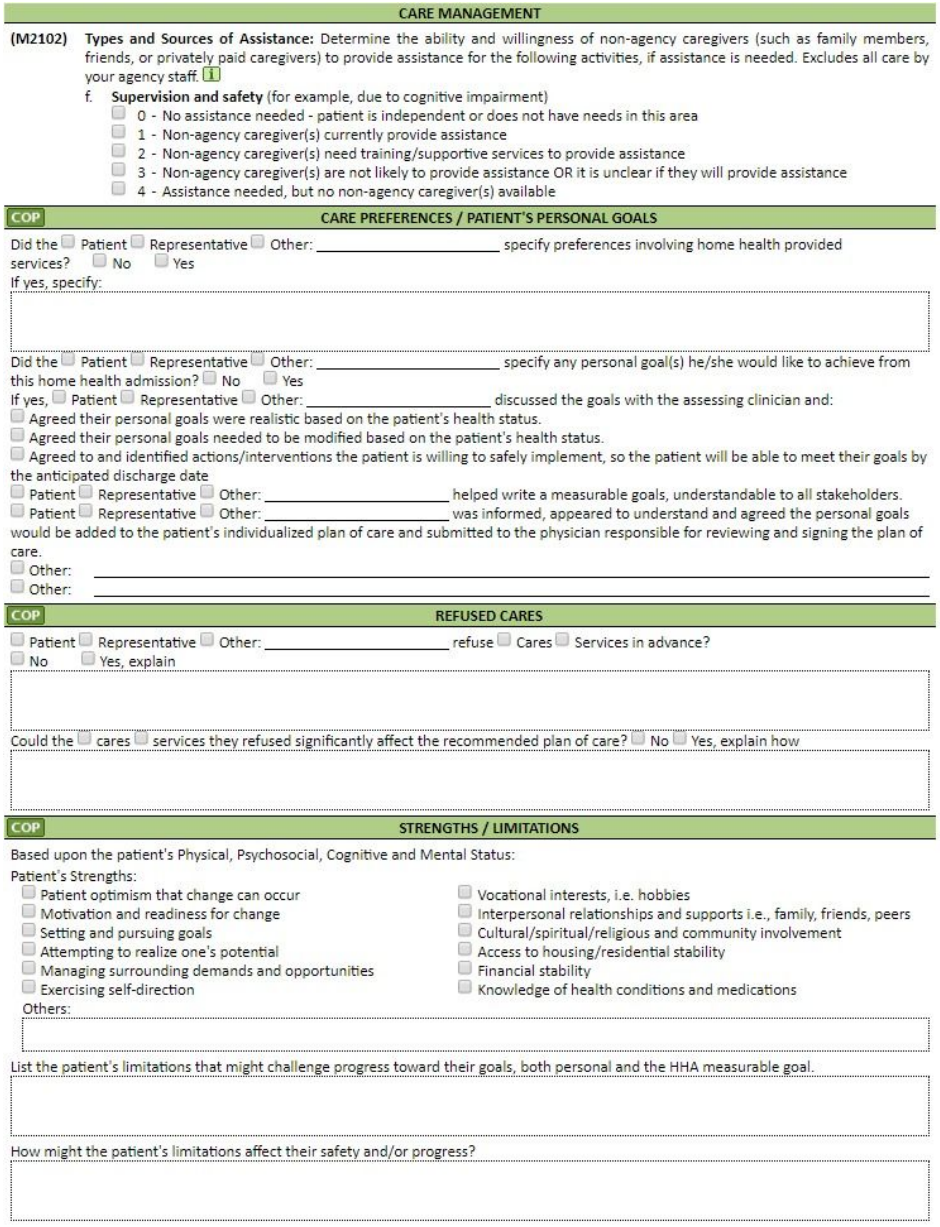
Enter all known ALLERGIES



Step 8 (cont)

Complete the whole section, especially the “COP” sections

Proper completion will help “paint” a better picture of the care and other circumstances that may hamper care and goals.



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.

