

...from the
OASIS ANSWERS Assessment Forms Manual...

Sample pages from the Nursing Start of Care
Assessment

[Note: the margin shifts are to accommodate
3-hole punching on double-sided forms]

NURSING START OF CARE ASSESSMENT
 (Also used for Resumption of Care Following Inpatient Stay)
 (page 1 of 16)

Patient Name:

Patient ID #:

(M0080) Discipline of Person Completing Assessment:
 1-RN 2-PT 3-SLP/ST 4-OT

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

(M0100) This Assessment is Currently Being Completed for the Following Reason:
Start/Resumption of Care
 1-Start of care—further visits planned
 3-Resumption of care (after inpatient stay)

ADVANCED DIRECTIVES:

Written Advance Directives Information Provided to Patient Yes No
 [If No; Provided to: (name/relationship to patient) _____]
 Patient has Executed an Advance Directive: No Yes
 [If Yes; Living Will Durable Power of Attorney for Health Care]
 Copy Requested for Clinical Record? Yes Not Applicable
 Copy Available? Yes No
 [If No; Arrangements Made to Obtain Copy New Advance Directive to be Completed]
 If copy of Advance Directive is not available, summarize content (treatment preferences, preferred surrogates, statements regarding wishes about a minimum quality of life):

 Content: Verbalized by Patient Verbalized by Caregiver (name/relationship):
 Patient's Physician Notified: No Yes; (date/means of notification):
 Staff Involved in Patient's Care Notified: No Yes; (date/means of notification):

REASON FOR REFERRAL TO HOME CARE:

PRIOR RELATED TREATMENTS/SERVICES:

Response to previous services:
 Achieved outcomes Partial benefit No benefit

IMMUNIZATIONS:

Pneumonia; date:
 Tetanus; date:
 Influenza; date:
 Hepatitis; date:
 Other; date:
 No Immunizations reported

PP\$ (M0175) From which of the following Inpatient Facilities was the patient discharged during the past 14 days? (Mark all that apply.)

1 - Hospital
 2 - Rehabilitation facility
 3 - Skilled nursing facility
 4 - Other nursing home
 5 - Other (specify) _____
 NA - Patient was not discharged from an inpatient facility [If NA, go to M0200]

(M0180) Inpatient Discharge Date (most recent):
 ___/___/___
 month day year UK - Unknown

Inpatient Admission Date:
 Name of Institution: _____
 ___/___/___
 month day year

(M0190) Inpatient Diagnoses and ICD code categories (three digits required; five digits optional) for only those conditions treated during an inpatient facility stay within the last 14 days (no surgical or V-codes):

Inpatient Facility Diagnosis	ICD
a. _____ (____ . ____)	
b. _____ (____ . ____)	

Effective 10/1/2003

List each Inpatient Diagnosis and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no surgical, E-codes, or V-codes):

Inpatient Facility Diagnosis	ICD-9-CM
a. _____ (____ . ____)	
b. _____ (____ . ____)	

(M0200) Medical or Treatment Regimen Change Within Past 14 Days: Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days? 0 - No [If No, go to M0220] 1 - Yes

(M0210) List the patient's Medical Diagnoses and ICD code categories (three digits required; five digits optional) for those conditions requiring changed medical or treatment regimen (no surgical or V-codes):

Changed Medical Regimen Diagnosis	ICD
a. _____ (____ . ____)	
b. _____ (____ . ____)	
c. _____ (____ . ____)	
d. _____ (____ . ____)	

Effective 10/1/2003

List the patient's Medical Diagnosis and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E-codes, or V-codes):

Changed Medical Regimen Diagnosis	ICD-9-CM
a. _____ (____ . ____)	
b. _____ (____ . ____)	
c. _____ (____ . ____)	
d. _____ (____ . ____)	

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Patient Name: _____

Patient ID # : _____

COMMUNITY RESOURCES:

Community/Social Support: (clergy, neighbors, friends, etc): _____

Other Organizations/Individuals Providing Paid Help (describe type and frequency): _____

Equipment Company: Name: _____ Phone: _____

Oxygen Supplier: Name: _____ Phone: _____

Pharmacy: Name: _____ Phone: _____

SYSTEMS REVIEW

HEAD/NECK:

- Headache
- Dizziness
- Mass/Nodes
- Tracheostomy
- Other: _____

- No Problems Observed
- No Problems Reported

EYES:

- Corrective Lenses
- Legally Blind
- Blurring/Visual Field Loss
- Cataracts
- Glaucoma
- Other: _____

- No Problems Observed
- No Problems Reported

PP\$ (M0390) Vision with corrective lenses if the patient usually wears them:

- 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

EARS:

- Hearing Loss
- Hearing Aid(s)
- Tinnitus
- Other: _____

- No Problems Observed
- No Problems Reported

(M0400) Hearing and Ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them):

- 0 - No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation.
- 1 - With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice.
- 2 - Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance.
- 3 - Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time.
- 4 - Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive.

