OASIS Class 3

Home Health VNA
Merrimack Valley Hospice
HomeCare, Inc.

The Leaders in Home Health and Hospice Care

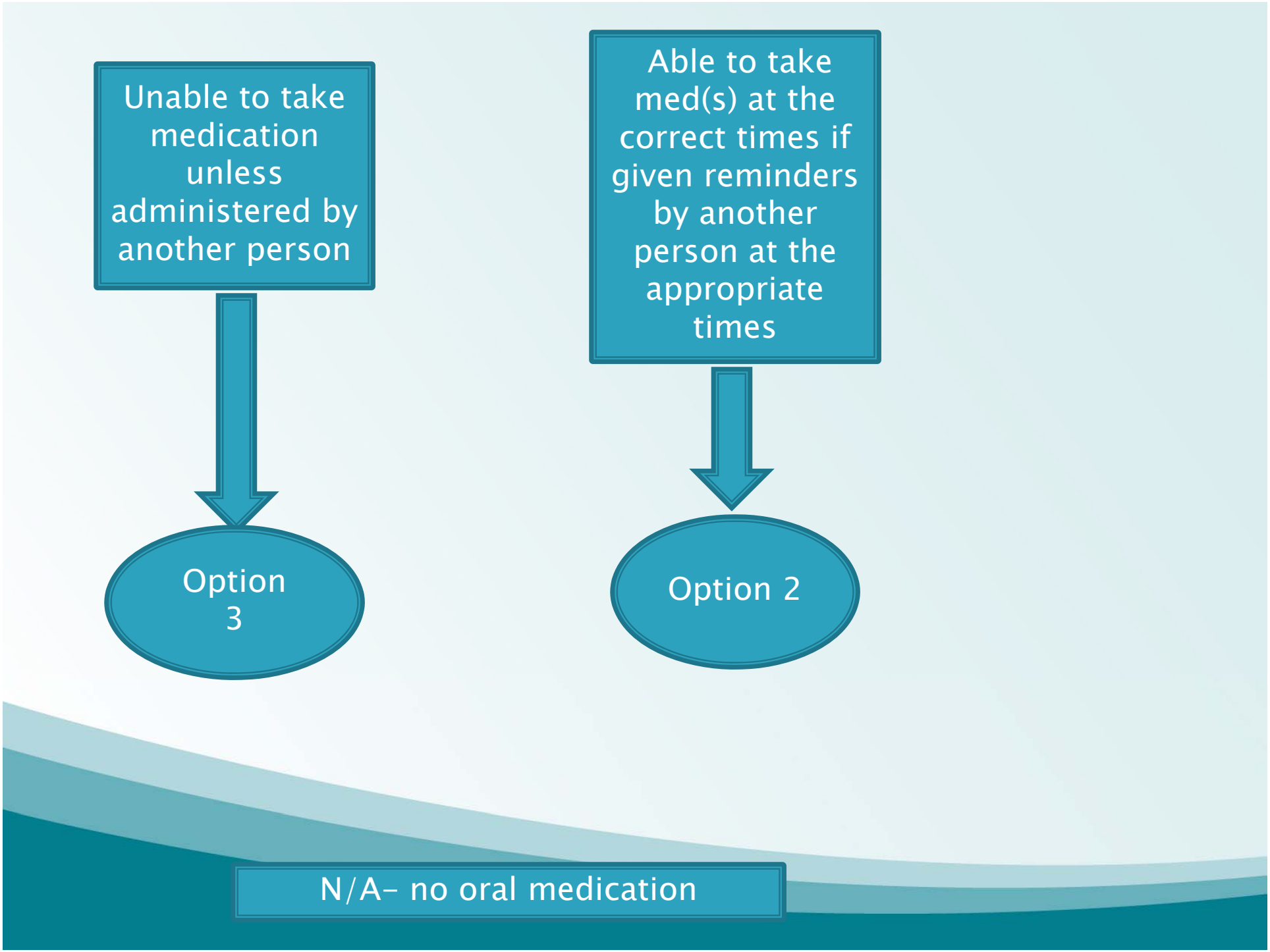
Syllabus