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

- ☐ 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

COP **CARE PREFERENCES / PATIENT'S PERSONAL GOALS**

Did the ☐ Patient ☐ Representative ☐ Other: _____ specify preferences involving home health provided services? ☐ No ☐ Yes

If yes, specify:

Did the ☐ Patient ☐ Representative ☐ Other: _____ specify any personal goal(s) he/she would like to achieve from this home health admission? ☐ No ☐ Yes

If yes, ☐ Patient ☐ Representative ☐ Other: _____ discussed the goals with the assessing clinician and:

- ☐ Agreed their personal goals were realistic based on the patient's health status.
- ☐ Agreed their personal goals 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 goals by the anticipated discharge date
- ☐ Patient ☐ Representative ☐ Other: _____ helped write a measurable goals, understandable to all stakeholders.
- ☐ Patient ☐ Representative ☐ Other: _____ was informed, appeared to understand and agreed the personal goals 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: _____

COP **REFUSED CARES**

☐ Patient ☐ Representative ☐ Other: _____ refuse ☐ Cares ☐ Services in advance?
☐ No ☐ Yes, explain

Could the ☐ cares ☐ services they refused significantly affect the recommended plan of care? ☐ No ☐ Yes, explain how

COP **STRENGTHS / LIMITATIONS**

Based upon the patient's Physical, Psychosocial, Cognitive and Mental Status:

Patient's Strengths:

- ☐ Patient optimism that change can occur
- ☐ Motivation and readiness for change
- ☐ Setting and pursuing goals
- ☐ Attempting to realize one's potential
- ☐ Managing surrounding demands and opportunities
- ☐ Exercising self-direction
- ☐ Vocational interests, i.e. hobbies
- ☐ Interpersonal relationships and supports i.e., family, friends, peers
- ☐ Cultural/spiritual/religious and community involvement
- ☐ Access to housing/residential stability
- ☐ Financial stability
- ☐ Knowledge of health conditions and medications

Others:

List the patient's limitations that might challenge progress toward their goals, both personal and the HHA measurable goal.

How might the patient's limitations affect their safety and/or progress?

Step 8 (cont)

Enter anticipated amount of therapy visit

Enter all DME (both present and to be ordered)

Under PATIENT/PRIMARY CAREGIVER EDUCATION… you may enter the following template:

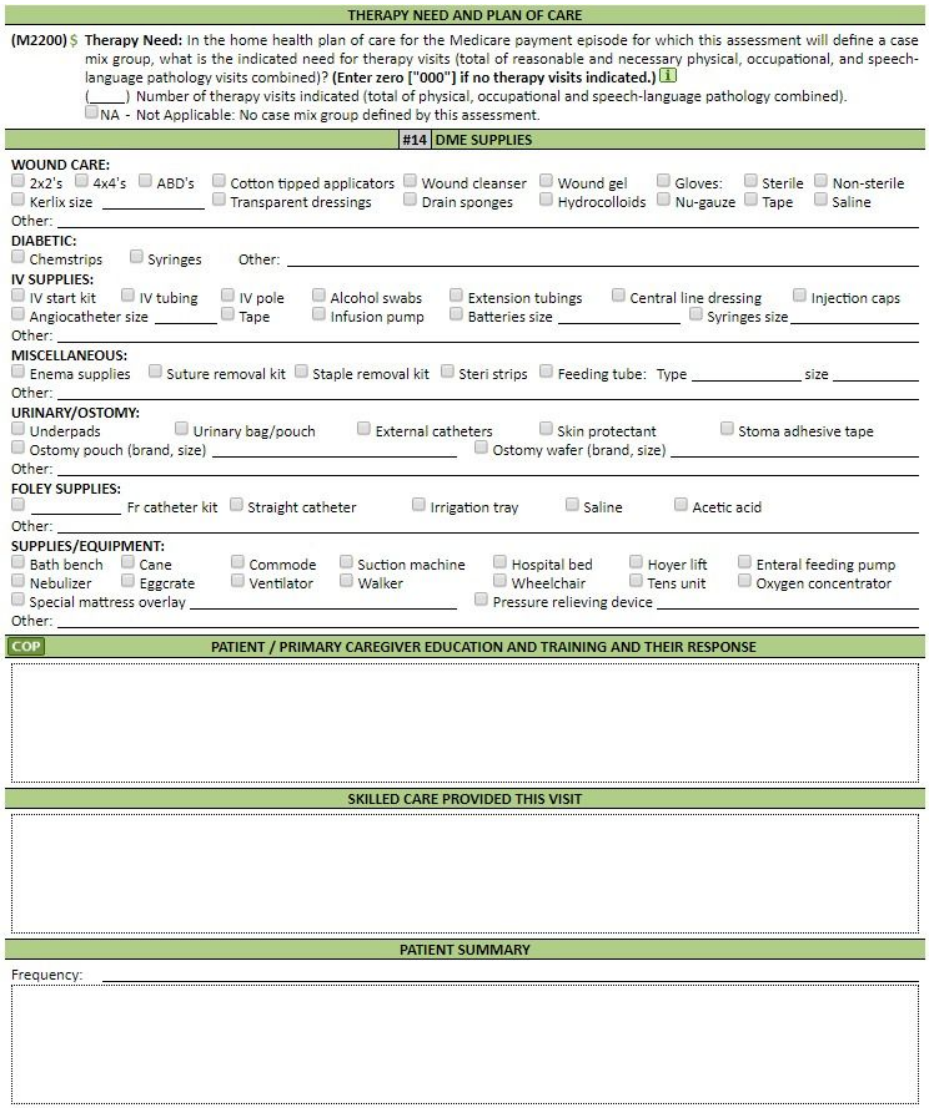
Pt/PCG educated on on disease process, S/SX's of exacerbation and reportable S/SXs. Instructed Pt/PCG on proper medication management and monitoring of effectiveness. Instructed patient on home safety and when to call MD, SN, and/or EMS. Instructed patient about Patient's Rights & Responsibilities, and Complaint Procedure and State Hotline #. Informed patient of Agency's hours of operation and after-hours/weekends on-call contact information. Patient/PCG expresses understanding

