OASIS ITEM

(M2001)	**Drug Regimen Review:** Did a complete drug regimen review identify potential clinically significant medication issues?
Enter Code ☐	0 No – No issues found during review **[*Go to M2010*]** 1 Yes – Issues found during review 9 NA – Patient is not taking any medications **[*Go to M2102*]**

ITEM INTENT

- Identifies if review of the patient's medications indicated any potential or actual clinically significant medication issues.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- The drug regimen review includes all medications, prescribed and over the counter (OTC) including nutritional supplements, vitamins and herbals, administered by any route (for example, oral, topical, sublingual and by infusion). The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.
- Potential or actual clinically significant medication issues may include, but are not limited to, the following:
  - adverse reactions to medications (such as a rash)
  - ineffective drug therapy (such as analgesic that does not reduce pain)
  - side effects (such as potential bleeding from an anticoagulant)
  - drug interactions (such as serious drug-drug, drug-food and drug-disease interactions)
  - duplicate therapy (such as generic name and brand name equivalent drugs are both prescribed)
  - omissions (such as missing drugs from a prescribed regimen)
  - dosage errors (either too high or too low)
  - nonadherence (purposeful or accidental)
- Any of the circumstances listed above must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations by midnight of the next calendar day, at the latest.
- Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.
- The drug regimen review is part of the comprehensive patient assessment. The comprehensive patient assessment is the responsibility of and must ultimately be completed by one clinician, but collaboration is allowed. Agency policy and practice will determine this process and how it is documented.

DEFINITION

DRUG REGIMEN REVIEW
The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.

DEFINITION

POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUE
A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest).

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2001)

- For example, for this drug regimen review item, collaboration in which the assessing clinician evaluates patient status (for example, presence of potential ineffective drug therapy or patient nonadherence), and another clinician (in the office) assists with review of the medication list (for example, possible duplicate drug therapy or omissions) is allowed.
- If portions of the drug regimen review (for example, identification of potential drug-drug interactions or potential dosage errors) are completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS, information on drug regimen review findings must be communicated to the assessing clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2001 may be entered.
- The M0090 date assessment completed will indicate the last day the clinician gathered or received any input used to complete the comprehensive assessment document, which includes the OASIS items.

Coding Instructions:

Code 0, No, No issues found during review, if, based on assessing clinician's professional judgment, no potential or actual clinically significant issues are identified. Examples may include, but are not limited to:

- Patient's inpatient facility discharge medication list matches medications patient has on hand.
- Patient has a plan for taking medications safely at the right time.
- Patient is not showing signs/symptoms that could be adverse reactions caused by medications.
- The diagnoses/conditions for which the patient is taking the medications appear adequately controlled.

Code 1, Yes, **issues found during review** if a drug regimen review is conducted upon SOC/ROC and based on assessing clinician's professional judgment, potential or actual clinically significant medication issues are identified. Examples may include, but are not limited to:

- Patient's list of medications from the inpatient facility discharge instructions DO NOT match the medications the patient shows the clinician at the SOC/ROC assessment visit.
- Assessment shows that diagnoses/symptoms for which the patient is taking medications are NOT adequately controlled.
- Patient seems confused about when/how to take medications indicating a high risk for medication errors.
- Patient has not obtained medications or indicates that s/he will not take prescribed medications because of financial, access, cultural, or other issues with medications.
- Patient has signs/symptoms that could be adverse reactions from medications.
- Patient takes multiple non-prescribed medications (OTCs, herbals) that could interact with prescribed medications.
- Patient has a complex medication plan with medications prescribed by multiple physicians and/or obtained from multiple pharmacies so that the risk of drug interactions is high.

Code 9, NA – Patient is not taking any medications, if a drug regimen review indicates there are no medications prescribed for the patient and the patient is not taking any medications, by any route, at the time of the assessment.

A dash is a valid response for this item. CMS expects dash use to be a rare occurrence. If elements of the drug regimen review were skipped, (for example drug-to-drug interactions were not completed), a dash (–) should be reported, indicating the drug regimen review was not completed.

