OASIS ITEM

(M1800)	**Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code ☐	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.

ITEM INTENT

- Identifies the patient's ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene.
- 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 perform grooming, 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 ADLs. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments, (for example, impaired vision or pain)
  - environmental barriers (for example, accessing grooming aids, mirror and sink).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
  - The grooming scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is currently able to do.
  - Grooming includes several activities. The frequency with which selected activities are performed (such as washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently performed activities (for example, washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1800)

- In cases where a patient's ability is different for various grooming tasks, enter the response that best describes the patient's level of ability to perform the majority of grooming tasks.
- Response 2 includes standby assistance or verbal cueing.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1810)	Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:	
Enter Code ☐	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.

ITEM INTENT

- Identifies the patient's ability to dress upper body, including the ability to obtain, put on, and remove upper body clothing. Assess ability to put on whatever clothing is routinely worn. This specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.
- 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 dress the upper body, 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 ADLs. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision or pain)
  - environmental barriers (for example, stairs, narrow doorways, location where dressing items are stored).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Prosthetic, orthotic, or other support devices applied to the upper body (for example, upper extremity prosthesis, cervical collar, or arm sling) should be considered as upper body dressing items/tasks.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The ability to dress upper body scale presents the most independent level first then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1810)

- In cases where a patient's ability is different for various upper body dressing tasks, enter the response that best describes the patient's level of ability to perform the majority of upper body dressing tasks.
- If the patient requires standby assistance (a "spotter") to dress safely or requires verbal cueing/reminders, enter Response 2.
- If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.
- The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient if he/she has difficulty dressing upper body. Observe the patient's general appearance and clothing and ask questions to determine if the patient has been able to dress independently and safely. Opening and removing upper body garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing. The patient also can be asked to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

DATA SOURCES/RESOURCES

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1820)	Current **Ability to Dress <u>Lower</u> Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
Enter Code ☐	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.

ITEM INTENT

- Identifies the patient's ability to dress lower body, including the ability to obtain, put on, and remove lower body clothing. Assess ability to put on whatever clothing is routinely worn.
- 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 dress the lower body, 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 ADLs. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision or pain)
  - environmental barriers (for example, stairs, narrow doorways, location where dressing items are stored).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Prosthetic, orthotic, or other support devices applied to the lower body (for example, lower extremity prosthesis, ankle-foot orthosis [AFO], or anti-embolism stockings) should be considered as lower body dressing items/tasks.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The ability to dress lower body scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1820)

- In cases where a patient's ability is different for various dressing lower body tasks, enter the response that best describes the patient's level of ability to perform the majority of dressing lower body tasks.
- If the patient requires standby assistance (a "spotter") to dress safely or verbal cueing/reminders, enter Response 2.
- If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.
- The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. The patient can report the lower body dressing procedure. Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. Ask the patient to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1830)	**Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**
Enter Code ☐	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.

ITEM INTENT

- Identifies the patient's ability to bathe entire body and the assistance that may be required to safely bathe, including transferring in/out of the tub/shower.
- 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 bathe, 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 ADLs. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision or pain)
  - environmental barriers (for example, stairs, narrow doorways, location of tub/shower, wash basin/sink).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Specifically excludes washing face and hands, and shampooing hair.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The bathing scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.
- If the patient requires standby assistance to bathe safely in the tub or shower or requires verbal cueing/reminders, then enter Response 2 or Response 3, depending on whether the assistance needed is intermittent ("2") or continuous ("3").
- If the patient's ability to transfer into/out of the tub or shower is the only bathing task requiring human assistance, enter Response 2. If a patient requires one, two, or all three of the types of assistance listed in Response 2 of M1830 but not the continuous presence of another person as noted in Response 3, then Response 2 is the best response.
- The patient's status should not be based on an assumption of a patient's ability to perform a task with equipment they do not currently have, preventing assessment.
- If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers. Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities.
- If the patient does not have a tub or shower in the home, or if the tub/shower is nonfunctioning or not safe for patient use, the patient should be considered unable to bathe in the tub or shower. Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities.
- For Response 4, the patient must be able to safely and independently bathe outside the tub/shower, including independently accessing water at the sink, or setting up a basin at the bedside, etc.
  - Enter Response 5 if the patient is unable to bathe in the tub/shower and needs intermittent or continuous assistance to wash their entire body safely at a sink, in a chair, or on a commode.
  - Enter Response 6 if the patient is totally unable to participate in bathing and is totally bathed by another person, regardless of where bathing occurs or if patient has a functioning tub or shower.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance in determining if the patient has been able to bathe self independently and safely. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower with assistance and/or a device. Evaluate the amount of assistance needed for the patient to be able to <u>safely</u> bathe in tub or shower.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1840)	**Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.
Enter Code ☐	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.