Under SKILLED CARE PROVIDED… enter the following template:

SN observation and assessment of all systems, medication compliance/efficacy/knowledge, pain levels/management. With patient input prepared a POC. SN provided skilled education on proper disease management, medication management, home safety, and EMS protocol. MD notified of findings and further plans. (Please add other skilled services provided (ie wound care))

Under PATIENT SUMMARY, :

Please "Copy and Paste" the narrative you created in the "Reason" section in the Admission Order



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.

#14 DME SUPPLIES

WOUND CARE:
2x2's 4x4's ABD's Cotton tipped applicators Wound cleanser Wound gel Gloves: Sterile Non-sterile
Kerlix size _____ Transparent dressings Drain sponges Hydrocolloids Nu-gauze Tape Saline
Other: _____

DIABETIC:
Chemstrips Syringes Other: _____

IV SUPPLIES:
IV start kit IV tubing IV pole Alcohol swabs Extension tubings Central line dressing Injection caps
Angiocatheter size _____ Tape Infusion pump Batteries size _____ Syringes size _____
Other: _____

MISCELLANEOUS:
Enema supplies Suture removal kit Staple removal kit Steri strips Feeding tube: Type _____ size _____
Other: _____

URINARY/OSTOMY:
Underpads Urinary bag/pouch External catheters Skin protectant Stoma adhesive tape
Ostomy pouch (brand, size) _____ Ostomy wafer (brand, size) _____
Other: _____

FOLEY SUPPLIES:
_____ Fr catheter kit Straight catheter Irrigation tray Saline Acetic acid
Other: _____

SUPPLIES/EQUIPMENT:
Bath bench Cane Commode Suction machine Hospital bed Hoyer lift Enteral feeding pump
Nebulizer Eggcrate Ventilator Walker Wheelchair Tens unit Oxygen concentrator
Special mattress overlay _____ Pressure relieving device _____
Other: _____