EXAMPLES

1. No issues identified

During the comprehensive assessment visit to Mr. K., the PT reviews all the patient's medications and identifies no problems except that the patient's newly prescribed pain medication is not in the home. The daughter, Nancy, states they were only going to pick it up from the pharmacy if "the pain got bad enough." The PT reviews the physician's instructions for the new medication with the Mr. K and Nancy; they agree the medication should be on hand, and to follow physician's instructions for administration. Prior to the PT leaving the home, the daughter has gone to the drugstore and returned with the medication.

Coding: M2001 would be coded 0, No – No issues found during review.

Rationale: Because the issue, in the PT's professional judgment, did not require physician (or physician-designee) contact by midnight of the next calendar day, at the latest to resolve, it does not meet the criteria for a potential or actual clinically significant medication issue.

2. Drug regimen review (DRR) not complete; use of the dash

During the SOC comprehensive assessment, Nurse Richard completes all elements of the DRR except for checking for drug-drug interactions.

Coding: M2001, enter a dash, "–"

Rationale: When any element is not assessed, the DRR is considered incomplete.

DATA SOURCES/RESOURCES

- Patient assessment
- HH Condition of Participation
- Clinical record including communication notes, medication list
- Collaboration with other agency staff as allowed, including review of documentation
- CMS OASIS Q&As related to the drug regimen review can be accessed through the CMS OASIS web page

OASIS ITEM

(M2003)	**Medication Follow-up:** Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
Enter Code ☐	0 No 1 Yes

ITEM INTENT

- Identifies if potential or actual clinically significant medication issues identified through the drug regimen review were communicated to the physician (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- For each potential or actual clinically significant medication issue identified during the SOC/ROC comprehensive assessment, identify if the physician/physician-designee was contacted, and prescribed/recommended actions were completed by midnight of the next calendar day (at the latest).
- Examples of ***by midnight of the next calendar day***:
- A clinically significant medication issue is identified at 10:00 AM on February 12th and physician/physician-designee prescribed/recommended action is completed on or before 11:59 PM on February 13th.
- A clinically significant medication issue is identified at 10:00 PM on February 12th. physician/physician-designee prescribed/recommended action is completed on or before 11:59 PM on February 13th.

DEFINITION

POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUE
A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest).

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2003)

Coding Instructions

Code 0, No, if all identified potential or actual clinically significant medication issues were not communicated to the physician/physician designee, with prescribed/recommended actions completed to the extent possible by midnight of the next calendar day.

- Examples:
  - Clinician did not communicate all clinically significant medication issues to physician/physician-designee until after midnight of the next calendar day.
  - Clinician communicated all clinically significant medication issues to physician/physician-designee by midnight of the next calendar day, but the clinician did not receive a response from the physician/physician-designee to communicate prescribed/recommended actions until after midnight of the next calendar day.
  - Clinician did not complete all physician/physician-designee prescribed/recommended actions until after midnight of the next calendar day.

Code 1, Yes, if the two-way communication AND completion of the prescribed/recommended actions to the extent possible occurred by midnight of the next calendar day after the potential clinically significant medication issue was identified.

- Examples:
  - Clinician communicated all identified clinically significant medication issue to the physician/physician-designee, and all physician/physician-designee prescribed/recommended actions for all identified medication issues were completed by midnight of the next calendar day.
  - Clinician contacted the physician/physician-designee regarding all identified medication issues, and the physician/physician-designee communicated to the clinician that no actions were necessary regarding the reported issues. All communications took place before midnight of the next calendar day.
  - If the physician/physician-designee recommends an action that will take longer than the allowed time to complete, then Response 1 – Yes should be entered as long as by midnight of the next calendar day the agency has taken whatever actions are possible to comply with the recommended action.
    - An example of a recommended action that would take longer than the allowed time to complete might include physician order(s) for intervention followed by monitoring the issue over the weekend and call if problem persists, or the physician instructs the patient to address the concern with his PCP on a visit that is scheduled in two days.
    - The actual type of actions recommended should be considered in determining if the agency has taken whatever actions are possible by midnight of the next calendar day.

A **dash** (–) is a valid response for this item. CMS expects dash use to be a rare occurrence.