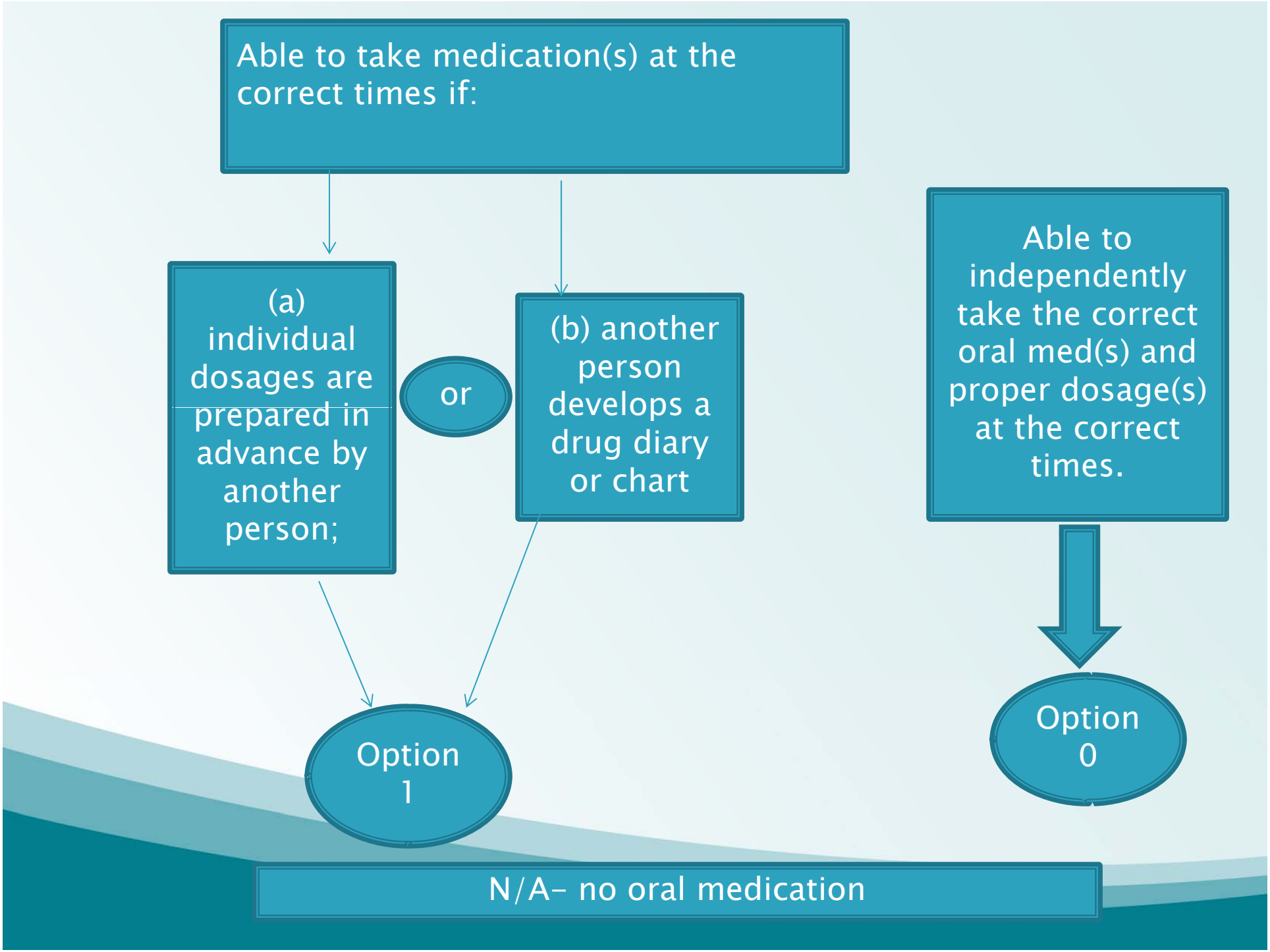
- Medication management
- ***2015 Drug Education***
- Pressure ulcers
- Stasis ulcer
- Sx wounds

(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.)

