OASIS ITEM

(M1600)	Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?
Enter Code ☐	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown **[*Omit "UK" option on DC*]**

ITEM INTENT

- Identifies treatment of urinary tract infection during the past 14 days.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- The term "past 14 days" is the two-week period immediately preceding the Start/Resumption of Care date (or for Discharge, the M0090 Date Assessment Completed). This means that for purposes of counting the 14-day period, the Start of Care date is day 0 and the day immediately prior to the Start of Care date is day 1. For example, if the patient's SOC date is August 20, any treatment for a UTI occurring on or after August 6 would be considered.
- Unknown is not an option at Discharge from Agency.
- Enter Response 0 – No, if patient has not been treated for a UTI within the past two weeks, including if the patient had symptoms of a UTI or a positive culture for which the physician did not prescribe treatment, or the treatment ended more than 14 days ago.
- Enter Response 1 – Yes, when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI.
- Enter Response 1 – Yes, if the patient is on prophylactic treatment and develops a UTI.
- Enter "NA" – if the patient is on prophylactic treatment to prevent UTIs.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Physician orders
- Review of health history
- Referral information
- Physician
- Medication list

OASIS ITEM

(M1610)	Urinary Incontinence or Urinary Catheter Presence:
Enter Code ☐	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)

ITEM INTENT

- Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter Response 0 if the patient has anuria or an ostomy for urinary drainage (for example: an ileal conduit), or if the patient has a urinary diversion that is pouched (ileal conduit, urostomy, ureterostomy, nephrostomy), with or without a stoma.
- Enter Response 1 if the patient is incontinent at any time (including “occasionally,” “only when I sneeze,” “sometimes I leak a little bit,” etc.).
- Enter Response 1 if the patient is incontinent or is dependent on a timed-voiding program. Timed voiding is defined as scheduled toileting assistance or prompted voiding to manage incontinence based on identified patterns. Time voiding is a compensatory strategy; it does not cure incontinence.
- Enter Response 2 if a catheter or tube is utilized for drainage (even if catheterizations are intermittent).
- Enter Response 2 if the patient requires the use of a catheter for urinary drainage for any reason (for example: retention, post-surgery, incontinence). Enter Response 2 and follow the skip pattern if the patient is both incontinent and requires a urinary catheter.
- Enter Response 2 if a catheter was inserted during the comprehensive assessment.
- A leaking urinary drainage appliance is not incontinence.
- A catheter solely utilized for irrigation of the bladder or installation with an antibiotic is not reported in this item.
- If a catheter was discontinued during the comprehensive assessment or if a catheter is both inserted and discontinued during the comprehensive assessment, Response 0 or 1 would be appropriate, depending on whether or not the patient is continent.
- Assessment strategies: Review the urinary elimination pattern as you take the health history. Does the patient admit having difficulty controlling the urine, or is he/she embarrassed about needing to wear a pad so as not to wet on clothing? Do you have orders to change a catheter? Is your stroke patient using an external catheter? Be alert for an odor of urine, which might indicate there is a problem with bladder sphincter control. If the patient receives aide services for bathing and/or dressing, ask for input from the aide (at follow-up assessment). This information can then be discussed with the patient. Urinary incontinence may result from multiple causes, including physiologic reasons, cognitive impairments, or mobility problems.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Physician orders
- Review of health history
- Referral information

OASIS ITEM

(M1620)	Bowel Incontinence Frequency:
Enter Code ☐	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown **[*Omit "UK" option on FU, DC*]**

ITEM INTENT

- Identifies how often the patient experiences bowel incontinence. Refers to the frequency of a symptom (bowel incontinence), not to the etiology (cause) of that symptom. This item does not address treatment of incontinence or constipation (for example: a bowel program).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Responses are arranged in order of least to most frequency of bowel incontinence.
- Response 4 – On a daily basis – indicates that the patient experiences bowel incontinence once per day.
- Enter "NA" if patient has an ostomy for bowel elimination.
- Unknown is not an option at follow-up or discharge.
- Assessment strategies: Review the bowel elimination pattern as you take the health history. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc. The patient's responses to these items may make you aware of an as yet unidentified problem that needs further investigation. If the patient is receiving aide services, question the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient. Incontinence may result from multiple causes, including physiologic reasons, mobility problems, or cognitive impairments.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Review of health history
- Referral information

OASIS ITEM

(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?
Enter Code ☐	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.

ITEM INTENT

- Identifies whether the patient has an ostomy for bowel elimination and, if so, whether the ostomy was related to a recent inpatient stay or caused a change in medical treatment plan.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up

RESPONSE-SPECIFIC INSTRUCTIONS

- Applies to any type of ostomy for bowel elimination (for example: colostomy, ileostomy). This item only addresses bowel ostomies, not other types of ostomies (for example: urinary ostomies, tracheostomies).
- If an ostomy has been reversed, then the patient does not have an ostomy at the time of assessment.
- If patient does not have an ostomy for bowel elimination, enter Response 0 – Patient does not have an ostomy for bowel elimination.
- If the patient does have an ostomy for bowel elimination, determine whether the ostomy was related to an inpatient stay or necessitated a change in the medical or treatment regimen within the last 14 days.
- The term “past fourteen days” is the two-week period immediately preceding the Start/Resumption of Care or Follow-Up assessment. This means that for purposes of counting the 14-day period, the Start of Care date is day 0 and the day immediately prior to the Start of Care date is day 1. For example, if the patient’s SOC date is August 20, any ostomy related to an inpatient stay or requiring medical or treatment regimen change that occurred on or after August 6 would be considered.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Physician orders
- Review of health history
- Referral information
- Physician
- Supplies list