DEFINITIONS

CONTACT WITH PHYSICIAN/ PHYSICIAN DESIGNEE

- Communication to the physician/physician-designee to convey an identified potential or actual clinically significant medication issue, AND a response from the physician/physician-designee to acknowledge receipt and/or convey prescribed/recommended actions in response to the medication issue.
- Communication can be in person, by telephone, voicemail, electronic means, facsimile, or any other means that appropriately conveys the message of patient status.
- Communication can be directly to/from the physician or physician-designee, or indirectly through physician's office staff on behalf of the physician or physician-designee, in accordance with the legal scope of practice.

MEDICATION FOLLOW-UP

- The process of contacting a physician/physician-designee to communicate the identified medication issue and, to the extent possible, completing all physician/physician-designee prescribed/recommended actions by midnight of the next calendar day (at the latest).

EXAMPLE

1. Clinically significant medication issue identified, with follow-up

During the SOC comprehensive assessment visit, the RN completes a drug regimen review and identifies that the patient is taking two antihypertensives; one which was newly prescribed during her recent hospital stay, and another that she was taking prior to her hospitalization. During the home visit, the RN contacts the physician's office, and leaves a message with office staff providing notification of the potential duplicative drug therapy and a request for clarification. The next day, the RN returns to the home to complete the comprehensive assessment and again contacts the physician from the patient's home. The physician's office nurse reports to the agency and patient that the physician would like the patient to continue with only the newly prescribed antihypertensive and discontinue the previous medication.

Coding: M2001, Drug Regimen Review, would be coded 1, Yes, Issues found during review.
M2003, Medication Follow-up, would be coded 1, Yes.

Rationale: Because the issue identified was determined by the clinician to be clinically significant, requiring physician contact by midnight of the next calendar day, it meets the criteria for a potential clinically significant medication issue (M2001). As the clinically significant issue was communicated to the physician and the prescribed/recommended action was completed by midnight of the next calendar day, M2003 would be coded 1 – Yes.

DATA SOURCES/RESOURCES

- Clinical record
- Communication notes
- Plan of Care
- Medication list

OASIS ITEM

(M2005)	**Medication Intervention:** Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?
Enter Code ☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

ITEM INTENT

- Identifies if potential or actual clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were communicated to the physician (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility
- Death at home
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- To complete M2005, the assessing clinician (alone or in collaboration with other agency staff) reviews the patient's clinical record back to and including the most recent SOC/ROC, to determine if for each clinically significant medication issue identified, communication occurred ***and***, to the extent possible, physician (or physician-designee) prescribed or recommended actions were completed by midnight of the next calendar day.
- Potential or actual clinically significant medication issues may include, but are not limited to, the following:
  - adverse reactions to medications (such as a rash)
  - ineffective drug therapy (such as analgesic that does not reduce pain)
  - side effects (such as potential bleeding from an anticoagulant)
  - drug interactions (such as serious drug-drug, drug-food and drug-disease interactions)
  - duplicate therapy (such as generic name and brand name equivalent drugs are both prescribed)
  - omissions (such as missing drugs from a prescribed regimen)
  - dosage errors (either too high or too low)
  - nonadherence (purposeful or accidental)

DEFINITION

POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUE
A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest).

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2005)

- Examples of ***by midnight of the next calendar day***:
  - A clinically significant medication issue is identified at 10:00 AM on February 12th. Communication occurs and the physician/physician-designee prescribed/recommended action is completed on or before 11:59 PM on February 13th.
  - A clinically significant medication issue is identified at 10:00 PM on February 12th. Communication occurs and the physician/physician-designee prescribed/recommended action is completed on or before 11:59 PM on February 13th.

Coding Instructions

Code 0, No, if all clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were not communicated to the physician/physician-designee and/or all prescribed/recommended actions were not completed, to the extent possible, by midnight of the next calendar day.