COP PATIENT / PRIMARY CAREGIVER EDUCATION AND TRAINING AND THEIR RESPONSE

SKILLED CARE PROVIDED THIS VISIT

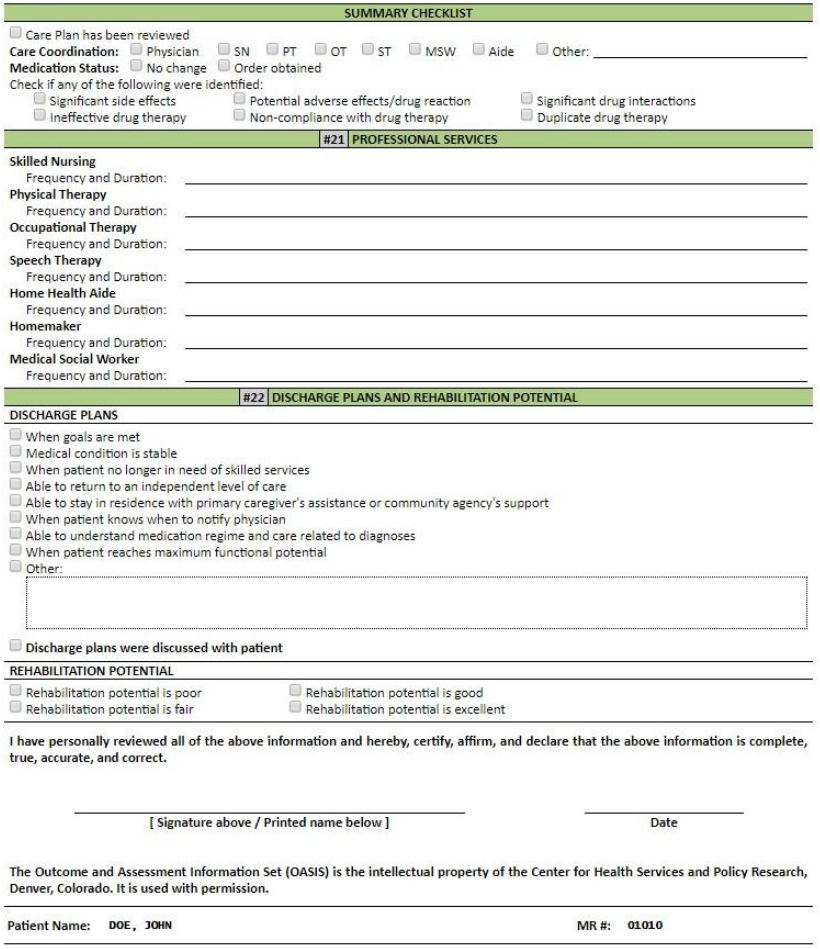
PATIENT SUMMARY

Frequency: _____

Step 8 (cont)

Complete the rest of the section with DC plans and Rehab potential

When done, proceed “Next” to setup the Care Plan Summary/Ongoing Plan of Care under the “CARE PLAN POINTERS” page.



SUMMARY CHECKLIST

☐ Care Plan has been reviewed
Care Coordination: ☐ Physician ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ Aide ☐ Other: _____
Medication Status: ☐ No change ☐ Order obtained
Check if any of the following were identified:
☐ Significant side effects ☐ Potential adverse effects/drug reaction ☐ Significant drug interactions
☐ Ineffective drug therapy ☐ Non-compliance with drug therapy ☐ Duplicate drug therapy

#21 PROFESSIONAL SERVICES

Skilled Nursing
Frequency and Duration: _____
Physical Therapy
Frequency and Duration: _____
Occupational Therapy
Frequency and Duration: _____
Speech Therapy
Frequency and Duration: _____
Home Health Aide
Frequency and Duration: _____
Homemaker
Frequency and Duration: _____
Medical Social Worker
Frequency and Duration: _____

#22 DISCHARGE PLANS AND REHABILITATION POTENTIAL

DISCHARGE PLANS

☐ When goals are met
☐ Medical condition is stable
☐ When patient no longer in need of skilled services
☐ Able to return to an independent level of care
☐ Able to stay in residence with primary caregiver's assistance or community agency's support
☐ When patient knows when to notify physician
☐ Able to understand medication regime and care related to diagnoses
☐ When patient reaches maximum functional potential
☐ Other:

☐ **Discharge plans were discussed with patient**

REHABILITATION POTENTIAL

☐ Rehabilitation potential is poor ☐ Rehabilitation potential is good
☐ Rehabilitation potential is fair ☐ Rehabilitation potential is excellent