Consider the following :

- all medications prescription and over the counter
- Ability not willingness or compliance
- Mental /emotional status
- Cognitive function
- Activities permitted


Unable to take medication unless administered by another person
Able to take med(s) at the correct times if given reminders by another person at the appropriate times
Option 3
Option 2
N/A- no oral medication


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
Able to independently take the correct oral med(s) and proper dosage(s) at the correct times.
Option 1
Option 0
N/A- no oral medication

- Environment can they get top the location the meds are normally stored at
- Pt has to be able to get the medication, read or identify medication, open the container select measure liquid and take the medication
- PO meds =placed in mouth and swallowed
- Does not include inhalers or swish and expectorate
- Report was is true on day of assessment
- If ability varies from med to med consider the medication that takes the most assistance

- If ability varies from med to med consider the medication that takes the most assistance
- If they are missing a medication you are unable to assess & therefore they are unable to take it
- If Prn medication is ordered and needed on day of assessment and pt needed reminders that they could take it and it was needed the score would be a 2
- If pt lives in an ALF and the meds are kept in med room and the sn administers use clinical judgment to determine if the pt is able to take correct oral medication & proper dosage a the correct time
- **Bubble packs**-If the pt receives them and they can take them independently if no one comes into the home to set them up the pt is independent . They were set up outside the home

APPLY WHAT YOU LEARN

At SOC MRS Jones has 3 oral meds prescribed daily. She has been safely taking her antihypertensive and stool softener for years at the appropriate times and dose, but is not taking her tapering dose of steroids as she doesn't understand which dose she should take which day. The RN established a drug chart and educated Mrs. Williams regarding proper medication.

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.

