Personal and Skilled Care Outcomes (PESO) Data Set
Assessment Guide

Complete Data Set

December 2007

This document contains the Personal and Skilled Care Outcomes (PESO) data set, together with (1) item-level strategies for assessing patients to obtain required information and (2) clarifying definitions and response-specific instructions known as "prompts." The document is organized in the following manner:

- The PESO data items are found on the right side of each page and are numbered sequentially.
- When appropriate, clarifying definitions and response-specific instructions are located in boxes next to specific data items.
- Assessment strategies that have been found to be effective in obtaining required item-level data are located on the left side of each page, directly opposite each specific data item and numbered correspondingly.
- Data items that should be administered through a direct interview of the patient are contained within bold-faced boxes. The question and response options for each of these Patient-Response Items should be read verbatim to the patient. The patient should choose an answer from the responses provided. All other items should be answered based on your conversation with and observation of the patient, and do not need to be asked verbatim of the patient.

AGENCY AND PATIENT INFORMATION

Assessment Strategy | **Data Item**

1. Agency NYS License Number
Agency administrator and billing staff can provide this information. This number can be preprinted on clinical documentation.

1. (PS010) Agency NYS License Number: __ __ __ __ **L** __ __ __

2. Patient ID
Agency-specific patient identifier, assigned to the patient for the purposes of record keeping. Agency medical records department is the usual source of this number.

2. (PS020) Patient ID:
__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Agency clinical record ID.

3. Patient Name
Patient's full name. Use the patient's legal name.

3. (PS030) Patient Name:

__ __ __ __ __ __ __ __ __ __ __ __ __
(First) (MI)

__ __
(Last) (Suffix)

4. Medicaid Number
If the patient has Medicaid, ask to see the patient's Medicaid card or other verifying documentation. Be sure that the coverage is still in effect. If the patient does not have Medicaid coverage, mark "NA - No Medicaid."

4. (PS040) Medicaid Number:

__ __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ NA – No Medicaid

5. Start of Care Date
Date that care begins. If uncertain as to the start of care date, clarify the date with agency administrative personnel.

5. (PS050) Start of Care Date: __ __ **/** __ __ **/** __ __ __ __
month day year

Date of first visit.

6. Resumption of Care Date
The date of the first visit following an inpatient stay for a patient already receiving services from the agency. If uncertain as to the resumption of care date, clarify with agency administrative staff.

6. (PS060) Resumption of Care Date:
__ __ **/** __ __ **/** __ __ __ __ ☐ NA – Not Applicable
month day year

Date of first visit following inpatient stay.

7. Date Assessment Completed
The date that the assessment visit is completed. For assessments that concern patient transfer to an inpatient facility or death at home, record the date that the agency learns of the transfer or death.

7. (PS070) Date Assessment Visit Completed:

__ __ /__ __ /__ __ __ __
month day year

AGENCY AND PATIENT INFORMATION

Assessment Strategy | **Data Item**

8. Reason for Assessment

Why is the assessment being completed? What has happened to the patient that indicates there is a need for an assessment?

8. (PS080) This Assessment is Being Completed for the Following Reason:

- ☐ 1 - Start of care
- ☐ 2 - Resumption of care
- ☐ 3 - Reassessment
- ☐ 4 - Transferred to an inpatient facility
- ☐ 5 - Death at home
- ☐ 6 - Discharge from agency

9. Changes Since Last Assessment

PS000 - Reassessment/ Follow-up & Discharge

Check "No" if no changes have occurred to the information reported in the items in the Patient Description section (Items PS040, PS120, PS130, PS140, PS150). If changes have occurred to any of these items, check "Yes" and complete the items for which new or updated information is available. Patient Description items for which no changes have occurred can be left blank. If this is the patient's first assessment using the PESO data set, complete all of the items in the Patient Description section, regardless of whether changes have occurred since the patient's last clinical assessment.

9. (PS000) Changes Since Last Assessment: Since the last PESO assessment, have changes occurred to the information reported in the items in the Patient Description section (Items PS040, PS120, PS130, PS140, PS150)? If no changes have occurred, check "No" and go to Item PS160. If changes have occurred, check "Yes," complete any item for which updated information is available, and then go to Item PS160.