ITEM INTENT

- Identifies the patient's ability to safely get to and from and transfer on and off the toilet or bedside commode.
- 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 perform toilet transferring, 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 ADLs. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision or pain)
  - environmental barriers (for example, stairs, narrow doorways, location of toilet or bedside commode).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Excludes personal hygiene and management of clothing when toileting.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The toilet transferring scale presents the most optimal level first, then proceeds to less optimal toileting methods. Read each response carefully to determine which one best describes what the patient is able to do.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1840)

- If the patient can get to and from the toilet during the day independently, but uses the commode at night for convenience, enter Response 0.
- If the patient requires standby assistance to get to and from the toilet safely or requires verbal cueing/reminders, enter Response 1.
- If the patient needs assistance getting to/from the toilet or with toileting transfer or both, then Response 1 is the best option.
- If the patient can independently get to the toilet, but requires assistance to get on and off the toilet, enter Response 1.
- A patient who is unable to get to/from the toilet or bedside commode, but is able to place and remove a bedpan/urinal independently, enter Response 3. This is the best response whether or not a patient requires assistance to empty the bedpan/urinal.
- In the absence of a toilet in the home, the assessing clinician would need to determine if the patient is able to use a bedside commode (Response 2), or if unable to use a bedside commode, if he is able to use a bedpan/urinal independently (Response 3). If the patient is not able to use the bedside commode or bedpan/urinal as defined in the responses, or if such equipment is not present in the home to allow assessment, then Response 4 – totally dependent in toileting would be appropriate.
- Assessment Strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient if he/she has any difficulty getting to and from the toilet or bedside commode. Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc. Determine the level of assistance needed by the patient to safely get on and off the toilet or commode. Tasks related to personal hygiene and management of clothing are not considered when responding to this item.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1845)	**Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.
Enter Code ☐	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.

ITEM INTENT

- Identifies the patient's ability to manage personal hygiene and clothing when toileting.
- 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 perform toileting hygiene, 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 ADLs. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision or pain)
  - environmental barriers (for example, stairs, narrow doorways, location of hygiene/clothing management supplies/implements).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Toileting hygiene includes several activities, including pulling clothes up or down and adequately cleaning (wiping) the perineal area.
- Toileting hygiene includes the patient's ability to maintain hygiene related to catheter care and the ability to cleanse around all stomas that are used for urinary or bowel elimination (for example, urostomies, colostomies, ileostomies).
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The toileting hygiene scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1845)

- This item refers to the patient's ability to manage personal hygiene and clothing with or without assistive devices. The word "assistance" in this question refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- Enter Response 0 if the patient is independent in managing toileting hygiene and managing clothing.
- Enter Response 1 if the patient is able to manage toileting hygiene and manage clothing IF supplies are laid out for the patient.
- If the patient can participate in hygiene and/or clothing management but needs some assistance with either or both activities, enter Response 2.
- Response 2 includes standby assistance or verbal cueing.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1850)	**Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
Enter Code ☐	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.

ITEM INTENT

- Identifies the patient's ability to safely transfer from bed to chair (and chair to bed), or position self in bed if bedfast.
- 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 transfer, 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 ADLs. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision or pain)
  - environmental barriers environmental barriers (for example, stairs, narrow doorways, location of current sleeping surface and a sitting surface).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- For most patients, the transfer between bed and chair will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair, and back into bed from the chair or sitting surface.
- If there is no chair in the patient's bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient's ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient's environment and need, (for example, a chair in another room, a bedside commode, the toilet, a bench, etc.). Include the ability to return back into bed from the sitting surface.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1850)

- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The transferring scale presents the most optimal level first, then proceeds to less optimal levels of transferring. Read each response carefully to determine which one best describes what the patient is able to do.
- Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (for example, a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities). If the patient is able to transfer self from bed to chair, but requires standby assistance to transfer safely, or requires verbal cueing/reminders, enter Response 1.
- For Response 1, "minimal human assistance" could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance.
- In order for the assistance to be considered minimal, it would mean the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.
- If the patient transfers either with minimal human assistance (but not device), or with the use of a device (but no human assistance), enter Response 1. If the patient requires both minimal human assistance and an assistive device to transfer safely, enter Response 2.
- If the patient can bear weight and pivot, but requires more than minimal human assist, enter Response 2.
- The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, enter Response 3.
- If the patient is bedfast, enter Response 4 or 5, depending on the patient's ability to turn and position self in bed. Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient about transferring ability. Observe the patient during transfers and determine the amount of assistance required for <u>safe</u> transfer from bed to chair.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1860)	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.	
Enter Code ☐	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.