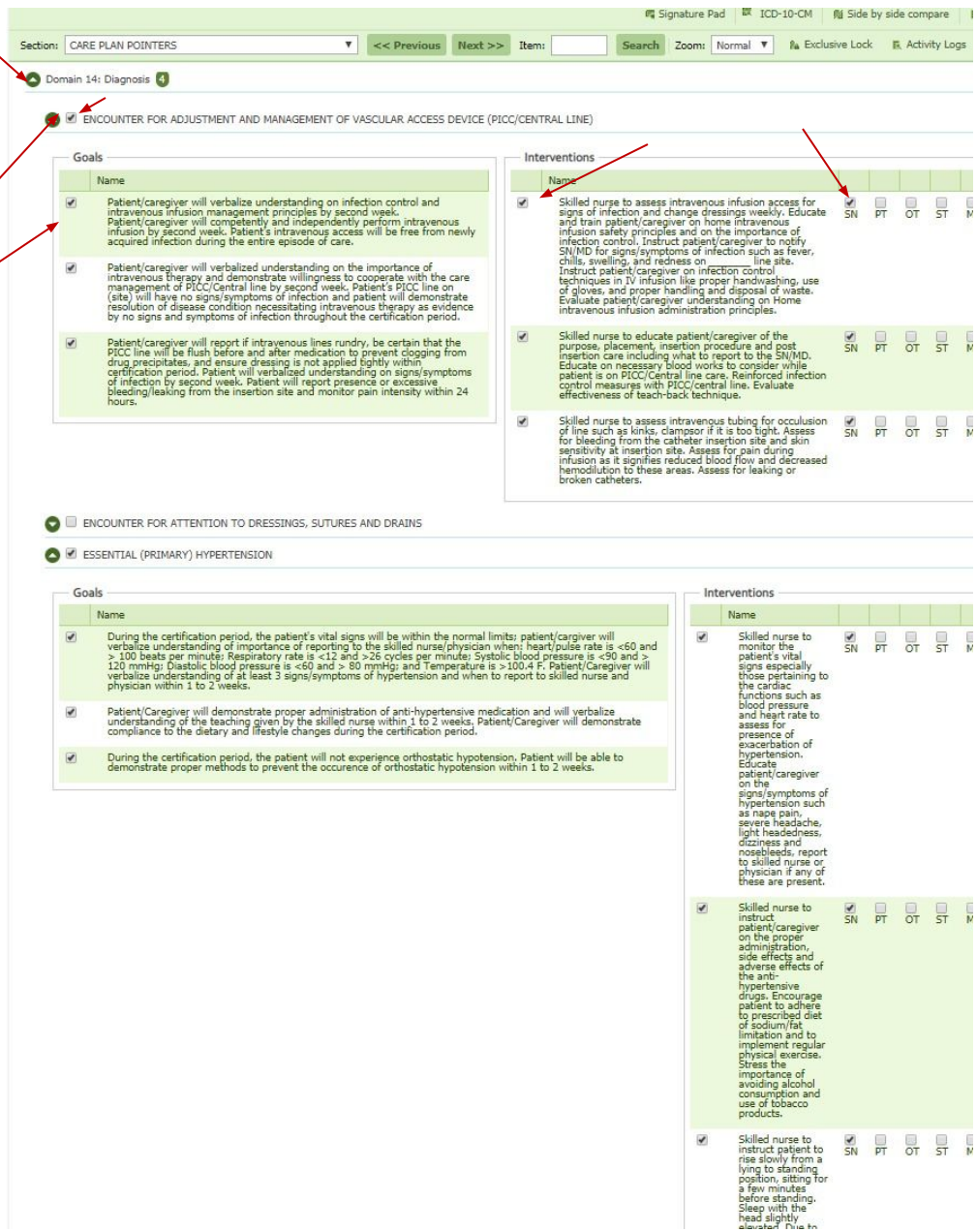
I have personally reviewed all of the above information and hereby, certify, affirm, and declare that the above information is complete, true, accurate, and correct.