- ☐ 0 - No **[Go to Item PS160]**
- ☐ 1 - Yes **[Complete Items that Have Changed, then Go to Item PS160]**

Changes Since Last Assessment

PS000 - Transfer

Check "No" if no changes have occurred to the information reported in the items in the Patient Description section (Items PS040, PS120, PS130, PS140, PS150). If changes have occurred to any of these items, check "Yes" and complete the items for which new or updated information is available. Patient Description items for which no changes have occurred can be left blank. If this is the patient's first assessment using the PESO data set, complete all of the items in the Patient Description section, regardless of whether changes have occurred since the patient's last clinical assessment.

(PS000) Changes Since Last Assessment: Since the last PESO assessment, have changes occurred to the information reported in the items in the Patient Description section (Items PS040, PS120, PS130, PS140, PS150)? If no changes have occurred, check "No" and go to Item PS810. If changes have occurred, check "Yes," complete any item for which updated information is available, and then go to Item PS810.

- ☐ 0 - No **[Go to Item PS810]**
- ☐ 1 - Yes **[Complete Items that Have Changed, then Go to Item PS810]**

AGENCY AND PATIENT INFORMATION

Assessment Strategy	Data Item
10. Discharge/Transfer/Death Date This item identifies the actual date of discharge, transfer, or death at home. Agency policy or physician order may establish discharge date. Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home. The transfer date is the actual date the patient was transferred to an inpatient facility. The death date is the actual date of the patient's death at home.	**10. (PS090) Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer, or death (at home) of the patient. __ __ /__ __ / __ __ __ __ month day year
11. Discharge Disposition This item identifies where the patient resides after discharge from the home health agency. Patients who are in assisted living or board and care housing are considered to be living in the community. Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.	**11. (PS100) Discharge Disposition:** Where is the patient after discharge from your agency? (Choose only one answer.) ☐ 1 - Patient remained in the community (not in hospital, nursing home, or rehab facility) ☐ 2 - Patient transferred to a noninstitutional hospice ☐ 3 - Unknown because patient moved to a geographic location not served by this agency **[Skip Remainder of Form]** ☐ UK - Other unknown **[Skip Remainder of Form]**
12. Services or Assistance This item identifies the services or assistance a patient receives after discharge from the home health agency. Ask the patient/caregiver what type of services or support the patient might be receiving after discharge. Item PS234 contains a list of services or assistance that can be used as a reference.	**12. (PS110)** After discharge, does the patient receive health, personal, or support **Services or Assistance? (Mark all that apply.)** ☐ 1 - No assistance or services received ☐ 2 - Yes, assistance or services provided by family or friends ☐ 3 - Yes, skilled home health care services provided by another agency ☐ 4 - Yes, assistance or services provided by other community resources (for example, meals-on-wheels, homemaker assistance, transportation assistance, assisted living, board and care)

DEMOGRAPHICS AND PATIENT HISTORY

Assessment Strategy | **Data Item**

13. Birth Date

If the patient is unable to respond to this item, ask a family member or the physician's staff. The date also might be available from other legal documents (for example, driver's license, state-issued ID card). Enter dashes for any unknown information (for example, if a patient was born in December 1954, but the precise date is not known, enter 12/ – – /1954).

13. (PS120) Birth Date: __ __ /__ __ /__ __ __ __
month day year

14. Gender

Patient gender as determined through observation or interview.

14. (PS130) Gender:

- ☐ 1 - Male
- ☐ 2 - Female

15. Race/Ethnicity

Determine through interview of patient or caregiver. These categories are those used by the US Census Bureau. The patient may self-identify with more than one group. Mark all categories that are mentioned. If you choose "UK - Unknown," no other options should be marked.

15. (PS140) Race/Ethnicity (as identified by patient): **(Mark all that apply.)**

- ☐ 1 - American Indian or Alaska Native
- ☐ 2 - Asian
- ☐ 3 - Black or African-American
- ☐ 4 - Hispanic or Latino
- ☐ 5 - Native Hawaiian or Pacific Islander
- ☐ 6 - White
- ☐ 7 - Other (specify) _____
- ☐ UK - Unknown

16. Current Payment Sources for Home Care

Referral source may provide information regarding payment, which can be verified with the patient or caregiver. Agency billing office also may have this information.

16. (PS150) Current Payment Sources for Home Care: (Mark all that apply.)

Payment sources for the care your agency is providing.