ITEM INTENT

- Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces.
- 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 ambulate or use a wheelchair, 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 ADLs. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision or pain)
  - environmental barriers (for example, stairs, narrow doorways, unsafe flooring).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Variety of surfaces refers to typical surfaces that the patient would routinely encounter in his/her environment, and may vary based on the individual residence.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1860)

- The ambulation/locomotion scale presents the most optimal level first, then proceeds to less optimal mobility abilities. Read each response carefully to determine which one best describes what the patient is able to do.
- Regardless of the need for an assistive device, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, enter Response 2 or Response 3, depending on whether the assistance required is intermittent ("2") or continuous ("3").
  - If the patient is safely able to ambulate without a device on a level surface, but requires minimal assistance on stairs, steps, and uneven surfaces, enter Response 2 (requires human supervision or assistance to negotiate stairs or steps or uneven surfaces).
  - If a patient does not require human assistance, but safely ambulates with a walker in some areas of the home, and a cane in other areas (due to space limitations, distances, etc.), enter the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters (for example, Response 2 is appropriate if a walker is required for safe ambulation in the hallway and living room, even if there are some situations in the home where a cane provides adequate support).
  - If a patient does not have a walking device but is clearly not safe walking alone, enter Response 3, able to walk only with the supervision or assistance should be reported, unless the patient is chairfast.
  - Responses 4 and 5 refer to a patient who is unable to ambulate, even with the use of assistive devices and/or continuous assistance. For a patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, enter Response 4 or 5, based on ability to wheel self.
  - Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, or demonstrates loss of balance or other actions that suggest a need for additional support for safe ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to safely propel wheelchair independently, whether the wheelchair is a powered or manual version.

DATA SOURCES/RESOURCES

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1870)	**Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.
Enter Code ☐	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.

ITEM INTENT

- Identifies the patient's ability to feed him/herself, including the process of eating, chewing, and swallowing food.
- 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 self-feed, 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 ADLs. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision or hearing, pain).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- This item excludes evaluation of the preparation of food items, and transport to the table. Respond to this item based on the assistance needed by the patient to feed himself once the food is placed in front of him. Assistance means human assistance by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- The patient's ability may change as the patient's condition improves or declines, or as medical restrictions are imposed or lifted. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1870)

- The feeding/eating scale presents the most optimal level first, then proceeds to less optimal feeding/eating abilities. Read each response carefully to determine which one best describes what the patient is able to do.
- Meal "set-up" (Response 1) includes activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc. – all of which are special adaptations of the meal for the patient.
- Enter Response 2 if the patient is either unable to feed themselves and/or must be assisted or supervised while eating.
- If a tube is being used to provide all or some nutrition, enter Response 3 or 4, depending on the patient's ability to take in nutrients orally. If a patient is being weaned from tube feeding, Response 3 or 4 will continue to apply until the patient no longer uses the tube for nutrition, at which time, enter Response 0, 1, or 2. This is true, even if the tube remains in place, unused for a period of time.
- Responses 4 and 5 include non-oral intake.
- Response 5 is the best response for patients who are not able to take in nutrients orally or by tube feeding. This may be the case for patients who receive all nutrition intravenously (such as TPN) or for patients who are receiving only intravenous hydration.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Nutritional assessment
- Physician orders
- Plan of Care
- Referral information
- Review of past health history

OASIS ITEM

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

ITEM INTENT

- Identifies whether the home health agency has assessed the patient and home environment for characteristics that place the patient at risk for falls. The multi-factor falls risk assessment must include at least one standardized, validated tool that 1) has been scientifically tested in a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elders, noninstitutionalized adults with disabilities, etc.) and shown to be effective in identifying people at risk for falls; and 2) includes a standard response scale. The standardized, validated tool must be both appropriate for the patient based on their cognitive and physical status and appropriately administered per the tool's instructions.
- 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

- CMS does not mandate that clinicians conduct falls risk screening for all patients, nor is there a mandate for the use of a specific tool.
  - A clinician other than the assessing clinician may complete the standardized, validated fall risk screening for consideration by the assessing clinician.
- For Responses 1 and 2, an agency may use a single comprehensive multi-factor falls risk assessment tool that meets the criteria as described in the item intent. Alternatively, an agency may incorporate several tools as long as one of them meets the criteria as described in the item intent. For example, a physical performance component (for example, Timed Up and Go), a medication review, review of patient history of falls, assessment of lower limb function and selected OASIS items (for example, OASIS items for cognitive status, vision, incontinence, ambulation, transferring).
- Use the scoring parameters specified in the tool to identify if a patient is at risk for falls. Enter Response 1 if the standardized, validated response scale rates the patient as no-risk, low-risk, or minimal risk. Enter Response 2 if the standardized, validated response scale rates the patient as anything above low/minimal-risk. If the tool does not provide various levels, but simply has a single threshold separating those "at risk" from those "not at risk," then enter Response 2 for the patient scoring "at risk."

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1910)

- Enter Response 0 if:
  - a standardized, validated multi-factor falls risk screening was NOT conducted by the home health agency,
  - a standardized, validated multi-factor falls risk screening was conducted by the home health agency but NOT during the required assessment time frame,
  - the patient is not able to participate in tasks required to allow the completion and scoring of the standardized, validated assessment(s) that the agency chooses to utilize.

DATA SOURCES/RESOURCES

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment
- Referral information
- Review of past health history
- Several links to guidelines listing Falls Risk Assessment factors can be found in Chapter 5 of this manual