_____ _____
[Signature above / Printed name below] **Date**

Patient Name: DOE, JOHN **MR #:** 01010

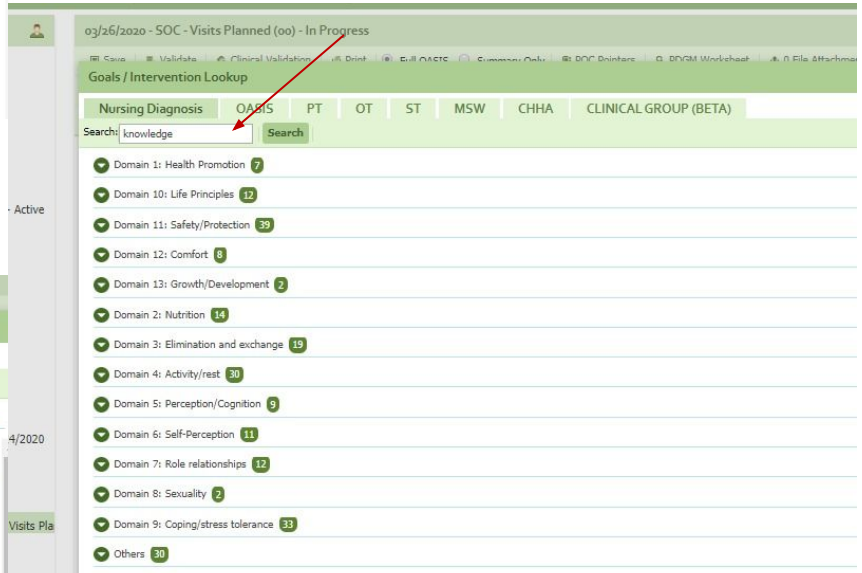
Step 9

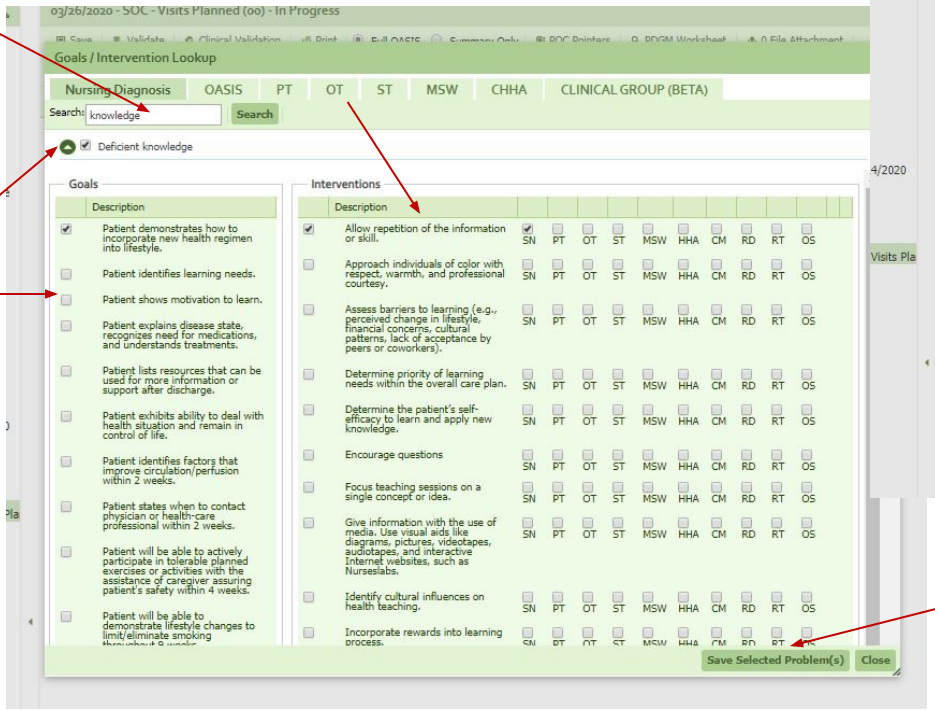
- Completing the CARE PLAN POINTER will populate the “Ongoing Care Plan/Care Plan Summary” that will help creat a road-map of care and intervention you can provide one every visit.
- Suggestions will automatically populate depending on your responses and diagnosis you entered in the OASIS.
- If you cannot find the appropriate Care Plan Pointer, you can add your own Care Plan Pointer.
- To add suggested pointers, choose the “Domain 14: Diagnosis” by clicking on the “Circle w/ a triangle” inside Icon to expand and reveal your choices
- You can expand the specific diagnosis by clicking on the same icon as above
- Click on the box to check them and add them as part of your Care Plan Pointers.
- Save when you are done choosing.



Step 9 (cont)

- You can add your own Care Plan Pointer if you don't see an appropriate Care Plan Pointer by choosing "Add Problem"
- You can search for a Care Plan Pointer by entering a key word under "Search"
- SUGGESTION: One of the best Care Plan Pointer to add to any patient is "Deficient Knowledge"
  - Choose the appropriate "Goals" and "Intervention"
  - When done, click on "Save Selected Problems"





Step 9 (cont)