- ☐ 0 - None; no charge for current services
- ☐ 1 - Medicaid (traditional fee-for-service)
- ☐ 2 - Medicaid (HMO/managed care)
- ☐ 3 - Workers' compensation
- ☐ 4 - Title programs (for example, Title III, V, or XX)
- ☐ 5 - Other government (for example, TRICARE, VA, EISEP)
- ☐ 6 - Private insurance
- ☐ 7 - Private HMO/managed care
- ☐ 8 - Self-pay
- ☐ 9 - Other (specify) _____
- ☐ UK - Unknown

DEMOGRAPHICS AND PATIENT HISTORY

Assessment Strategy | **Data Item**

17. Services Provided and Ordered

PS160-PS164 - Start/Resumption of Care

Examine the patient's current care plan. Confer with a case manager if indicated. Interview the patient or caregiver to determine whether skilled services (outside of the required assessments) and/or personal care services are being provided to or are ordered for the patient. Skilled services are those provided by a registered nurse or therapist. Care provided by a Certified Nursing Assistant (CNA) should not be recorded as skilled care. A visit conducted by a nurse for the sole purpose of supervising the aide/personal care aide also should not be considered a skilled service.

17. Services Provided and Ordered

a. **(PS160)** Is <u>your agency</u> providing (or ordered to provide) skilled services to the patient?

- ☐ 0 - No
- ☐ 1 - Yes

b. **(PS162)** Is <u>another agency</u> providing (or ordered to provide) skilled services to the patient?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ UK - Unknown

c. **(PS164)** Is your agency providing (or ordered to provide) personal care services to the patient?

- ☐ 0 - No
- ☐ 1 - Yes

PS160-164 - Reassessment/ Follow-Up & Discharge

Services Provided and Ordered

Examine the patient's current care plan. Confer with a case manager if indicated. Interview the patient or caregiver to determine whether skilled services (outside of the required assessments) and/or personal care services are being provided to or are ordered for the patient. Skilled services are those provided by a registered nurse or therapist. Care provided by a Certified Nursing Assistant (CNA) should not be recorded as skilled care. A visit conducted by a nurse for the sole purpose of supervising the aide/personal care aide also should not be considered a skilled service.

Services Provided and Ordered

a. **(PS160)** Since the last assessment, has <u>your agency</u> provided (or been ordered to provide) skilled services to the patient?

- ☐ 0 - No
- ☐ 1 - Yes

b. **(PS162)** Since the last assessment, has <u>another agency</u> provided (or been ordered to provide) skilled services to the patient?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ UK - Unknown

c. **(PS164)** Since the last assessment, has your agency provided (or been ordered to provide) personal care services to the patient?

- ☐ 0 - No
- ☐ 1 - Yes

DEMOGRAPHICS AND PATIENT HISTORY

Assessment Strategy	Data Item

PS160 & PS164 - Satisfaction Form for Current Patients

Skilled Services Provided
Examine the patient's current care plan. Confer with a case manager if indicated. Interview the patient or caregiver to determine whether skilled services (outside of the required assessments) are being received by the patient. Skilled services are those provided by a registered nurse or therapist. Care provided by a Certified Nursing Assistant (CNA) should not be recorded as skilled care. A visit conducted by a nurse for the sole purpose of supervising the aide/personal care aide also should not be considered a skilled service.

(PS160) Skilled Services Provided: Is your agency providing skilled services to the patient?

- ☐ 0 - No **[Go to Item PS164]**
- ☐ 1 - Yes

Personal Care Services Provided
Examine the patient's current care plan. Confer with a case manager if indicated. Interview the patient or caregiver to determine whether personal care services are being received by the patient.

(PS164) Personal Care Services Provided: Is your agency providing personal care services to the patient?

- ☐ 0 - No **[Go to Item PS790]**
- ☐ 1 - Yes

PS160 & PS164 - Satisfaction Form for Discharged Patients

Skilled Services Provided
Examine the patient's care plan. Confer with a case manager if indicated. Interview the patient or caregiver to determine whether skilled services (outside of the required assessments) were received by the patient prior to discharge. Skilled services are those provided by a registered nurse or therapist. Care provided by a Certified Nursing Assistant (CNA) should not be recorded as skilled care. A visit conducted by a nurse for the sole purpose of supervising the aide/personal care aide also should not be considered a skilled service.

(PS160) Skilled Services Provided: Prior to discharge, did your agency provide skilled services to the patient?

- ☐ 0 - No **[Go to Item PS164]**
- ☐ 1 - Yes

Personal Care Services Provided
Examine the patient's care plan. Confer with a case manager if indicated. Interview the patient or caregiver to determine whether personal care services were received by the patient prior to discharge.