- Examples:
  - At the time of or at any time since the most recent SOC/ROC, the clinician(s) did not communicate all identified potential or actual clinically significant medication issues to the physician until after midnight of the next calendar day.
  - At the time of or at any time since the most recent SOC/ROC, the clinician's communicated to the physician/physician-designee all identified potential or actual clinically significant medication issues, but the physician/physician-designee did not respond until after midnight of the next calendar day.
  - At the time of or at any time since the most recent SOC/ROC, the clinician(s) did not complete all physician/physician-designee prescribed/recommended actions for all identified potential or actual clinically significant medication issues by midnight of the next calendar day.

Code 1, Yes, if all clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were communicated to the physician/physician-designee and all prescribed/recommended actions were completed, to the extent possible, by midnight of the next calendar day each time a potential clinically significant issue was identified.

- Examples:
  - At the most recent SOC/ROC and throughout the quality episode, the clinician(s) communicated all identified clinically significant medication issues to the physician/physician-designee, and all physician/physician-designee prescribed/recommended actions for the identified issues were completed by midnight of the next calendar day.
  - At the most recent SOC/ROC and throughout the quality episode, the clinician(s) contacted the physician/physician-designee regarding all identified potential or actual clinically significant medication issues, and the physician/physician-designee communicated to the clinician(s) that no actions were necessary regarding the reported issues. All communications took place before midnight of the next calendar day.

DEFINITIONS

CONTACT WITH PHYSICIAN/ PHYSICIAN DESIGNEE

- Communication to the physician/physician-designee to convey an identified potential or actual clinically significant medication issue, AND a response from the physician/physician-designee to acknowledge receipt and/or convey prescribed/ recommended actions in response to the medication issue.
- Communication can be in person, by telephone, voicemail, electronic means, facsimile, or any other means that appropriately conveys the message of patient status.
- Communication can be directly to/from the physician or physician-designee, or indirectly through physician's office staff on behalf of the physician or physician-designee, in accordance with the legal scope of practice.

MEDICATION FOLLOW-UP

- The process of contacting a physician/physician-designee to communicate the identified medication issue and, to the extent possible, completing all physician/ physician-designee prescribed/ recommended actions by midnight of the next calendar day (at the latest).

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2005)

- If the physician/physician-designee recommends an action that will take longer than the allowed time to complete, then Response 1 – Yes should be entered as long as by midnight of the next calendar day the agency has taken whatever actions are possible to comply with the recommended action. An example of a recommended action that would take longer than the allowed time to complete might include physician instruction to agency staff to continue to monitor the issue over the weekend and call if problem persists. The actual type of actions recommended should be considered in determining if the agency has taken whatever actions are possible by midnight of the next calendar day.

Code 9, NA, if there were no potential or actual clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC, or if the patient is not taking any medications at the time of or at any time since the most recent SOC/ROC.

A dash (–) value is a valid response for this item. CMS expects dash use to be a rare occurrence.

EXAMPLES

1. No clinically significant medication issues identified throughout the episode

During the Discharge assessment visit, the RN reviews the patient's medication list and confirms that no potential clinically significant medication issues are present. In reviewing the clinical record, there is documentation that a drug regimen review was conducted at SOC, and no potential clinically significant medication issues were identified. There is no other documentation to indicate that potential or actual clinically significant medication issues occurred during the episode of care.

Coding: M2005: ENTER Response 9 (NA) – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications.

Rationale: This item is reported as NA because there is documentation that the agency looked for potential clinically significant medication issues via completion of a drug regimen review and that no potential or actual clinically significant medication issues were identified at any time during the episode, from SOC through Discharge.

2. Clinically significant medication issue identified, late follow-up

During the SOC comprehensive assessment, the RN completes the drug regimen review and identifies a potential clinically significant medication issue. On that day of admission, the RN calls and leaves a message with the physician's office related to the medication issue. The physician does not return her call until after midnight of the next calendar day. No other medication issues arise during the episode, and the patient is discharged from home health.

Coding:

At SOC:
M2001: ENTER Response 1 – Yes – Issues found during review.
M2003: ENTER Response 0 – No.

At DC:
M2005: enter Response 0 – No.