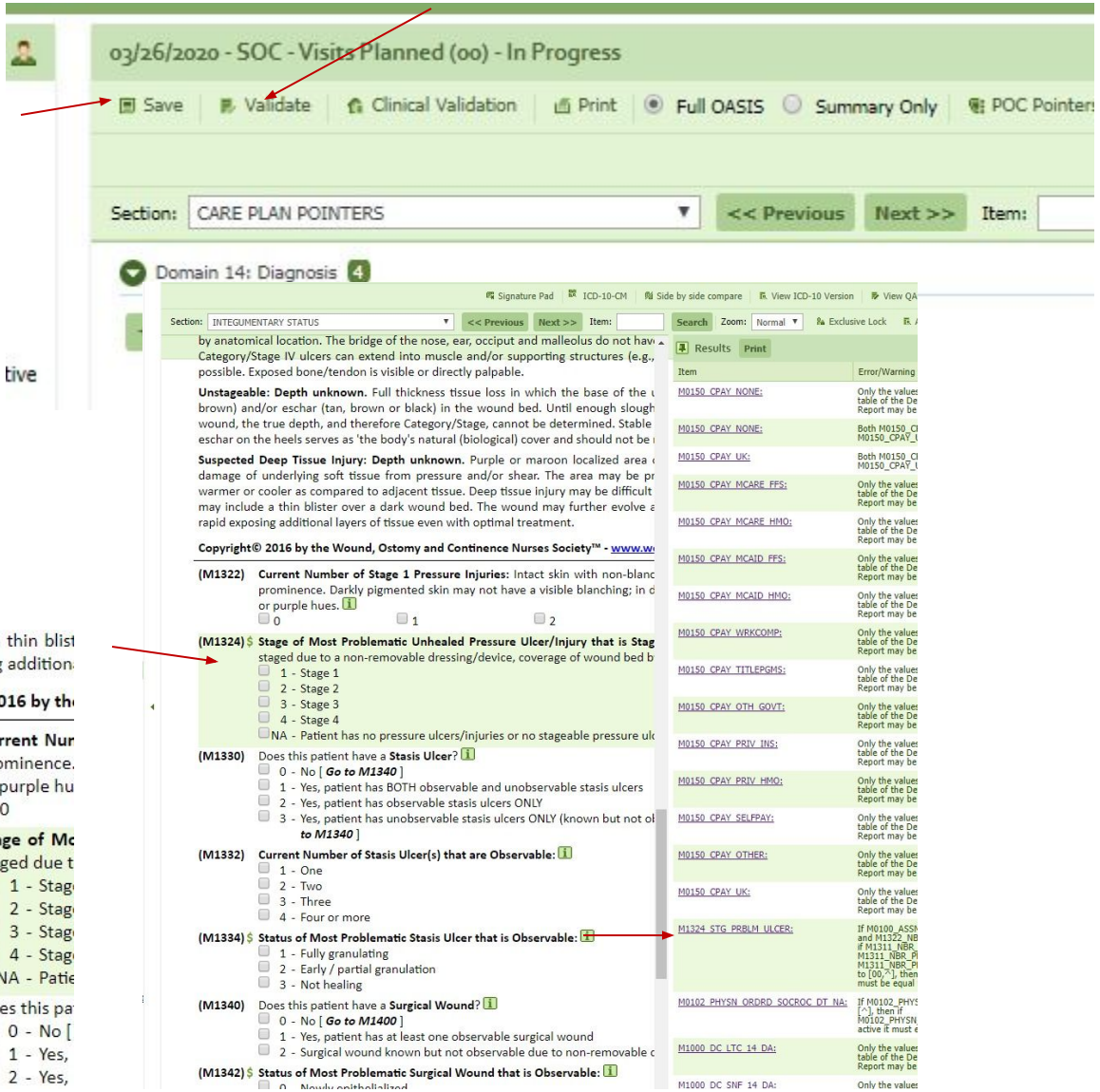
Save, wait for a couple of seconds, then Validate

Fix Errors and Problems as best as you can by choosing the item and it will bring you to the problem

Some Errors can only be fixed by us in the office due to their technical nature (ie incorrect ICD-10 code)