(PS164) Personal Care Services Provided: Prior to discharge, did your agency provide personal care services to the patient?

- ☐ 0 - No **[Go to Item PS790]**
- ☐ 1 - Yes

DEMOGRAPHICS AND PATIENT HISTORY

Assessment Strategy

18. Inpatient Facility Discharge Within Past 14 Days

a. Ask the patient, caregiver, family member, physician, or referral source. When uncertain about the type of facility or whether it is an inpatient facility, it may be necessary to check with the facility itself regarding licensure or designation. You should mark all applicable responses. For example, the patient may have been discharged from both a hospital and a rehabilitation facility within the past 14 days. If you choose "NA," no other options should be marked.

Option 2: A rehabilitation facility is a freestanding rehabilitation hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital.

Option 3: Nursing home includes both Medicare-certified nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), and nursing facilities. If the patient has been discharged from a swing-bed hospital, determine whether the patient was occupying a designated hospital bed (option 1) or a nursing home bed at a lower level of care (option 3).

b. The inpatient discharge date identifies the date of the most recent discharge from an inpatient facility (within past 14 days). If the patient has been discharged from more than one facility in the past 14 days, use the most recent date of discharge from any inpatient facility. If the date or month is only one digit, that digit is preceded by a "0" (for example, May 4, 1998 = 05/04/1998). Enter all four digits for the year.

c. Provide diagnosis(es) for which the patient was receiving treatment in an inpatient facility within the past 14 days. Obtain information from patient, care-giver, or referring physician. The current ICD-9-CM code book should be the source for coding. Codes should be provided to the greatest degree of specificity. No surgical codes should be provided. Instead, list the underlying diagnosis(es).

Data Item

18. Inpatient Facility Discharge Within Past 14 Days

a. **(PS170)** From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply.)**

- ☐ 1 - Hospital
- ☐ 2 - Rehabilitation facility
- ☐ 3 - Nursing home
- ☐ 4 - Other (specify) _____
- ☐ NA - Patient was not discharged from an inpatient facility **[Go to Item PS180]**

b. **(PS172) Inpatient Discharge Date** (most recent):

__ __ /__ __ / __ __ __ __
month day year

☐ UK - Unknown

c. **(PS174) Inpatient Diagnoses** and ICD-9-CM code categories (codes should be provided to the greatest degree of specificity) for only those conditions treated during an inpatient facility stay within the past 14 days (no surgical codes):

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

DEMOGRAPHICS AND PATIENT HISTORY

Assessment Strategy | **Data Item**

19. Medical or Treatment Regimen Change Within Past 14 Days

PS180 - Start/ Resumption of Care

This item identifies whether a change has occurred to the patient's treatment regimen, health care services, or medications due to a new diagnosis or exacerbation of an old diagnosis within the past 14 days. Obtain information from patient, caregiver, or referring physician. The diagnoses that have caused the medical or treatment regimen change should be listed. Three digit codes are required; digits to the right of the decimal are optional. Do not provide surgical codes. Instead, identify the underlying diagnosis(es).

19. Medical or Treatment Regimen Change Within Past 14 Days

a. **(PS180)** Has this patient experienced a change in medical or treatment regimen (for example, medication, treatment, or service change due to new or additional diagnosis, etc.) within the past 14 days?

☐ 0 - No **[Go to Item PS190]**
☐ 1 - Yes

b. **(PS182)** List the patient's **Medical Diagnoses** and ICD-9-CM code categories (three digits required; five digits optional) for those conditions requiring changed medical or treatment regimen (no surgical codes):

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

Medical or Treatment Regimen Change Within Past 14 Days

PS180 - Reassessment/ Follow-up

This item identifies whether a change has occurred to the patient's treatment regimen, health care services, or medications due to a new diagnosis or exacerbation of an old diagnosis within the past 14 days. Obtain information from patient, caregiver, or referring physician. The diagnoses that have caused the medical or treatment regimen change should be listed. Three digit codes are required; digits to the right of the decimal are optional. Do not provide surgical codes. Instead, identify the underlying diagnosis(es).

Medical or Treatment Regimen Change Within Past 14 Days

a. **(PS180)** Has this patient experienced a change in medical or treatment regimen (for example, medication, treatment, or service change due to new or additional diagnosis, etc.) within the past 14 days?