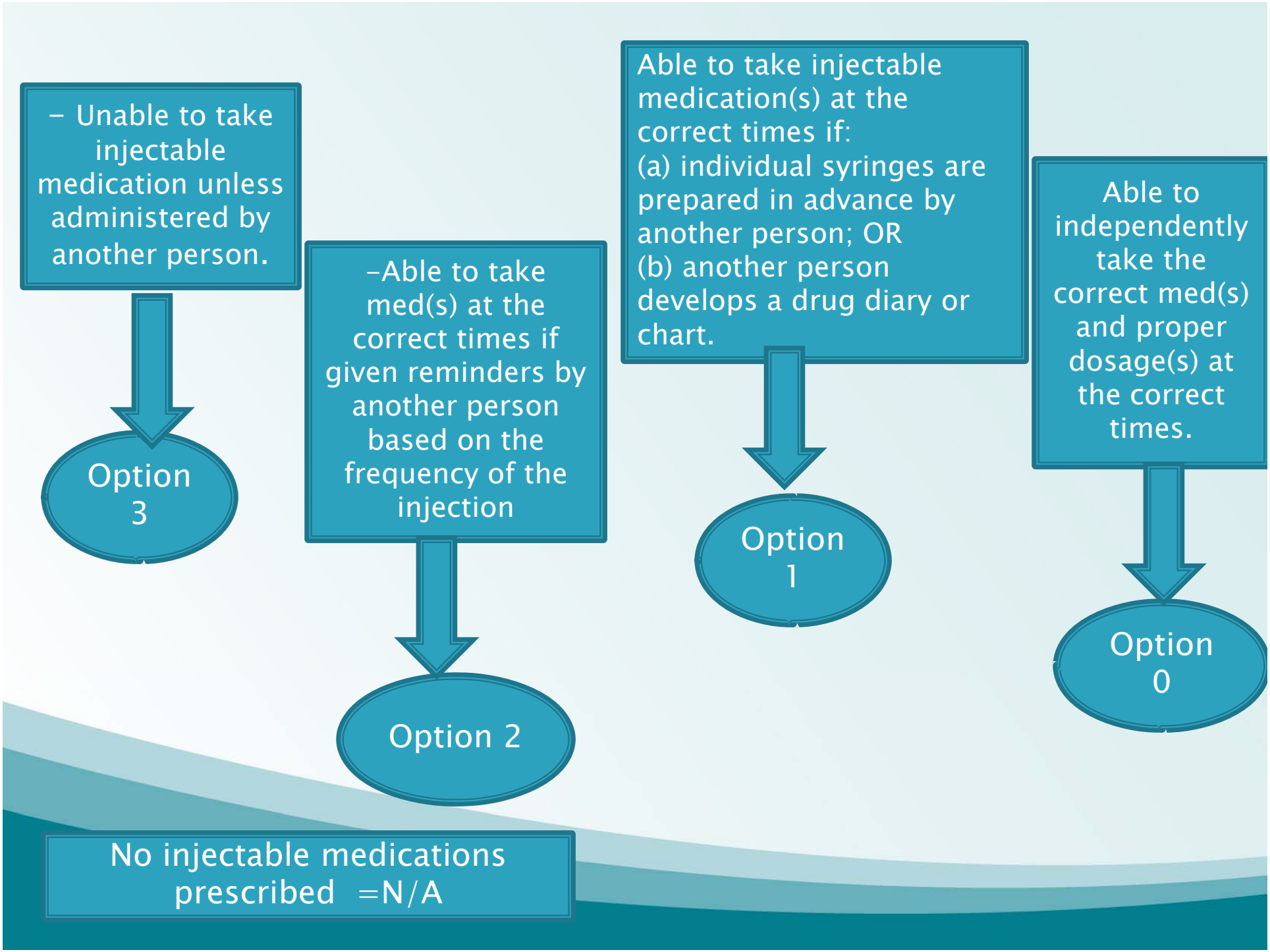
2 – Able to take medication(s) at the correct times if given reminders by another person at the appropriate times

3 – Unable to take medication unless administered by another person.

NA – No oral medications prescribed.

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.

- Include medication ordered even if not administered on day of assessment
- The B12 for example that is not due but ordered monthly
- You may make inferences based on the pt's cognitive and physical status


– Unable to take injectable medication unless administered by another person.
Option 3
–Able to take med(s) at the correct times if given reminders by another person based on the frequency of the injection
Option 2
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.
Option 1
Able to independently take the correct med(s) and proper dosage(s) at the correct times.
Option 0
No injectable medications prescribed =N/A

- Pt's current ability to prepare all injectable medications reliably and safely. Excludes IV meds
- Includes obtaining , drawing up ,aseptic technique
- Disposing of needle properly
- If ability varies between 2 medications consider the one that takes the most assistance
- PRN injections, even if not used on day of assessment

  i.e. epi pens , insulin

Apply What You Learn

Mr. James has drawn up and injected his insulin without difficulty for at least a decade. With his progressing dementia, he now needs an alarm system to remind him when its time to administer the injection. Mr. James is unable to set up the alarm and depends on his daughter to do that for him. You assess this system is working successfully.

How would you score the oasis?

0-Able to independently take the correct medication and proper dose at the correct time

1- Able to take injectable medication at the correct time 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 at the correct time if given reminders by another person based on the frequency of the injection

3- unable to take the medication unless administered by another person

NA - no injectable medication

Star Rating – Drug Education on All Medications

(M2015) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the previous OASIS 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?