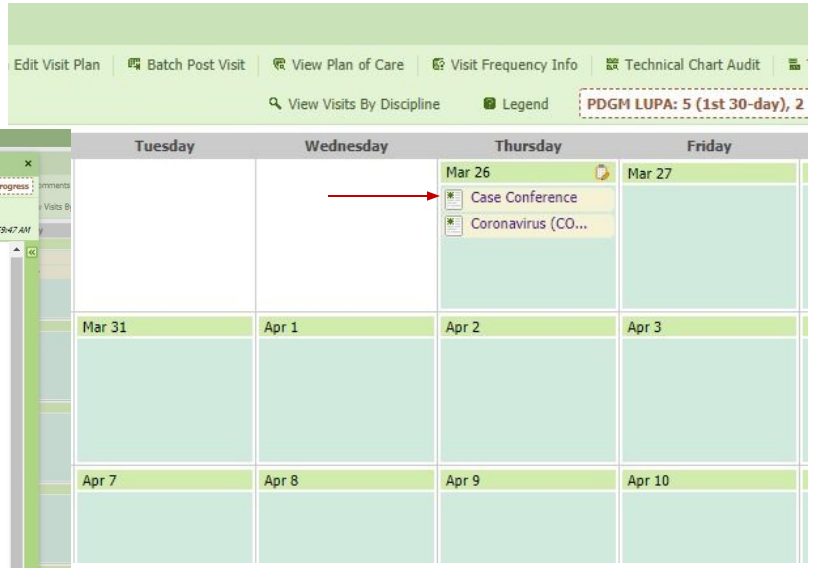
Save and re-Validate when done

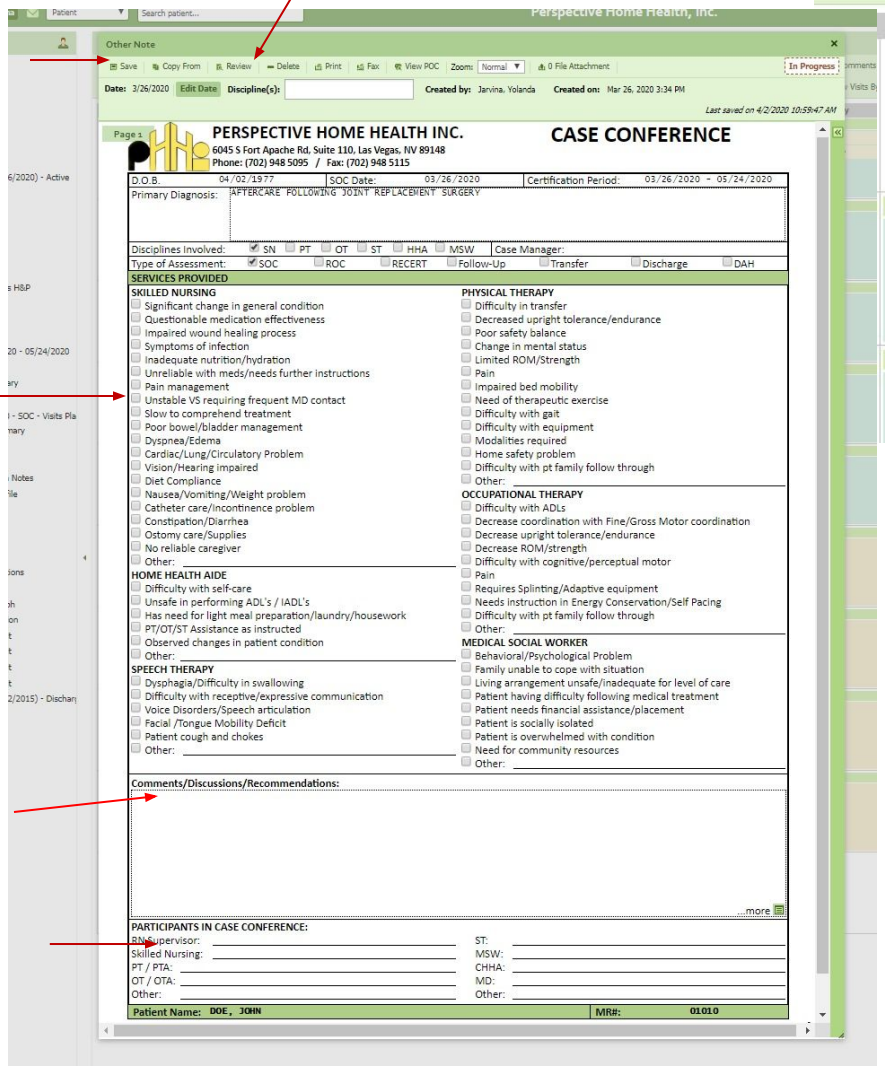
Then go back to the patient calendar by clicking the calendar



Step 10

- Complete the “Case Conference” form by clicking on the Case Conference Icon





Write down Diagnosis if known

Choose identified SN problems being dealt with

“Copy & Past” the narrative you created in the Admission Order into the “Comment” section.

Enter your name in the “RN Supervisor” and/or Skilled Nursing

“Save” then “Review