☐ 0 - No **[Go to Item PS200]**
☐ 1 - Yes

b. **(PS182)** List the patient's **Medical Diagnoses** and ICD-9-CM code categories (three digits required; five digits optional) for those conditions requiring changed medical or treatment regimen (no surgical codes):

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

DEMOGRAPHICS AND PATIENT HISTORY

Assessment Strategy | **Data Item**

20. Conditions Prior to Inpatient Stay or Medical/Treatment Regimen Change Within Past 14 Days

PS190 - Start/ Resumption of Care

This item identifies the existence of condition(s) prior to a medical or treatment regimen change or inpatient stay occurring within past 14 days. Interview patient/caregiver to obtain past health history. Additional information may be obtained from the physician. Determine any conditions existing before the inpatient facility stay or before the change in medical or treatment regimen. Mark "NA" if no inpatient facility discharge and no change in medical or treatment regimen in past 14 days. Note that both situations must be true for this response to be correct.

20. (PS190) Conditions Prior to Inpatient Stay or Medical or Treatment Regimen Change Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

- ☐ 1 - Urinary incontinence
- ☐ 2 - Indwelling/suprapubic catheter
- ☐ 3 - Intractable pain
- ☐ 4 - Impaired decision-making
- ☐ 5 - Disruptive or socially inappropriate behavior
- ☐ 6 - Memory loss to the extent that supervision required
- ☐ 7 - None of the above
- ☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
- ☐ UK - Unknown

Conditions Prior to Medical/Treatment Regimen Change Within Past 14 Days

PS190 - Reassessment/ Follow-up

This item identifies the existence of condition(s) prior to a medical or treatment regimen change occurring within past 14 days. Interview patient/caregiver to obtain past health history. Additional information may be obtained from the physician. Determine any conditions existing before the change in medical or treatment regimen.

(PS190) Conditions Prior to Medical or Treatment Regimen Change Within Past 14 Days: If this patient experienced a change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the change in medical or treatment regimen. **(Mark all that apply.)**

- ☐ 1 - Urinary incontinence
- ☐ 2 - Indwelling/suprapubic catheter
- ☐ 3 - Intractable pain
- ☐ 4 - Impaired decision-making
- ☐ 5 - Disruptive or socially inappropriate behavior
- ☐ 6 - Memory loss to the extent that supervision required
- ☐ 7 - None of the above
- ☐ UK - Unknown

DEMOGRAPHICS AND PATIENT HISTORY

Assessment Strategy

21. Diagnoses and Severity Index

This item identifies each diagnosis for which the patient is receiving home care and its ICD code. Each diagnosis is categorized according to its severity. The primary diagnosis (PS200) should be the condition representing the chief reason for which home care is being provided. Obtain information from the patient, caregiver, and/or physician. Review current medications and other treatment approaches. Codes should be provided to the greatest degree of specificity. Do not provide surgical codes. Assessing severity includes a review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Data Item

21. Diagnoses and Severity Index: List each medical diagnosis or problem for which the patient is receiving home care and ICD-9-CM code category (codes should be provided to the greatest degree of specificity – no surgical codes) and rate them using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses.

Severity Rating
0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled, history of rehospitalizations

	(PS200) Primary Diagnosis	ICD-9-CM	Severity Rating
a.	_____	(__ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
	(PS202) Other Diagnoses	ICD-9-CM	Severity Rating
b.	_____	(__ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
c.	_____	(__ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
d.	_____	(__ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.	_____	(__ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
f.	_____	(__ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

LIVING ARRANGEMENTS

Assessment Strategy

22. Patient Lives With

Note categories of all persons with whom the patient currently is living. If the patient lives with his/her spouse, significant other, family member, or friend and this person is paid to provide care to the patient, you should choose only option 2 ("with spouse, significant other, or other family member") or option 3 ("with a friend"), as appropriate.

Data Item

22. (PS210) Patient Lives With: (Mark all that apply.)

Identifies persons with whom the patient currently lives.

☐ 1 - Lives alone
☐ 2 - With spouse, significant other, or other family member
☐ 3 - With a friend
☐ 4 - With paid help (other than home care agency staff)
☐ 5 - With other than above

Option 4 includes help provided under a special program, even if the patient does not pay for the help directly.