0 – No

1 – Yes

NA – Patient not taking any drugs

OASIS Time Points Completed

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

Item Intent

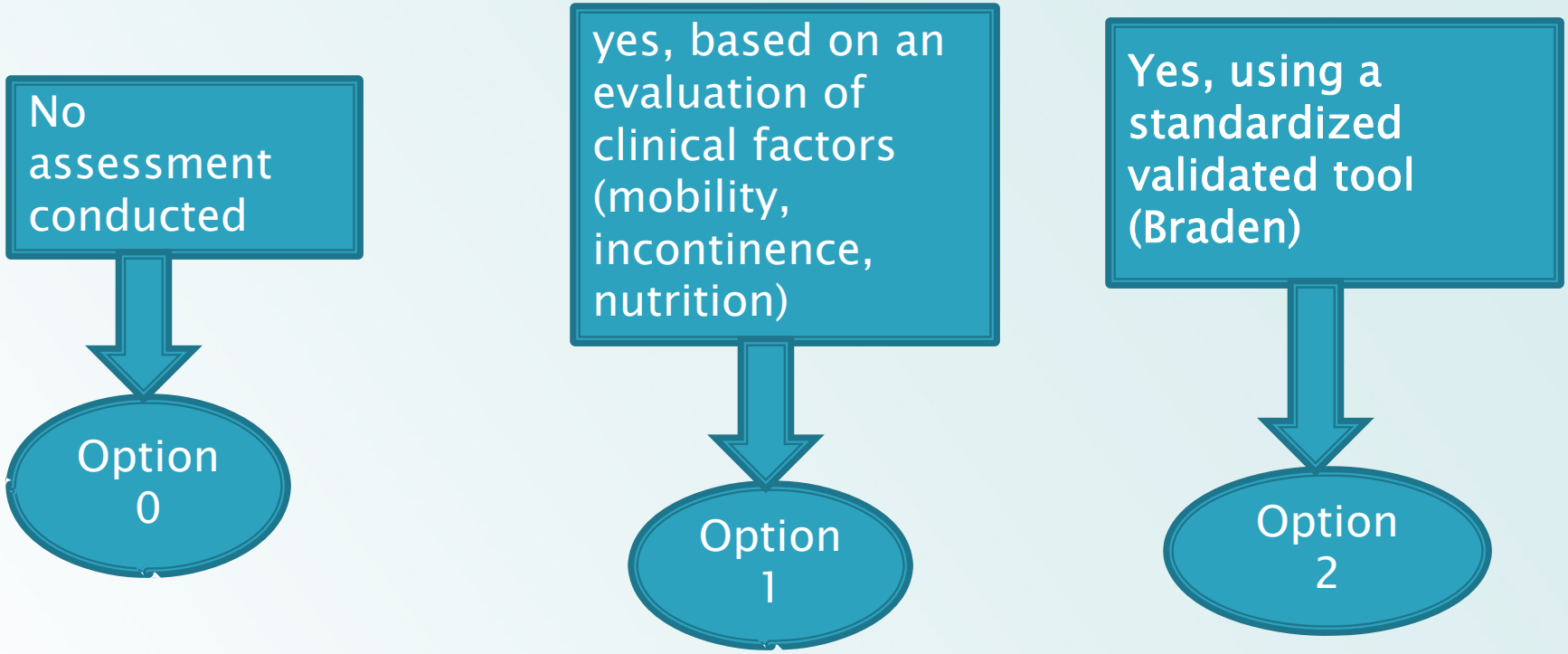
- Identifies if clinicians instructed the patient/caregiver about how to manage medications effectively and safely. Drug education interventions for M2015 should address all medications the patient is taking – prescribed and over-the-counter – by any route
- Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment.

- Current agency best-practice and established procedure is that all patients receive medication education on effective and adverse reactions. Teaching is ongoing throughout the course of care, and is documented in the Med Review section of the clinical note.

- **Current Agency Average Score = 97%** **Goal = 99%**

M1300 Pressure ulcer Assessment

Was the pt assessed for risk for developing a pressure ulcer?