ORAL:

- Dentures
(upper / lower / partial)
- Lesions
- Toothache
- Missing Teeth
- Other: _____

- No Problems Observed
- No Problems Reported

(M0410) Speech and Oral (Verbal) Expression of Language (in patient's own language):

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

FUNCTIONAL COMMUNICATION/LANGUAGE BARRIER:

- Independent Independent with equipment /special devices:
- Communication Deficits;(describe): _____
- Language Spoken if other than English: _____
- Able to Read English? yes no Needs interpreter no yes
- No Problems Observed No Problems Reported

NOSE / THROAT:

- Epistaxis Congestion
- Drainage Sinusitis
- Loss of Smell Sore Throat
- Dysphagia Hoarseness
- History of Choking/Aspiration
- Other: _____
- No Problems Observed
- No Problems Reported

NURSING START OF CARE ASSESSMENT
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Patient Name:

Patient ID # :

WOUND TABLE		Lesion #1	Lesion #2	Lesion #3	Lesion #4
Lesion Type: (ostomy, pressure ulcer [+ stage], stasis ulcer, surgical wound, rashes, burn, skin tear, etc.)					
Size: (length [head to toe] x width [left to right])					
Exudate/Drainage: (none/light/moderate/heavy, color, odor)					
Tissue Type:	% Necrotic				
	% Slough				
	% Granulation				
	% Epithelial				
	Closed				
Wound History & Status: (dates/events related to onset; healed/improving/static/deteriorating)					
Description: (staples/sutures, dressing/supplies, etc)					
Comments:					

PP\$ (M0445) Does this patient have a **Pressure Ulcer**? 0 -No [If No, go to **M0468**] 1 -Yes

Does patient have at least one **healed** Pressure Ulcer? No Yes; (describe stage/location/course for history and include Pressure Ulcer in M0450)

PP\$ (M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)	Pressure Ulcer Stages				Number of Pressure Ulcers					
	a) Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.	0	1	2	3	4 or more				
	b) Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.	0	1	2	3	4 or more				
	c) Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.	0	1	2	3	4 or more				
	d) Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.)	0	1	2	3	4 or more				
	e) In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes									

<p>PP\$ (M0460) Stage of Most Problematic (Observable) Pressure Ulcer:</p> <input type="checkbox"/> 1 - Stage 1 <input type="checkbox"/> 2 - Stage 2 <input type="checkbox"/> 3 - Stage 3 <input type="checkbox"/> 4 - Stage 4 <input type="checkbox"/> NA - No observable pressure ulcer	<p>(M0464) Status of Most Problematic (Observable) Pressure Ulcer:</p> <input type="checkbox"/> 1 - Fully granulating <input type="checkbox"/> 2 - Early/partial granulation <input type="checkbox"/> 3 - Not healing <input type="checkbox"/> NA- No observable pressure ulcer	<p>(M0468) Does this patient have a Stasis Ulcer?</p> <input type="checkbox"/> 0 - No [If No, go to M0482] <input type="checkbox"/> 1 - Yes
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<p>(M0470) Current Number of Observable Stasis Ulcer(s):</p> <input type="checkbox"/> 0 - Zero <input type="checkbox"/> 1 - One <input type="checkbox"/> 2 -Two <input type="checkbox"/> 3 -Three <input type="checkbox"/> 4 -Four or more	<p>(M0474) Does this patient have at least one Stasis Ulcer that Cannot be Observed due to the presence of a nonremovable dressing?</p> <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes	<p>PP\$ (M0476) Status of Most Problematic (Observable) Stasis Ulcer:</p> <input type="checkbox"/> 1 - Fully granulating <input type="checkbox"/> 2 - Early/partial granulation <input type="checkbox"/> 3 - Not healing <input type="checkbox"/> NA - No observable stasis ulcer
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Patient Name:

Patient ID #:

BREASTS:(Pertinent History):

- Lump(s) Tenderness Pain Discharge Breast self-exam (knowledge/skill/compliance):
 No Problems Observed No Problems Reported

Mammogram (date/findings):

GENITOURINARY STATUS:

Urination:

- Frequent Urgency Painful/Burning
 Oliguria Nocturia Retention
 Hematuria Clear Cloudy
 Sediment Other:
 Color:
 Amount:
 Odor:
 Vaginal/Penile Discharge:

(M0510) 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

(M0520) Urinary Incontinence or Urinary Catheter Presence:

- 0-No incontinence or catheter (includes anuria or ostomy for urinary drainage) [**Go to Gastrointestinal Status**]
 1-Patient is incontinent [**Go to M0530**]
 2-Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic)

CATHETER: [If applicable, complete section **Then go to Gastrointestinal Status**]

Catheter (size/type/management):

Date of Last Catheter Change:

PP\$ (M0530) When does Urinary Incontinence occur?

- 0-Timed-voiding defers incontinence
 1-During the night only
 2-During the day and night

CAUSE(S) OF URINARY INCONTINENCE: N/A

- Sphincter Control Dysfunction Cognitive Deficits Mobility Deficits
 Environmental Barriers Pain Activity Restrictions
 Other:

Incontinence Products:

GASTROINTESTINAL STATUS:

Digestion: WNL Nausea Vomiting Gas Heartburn **Bowel Sounds:** Active/Present Absent

Abdomen: Guarding Pain Distention

Date last BM: _____ **Usual Frequency:** _____

- Ascites Diarrhea Constipation Bowel Routine (if any)
 Hx of Fecal Impaction Stool Characteristics Bowel Incontinence Rectal Bleeding
 Hemorrhoids Other:

Ileostomy (management/detail)

No Problems Observed No Problems Reported

PP\$ (M0540) 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

PP\$ (M0550) 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.

NUTRITIONAL STATUS:

- Appetite:** WNL
 Diminished Anorexia
Hydration: WNL
 Diminished Inadequate
 Increase Fluids:
 Restrict Fluids:
Recent Weight Change:
 Intended Unintended
 Gain Loss
 # of lbs. ___ in ___ days/wks/mos.
Alcohol Intake:

NUTRITIONAL SCREEN: (scored based on patient report)

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat	2
I eat fewer than 2 meals per day	3
I eat few fruits or vegetables, or milk products	2
I have 3 or more drinks of beer, liquor or wine almost every day	2
I have tooth or mouth problems that make it hard for me to eat	2
I don't always have enough money to buy the food I need	4
I eat alone most of the time	1
I take 3 or more different prescribed or over-the-counter drugs a day	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months	2
I am not always physically able to shop, cook, and/or feed myself	2

Score of 3-5 = Moderate Nutritional Risk, see care plan
 Score of 6 or > = High Nutritional Risk, see care plan

Source: Nutritional Screening Initiative (American Academy of Family Physicians, American Dietetic Association, National Council on the Aging)

TOTAL

Nutritional Requirements/Diet:

NURSING START OF CARE ASSESSMENT (Also used for Resumption of Care Following Inpatient Stay) (page 16 of 16)	Patient Name: Patient ID # :
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NURSING CARE PLAN	(Last page of assessment may be used as SN Plan of Care/Physician's Orders) See also <input type="checkbox"/> 485 <input type="checkbox"/> 487 See <input type="checkbox"/> also <input type="checkbox"/> instead preprinted/standardized agency care plans <input type="checkbox"/> N/A
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SN: Visit Orders/Frequency/Duration

HHA: Visit Orders/Frequency/Duration

Problems/Needs:	Interventions:	Goals: (Short term/Long term)

Sample

NEED FOR INTERDISCIPLINARY REFERRAL? <input type="checkbox"/> No <input type="checkbox"/> Yes, (explain)	PROGNOSIS: <input type="checkbox"/> Poor <input type="checkbox"/> Guarded <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent	REHAB POTENTIAL (for achievement of above stated goals) <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
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<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> MSW <input type="checkbox"/> Aide Verbal order received? <input type="checkbox"/> Yes <input type="checkbox"/> No, (explain)	PATIENT/CAREGIVER AWARE OF AND AGREEABLE TO TREATMENT PLAN/SCHEDULE? <input type="checkbox"/> Yes <input type="checkbox"/> No,
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DISCHARGE PLAN: When goals met, maximum function achieved, or at request of patient or physician...

Discharge to self care with home program Discharge to care of caregiver Transition to Outpatient services
 Other:

DATE:	TIME IN:	TIME OUT:
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NURSE SIGNATURE:	PATIENT SIGNATURE: (if applicable) X
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PHYSICIAN SIGNATURE: (if applicable)	DATE:
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