Rationale: Because an issue identified was determined by the clinician to be clinically significant, warranting physician contact by midnight of the next calendar day, it meets the criteria for a clinically significant medication issue (1 – Yes for M2001). While the clinician initiated communication with the physician, the required two-way communication did not occur until after midnight of the next calendar day, resulting in 0 – No responses for M2003 and M2005.

DATA SOURCES/RESOURCES

- Clinical record
- Communication notes
- Medication list
- Plan of Care

OASIS ITEM

(M2010)	**Patient/Caregiver High-Risk Drug Education:** Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
Enter Code ☐	0 No 1 Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

ITEM INTENT

- Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes. High-risk medications are those identified by an authoritative source, such as the Institute for Safe Medication Practices as having considerable potential for causing significant patient harm when they are used erroneously.
- This item is targeted to high-risk medications as it may be unrealistic to expect that patient education on all medications occur on admission and failure to provide patient education on high-risk medications such as hypoglycemics and anticoagulants (and others) at SOC/ROC could have severe negative impacts on patient safety and health.
- The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter Response 0 – No, if the interventions are not completed as outlined in this item. However, in this case, the care provider should document rationale in the clinical record unless the patient is not taking any drugs.
- Enter Response 1 – Yes, if high-risk medications are prescribed and education was provided.
- Enter Response NA – If patient/caregiver is fully knowledgeable about special precautions associated with all high-risk medications in his/her medication profile.
- High-risk medications should be identified based on one or more authoritative sources.
- If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2010 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of and ultimately must be completed by one clinician.

DATA SOURCES/RESOURCES

- Clinical record
- Communication notes
- Medication list
- Plan of Care
- Documentation of other agency staff responsible for educating patient/caregivers on medications.
- Authoritative sources to identify high-risk medications for the purposes of responding to this item can include but are not limited to the Institute for Safe Medication Practices, the American Geriatrics Society, and The Joint Commission.
- Links to resources for identifying high-risk medications can be found in Chapter 5 of this manual.

OASIS ITEM

(M2016)	**Patient/Caregiver Drug Education Intervention**: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?
Enter Code ☐	0 No 1 Yes NA Patient not taking any drugs

ITEM INTENT

- Identifies if agency staff and/or other health care providers, such as pharmacists, instructed the patient/caregiver about how to manage all medications effectively and safely within the time period under consideration, including instruction related to monitoring the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur.
- The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Drug education interventions for M2016 should address all medications the patient is taking, prescribed and over-the-counter, by any route.
- Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider.
- Enter Response 1 if *all* interventions were provided (monitor effectiveness of drug therapy, adverse drug reactions and significant side effects, and how and when to report problems that may occur).
  - AND, Within the time period under consideration (at or since the most recent SOC/ROC)
  - AND, By agency staff and/or other health care providers
- If the interventions are not completed as outlined in this item, enter Response 0 (No). However, in this case, the care provider should document rationale in the clinical record.

DATA SOURCES/RESOURCES

- Review of clinical record including teaching guidelines, flow sheets, clinical notes, etc.
- Medication list
- Plan of Care
- Documentation of other agency staff responsible for educating patient/caregivers on medications
- Links to a resource for drug information can be found in Chapter 5 of this manual

OASIS ITEM

(M2020)	**Management of Oral Medications:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**
Enter Code ☐	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. 1 Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times 3 Unable to take medication unless administered by another person. NA No oral medications prescribed.

ITEM INTENT

- This item is intended to identify the patient's ability to take **all** oral (p.o.) medications reliably and safely on the day of assessment.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely take oral medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:

  - physical impairments (for example, limited manual dexterity);
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear);
  - sensory impairments (for example, impaired vision, pain);
  - environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- Includes all prescribed and OTC (over-the-counter) p.o. medications that the patient is currently taking and are included on the Plan of Care.
- Excludes topical, injectable, and IV medications.
- Only medications whose route of administration is p.o. should be considered for this item. Medications are considered to be p.o. if they are placed in the mouth and swallowed, with absorption occurring through the gastrointestinal system. Medications administered by other routes, including sublingual, buccal, swish and expectorate, or administered per gastrostomy (or other) tube are not to be considered for this item.
- If the patient sets up her/his own "planner device" and is able to take the correct medication in the correct dosage at the correct time as a result of using this device, enter Response 0.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2020)

- Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, the ability to read the label (or otherwise identify the medication correctly, for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications), open the container, select the pill/tablet or milliliters of liquid and orally ingest it at the correct times.
- Enter Response 1 if the patient is independent in oral medication administration if another person must prepare individual doses (for example, place medications in a medi-planner or other device) and/or if another person in the home must modify the original medication container to enable patient access (for example, removing childproof lids, marking labels for the visually impaired or those who cannot read), or if someone in the home must develop a drug diary or chart which the patient relies on to take medications appropriately.
- Enter Response 2 if daily reminders to take medications are necessary, regardless of whether the patient is independent or needs assistance in preparing individual doses (for example, setting up a "planner device") and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently set up and manage are not considered "assistance" or "reminders.")
- If a medication is ordered PRN and the medication is needed by the patient on the day of assessment – and the patient needed a reminder to take this PRN medication on the day of assessment, Enter Response 2. If the patient did not need any PRN medications on the day of the assessment and therefore no reminders were necessary, assess the patient's ability on all of the medications taken on the day of assessment.
- Enter Response 3 if the patient does not have the physical or cognitive ability on the day of assessment to take all medications correctly (right medication, right dose, right time) as ordered and every time ordered, and it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful. The clinician would need to return to assess if the new interventions, such as reminders or a med planner, provided adequate support for the patient to take all medications safely.
- If the patient's ability to manage oral medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.
- For a patient residing in an assisted living facility where the facility holds and administers medications, M2020 should continue to report the patient's ability to take the correct oral medication(s) and proper dosage(s) at the correct times. Report ability based on assessment of the patient's vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, despite the facility's requirement.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Documentation of other agency staff
- Patient/caregiver interview
- Physical assessment
- Cognitive assessment
- Environmental assessment
- CMS OASIS Q&As can be accessed through the CMS OASIS web page

OASIS ITEM

(M2030)	**Management of Injectable Medications:** Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**
Enter Code ☐	0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times. 1 Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection 3 Unable to take injectable medication unless administered by another person. NA No injectable medications prescribed.

ITEM INTENT

- This item is intended to assess the patient's ability to take all injectable medications reliably and safely at on day of assessment.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely manage injectable medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:

  - physical impairments (for example, limited manual dexterity);
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear);
  - sensory impairments (for example, impaired vision, pain);
  - environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorway.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- Excludes IV medications, infusions (for example, medications given via a pump), and medications given in the physician's office or other settings outside the home.
- Includes one-time injections administered in the home.
- Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.
- Enter Response 0 if the patient sets up her/his own individual doses and is able to take the correct medication in the correct dosage at the correct time as a result of this.
- Enter Response 1 for a patient independent in injectable medication administration if another person must prepare individual doses and/or if another person must develop a drug diary or chart.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2030)

- Enter Response 2 if reminders to take medications are necessary, regardless of the whether the patient is independent or needs assistance in preparing individual doses and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.")
- Enter Response 3 if the physician ordered the RN to administer an injection in the home.
- If the patient's ability to manage injectable medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.
- PRN injectables, ordered and included on POC, are to be considered when determining the patient's ability to manage injectable medications. If the PRN medication was not needed during the assessment timeframe, use clinical judgment and make an inference regarding the patient's ability by asking them to describe and demonstrate the steps for administration and needle disposal, considering the patient's cognitive and physical status as well as any other barriers.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.
- For a patient residing in an assisted living facility where the facility holds and administers medications, M2030 should continue to report the patient's ability to administer all injectable medication(s) reliably and safely at the correct times. When medications are stored by the facility, use clinical judgment and make an inference regarding the patient's ability by asking the patient to describe and demonstrate the steps for administration and needle disposal, considering the patient's cognitive and physical status as well as any other barriers.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Documentation of other agency staff
- Patient/caregiver interview
- Physical assessment
- Cognitive assessment
- Environmental assessment
- CMS OASIS Q&As can be accessed through the CMS OASIS web page
- Chapter 5 of this manual has a link to the OASIS Q&As