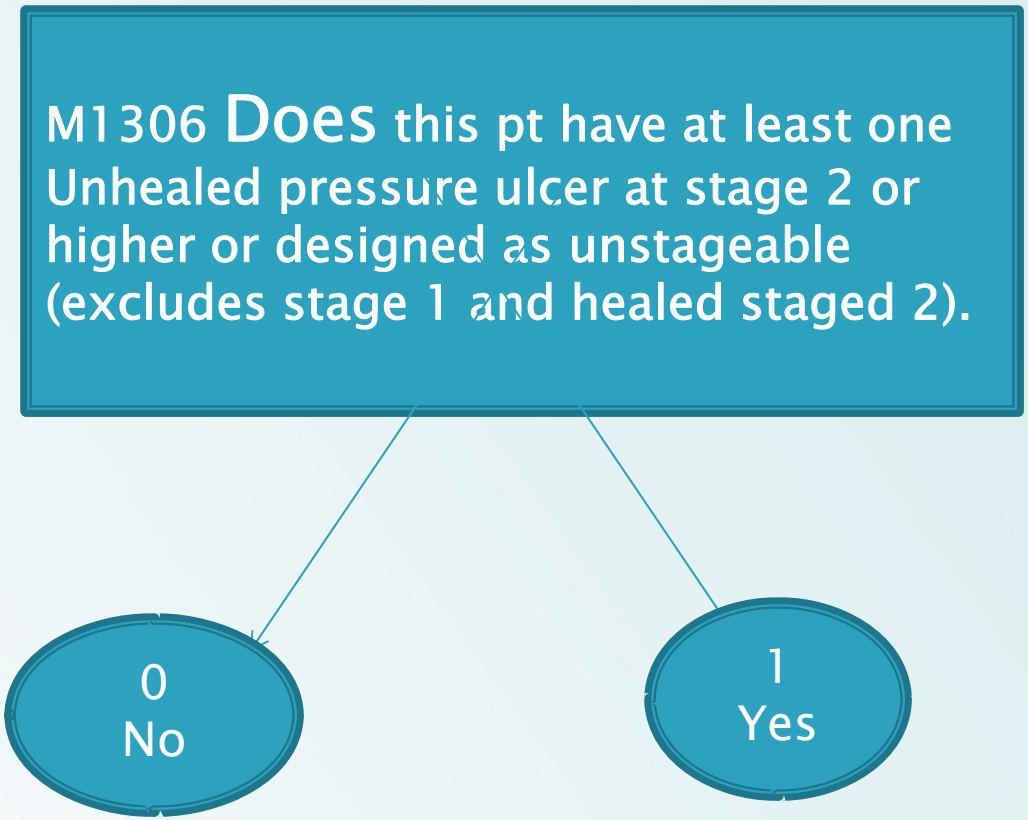


0- should not be used
You must assess – agency uses the Braden

M1302 Does this pt have risk for Developing Ulcers?

If Braden was 18 or less pt is at risk AND there needs to be an intervention on the poc specifically for Pressure ulcer prevention and then we must provide that care.

* *** A full head to toe skin assessment must be done in ordered to answer these questions. This is not an interview question****



0-No if the only pressure ulcers are stage 1 or there was a 2 that is healed

1- Yes if the pt has an unhealed stage 2 or 3 OR stage 4 ulcer at any healing status or if the pt has unstagable ulcer

M1307 –The oldest stage 2 pressure ulcer that is present at d/c

1 Was present at the most recent SOC /ROC assessment

2 Developed since the most recent SOC /ROC assessment. RECORD the date pressure ulcer 1st identified

N/A

The intent is to :

- Identify the oldest stage 2 pressure ulcer that is present at d/c and is not fully epithelialized, assess the length of time this ulcer remained unhealed while the patient received care from the home health agency
- And to identify patient who developed stage 2 pressure ulcers while under the care of the HHA

M1308 Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable: (Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers) Stage Descriptions—unhealed pressure ulcers

Number Currently Present

a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

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b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

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c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

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d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device

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d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.

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d.3 Unstageable: Suspected deep tissue injury in evolution

- Identifies the number of Stage II or higher pressure ulcers at each stage present at the time of assessment. Stage I pressure ulcers are not reported in this item.

- Report the number of Stage II or higher pressure ulcers that are present on the current day of assessment

- A pressure ulcer treated with a muscle/rotational flap is a surgical wound
- A pressure ulcer treated w/ a skin graft is a remains a pressure ulcer
- Until the graft edges completely heal, the grafted pressure ulcer should be reported as unstageable
- Once the graft edges heal the closed stage 3 or 4 would continue to be regarded as a pressure ulcer at its worse stage
- A pressure ulcer that has been surgically debrided remains a pressure ulcer and should not be reported as a sx wound on M1342

M1309 Worsening in Pressure Ulcer Status since SOC/ROC: Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC

- This item documents the number of pressure ulcers that are new or have "worsened" (increased in numerical stage) since the most recent Start or Resumption of Care assessment. Definitions of pressure ulcer stages are derived from the National Pressure Ulcer Advisory Panel (NPUAP).

- See chart attached hand out

Review the history of each current pressure ulcer. Specifically, compare the current stage of the pressure ulcer to the stage of that ulcer at the most recent SOC/ROC to determine whether the pressure ulcer currently present is **new or worsened** when compared to the presence or stage of that pressure ulcer at the most recent SOC/ROC.

Utilize the WOCN Guidance to determine status of the most problematic observable pressure ulcer:

Newly Epithelialized:

wound bed completely covered with new epithelium, no exudate, no avascular tissue (eschar and/or slough); no signs or symptoms of infection.

Fully Granulating:

wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue (eschar and/or slough); no signs or symptoms of infection; wound edges are open

Early/Partial Granulation: wound with ≥25% of the wound bed covered with granulation tissue; <25% of the wound bed covered with avascular tissue (eschar and/or slough); may have dead space; no signs or symptoms of infection; wound edges open.

Not Healing: wound with ≥25% avascular tissue (eschar and/or slough) OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management

- Because Stage II ulcers do not granulate and newly epithelialized Stage II ulcers are not counted, the only appropriate response for a Stage II ulcer is (3) – Not Healing.

- Since a suspected Deep Tissue Injury in evolution does not granulate and would not be covered with new epithelial tissue, the only appropriate response for a suspected Deep Tissue Injury is
- (3)– Not Healing.

- **M1320 Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)**

0 – Newly epithelialized

1 – Fully granulating

2 – Early/partial granulation

3 – Not healing

NA – No observable pressure ulcer

- Identifies the degree of closure visible in the most problematic observable pressure ulcer, Stage II or higher. Please note, Stage I pressure ulcers are not considered for this item.

M1322 Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue.

1–4 or more

M1324 Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

1 – Stage I

2 – Stage II

3 – Stage III

4 – Stage IV

A – Patient has no pressure ulcers or no stageable pressure ulcers

Suspected Deep Tissue Injury

- Purple or maroon localized area of discolored intact skin or blood-filled blister The area maybe be painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar

Stage I

- Intact skin with non-blanchable redness of localized area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area
- The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. May be difficult to detect in individuals with dark skin tones.

Stage II

- Partial thickness loss of dermis presented as a shallow open ulcer with a red pink wound bed, **without slough**.
- May also present as an intact or open/ruptured serum filled blister
- Presents as a shiny or dry shallow ulcer without slough or bruising.
- This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

Stage III

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

Stage IV

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

Unstageable

- Full thickness tissue loss in which the base of the ulcer is covered by slough
- (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the
- wound bed.
- Until enough slough and/or eschar is removed to expose the base of the wound,

  the true depth, and therefore stage, cannot be determined. Stable (dry, adherent,

  intact without erythema or fluctuance) eschar on the heel serves as “the body’s

  natural (biological) cover” and should not be removed.

(M1330) Does this patient have a Stasis Ulcer?

0 – No [Go to M1340]

1 – Yes, patient has BOTH observable and unobservable stasis ulcers

2 – Yes, patient has observable stasis ulcers ONLY

3 – Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) [Go to M1340]

- Report only current stasis ulcers
- If completely epithealialized , no longer a stasis ulcer
- Select 0-no if all stasis ulcers are completely healed

(M1332) Current Number of Stasis Ulcer(s) that are Observable:

1 – One

2 – Two

3 – Three

4 – Four or more

(M1334) Status of Most Problematic Stasis Ulcer that is Observable:

1 – Fully granulating

2 – Early/partial granulation

3 – Not healing

(M1340) Does this patient have a Surgical Wound?

0 – No [At SOC/ROC, go to M1350 ; At FU//DC, go to M1400]

1 – Yes, patient has at least one observable surgical wound

2 – Surgical wound known but not observable due to non-removable dressing/device [At SOC/ROC, go to M1350 ; At FU/DC, go to M1400]

- Surgical wounds are more than just surgical incisions and not all surgical incisions are surgical wounds

- See attached sheet

M1342 Status of Most Problematic Surgical Wound that is Observable

0 – Newly epithelialized
1 – Fully granulating
2 – Early/partial granulation
3 – Not healing

- Primary intention=closed by sutures, staples, or chemical bonding
- Secondary intention= left open closing from within

- Considered a surgical wound for approximately 30 days after re-epithelialization take place

- After that it is a scar/lesion and not included here

Scab does not automatically mean non healing

If scab is adhering to underlying tissue , full epithelialization has not occurred in the scabbed area

Date of complete epithelialization:

- consider date of sx, any reported wound healing progress/complications and clinical assessment findings
- If could have been epithelialized for 30 days , wound is considered healed and not considered here

- Is the incision line completely re-epithelialized with no signs or symptoms of infection (if completely closed, re-epithelialization generally takes place in 3 days)
- If yes newly epithelialized for 30 days then it's a scar
- If not e.g scab is adhering to incisional tissue and /or s/s infection then =non healing

- If openings or disruptions present in the incision= wound healing by secondary intention and you can have the choice of early partial fully granulating or newly epithelialized

Apply What you Learned

Pt is a 76 y/o female s/p L TKR. Pt has TKR 1.5 weeks ago. SN noted the wound was closed w/ staples. There was no redness or warmth to the areas but noted drainage at the site. How would you score the sx wound ?

0 -Newly epithelialized

1 -Fully granulating

2-Earlt/partial granulation

3- Not healing

Skin Lesion M1350

(M1350) Does this patient have a Skin Lesion or Open Wound (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?

0 – No

1 – Yes

Certain open wounds/lesions **are not** included in this item. These include:

- bowel ostomies (which are reported in OASIS item M1630)
- – wounds resulting from cataract surgery, surgery to mucosal membranes, or gynecological surgical procedures by a vaginal approach
- tattoos, piercings, and other skin alterations unless ongoing assessment and/or clinical intervention by the home health agency is a part of the planned/provided care

Response 0 – "No" should be selected if:

- – the patient does not have any open wounds/skin lesions (as defined above), or
- – all of the patient's open wounds/skin lesions have been addressed in other OASIS-C1 Integumentary Items (pressure ulcer, stasis ulcer, or surgical wound)
- – the patient's open wounds/skin lesions are not receiving clinical intervention from the home health agency (as defined above)

Response 1 – "Yes" should be selected for all types of other open wounds/skin lesions that are part of the agency's planned/provided care but are NOT addressed in other OASIS-C1 Integumentary Items. Examples include but are not limited to:

- – burns, diabetic ulcers, cellulitis, abscesses, edema, wounds caused by trauma of various kinds
- – PICC line and peripheral IV sites
- – non-bowel ostomies (for example, tracheostomies, thoracostomies, urostomies, jejunostomies, gastrostomies) if clinical interventions (for example, cleansing, dressing changes, assessment) are being provided by the home health agency during the care episode