LIVING ARRANGEMENTS

Assessment Strategy

23. Current Residence

Observe the environment in which the visit is being conducted. Interview the patient or caregiver about others living in the residence, their relationship to the patient, and any services being provided. If the residence is considered to be the patient's, choose option 1. Choose option 2 if the residence belongs to a friend or family member. Option 1 does not include board and care or assisted living facilities, which are identified in option 4.

Data Item

23. (PS220) Current Residence:

- ☐ 1 - Patient's residence (house, apartment, or mobile home owned or rented by patient/couple/significant other)
- ☐ 2 - Friend or family member's residence
- ☐ 3 - Boarding home or rented room
- ☐ 4 - Board and care or assisted living facility
- ☐ 5 - Other (specify) _____

For option 4, some care or health-related services are provided to the patient in addition to living quarters.

SUPPORTIVE ASSISTANCE

Assessment Strategy

24. Support Network Availability and Assistance

a. **Support Network Availability**

Interview patient or caregiver to determine whether patient has an available support network. A support network includes family members, friends, and/or others who provide unpaid assistance and support to the patient. Paid help should not be considered part of the patient's support network.

b. **Support Network Members**

Identify all members of the patient's support network. Option 2 includes all immediate and extended family members other than the spouse/significant other.

c. **Types of Assistance Provided**

Indicate all types of assistance the members of the patient's support network provide. If the members of the support network do not provide assistance, choose the "NA" option.

Data Item

24. Support Network Availability and Assistance

a. **(PS230) Support Network Availability:** Does the patient have a support network?

- ☐ 0 - No, the patient has no support network **[Go to Item PS240]**
- ☐ 1 - Yes, a support network is available

Item excludes paid help.

b. **(PS232) Support Network Members:** Place a checkmark in the appropriate boxes to identify the members of the patient's support network. **(Mark all that apply.)**

- ☐ 1 - Spouse/significant other
- ☐ 2 - Family member
- ☐ 3 - Friend or community member

c. **(PS234) Types of Assistance Provided:** What types of assistance are provided by the members of the patient's support network? **(Mark all that apply.)**

- ☐ 1 - ADL assistance (grooming, transferring, ambulation/locomotion, bathing, dressing, toileting, feeding/eating)
- ☐ 2 - IADL assistance (medication management, meal preparation, housekeeping, laundry, shopping, transportation)
- ☐ 3 - Environmental support (home maintenance)
- ☐ 4 - Social support (companionship, recreation)
- ☐ 5 - Facilitation of medical or health care
- ☐ NA - No assistance is provided by members of the support network

ENVIRONMENTAL CONDITIONS

Assessment Strategy | **Data Item**

25. Sanitation and Safety Hazards

Begin your observations as you approach and enter the patient's residence, when you wash your hands, and when you ask to see the bathroom, bedroom, and kitchen. If you choose option 0 ("None"), no other options should be marked.

25. (PS240) Sanitation and Safety Hazards found in the patient's current place of residence: **(Mark all that apply.)**

- ☐ 0 - None
- ☐ 1 - No running water
- ☐ 2 - Contaminated water
- ☐ 3 - No indoor toileting facilities
- ☐ 4 - Inadequate safety devices in bathroom (for example, grab bars)
- ☐ 5 - Inadequate sewage disposal
- ☐ 6 - Inadequate/improper food storage
- ☐ 7 - No cooking facilities
- ☐ 8 - Unsafe gas/electric appliance
- ☐ 9 - Insects/rodents present
- ☐ 10 - No scheduled trash pickup
- ☐ 11 - Cluttered/soiled living area
- ☐ 12 - Obstructed traffic areas
- ☐ 13 - Inadequate floor, roof, or windows
- ☐ 14 - Unsafe floor coverings
- ☐ 15 - Inadequate stair railings, stairs, and/or ramps
- ☐ 16 - Inadequate lighting
- ☐ 17 - Inadequate heating or cooling
- ☐ 18 - Lack of working fire safety devices
- ☐ 19 - Improperly stored hazardous materials
- ☐ 20 - Lack of working telephone
- ☐ 21 - Other (specify) _____

26. Structural Barriers

Observe the patient's environment and the patient's ability to maneuver within that environment. Focus particular attention on stairs and doorways that limit independent mobility, especially in or near toilet and food preparation areas. If you choose option 0 ("None"), no other options should be marked.

26. (PS250) Structural Barriers in the patient's environment limiting independent mobility: **(Mark all that apply.)**

- ☐ 0 - None
- ☐ 1 - Stairs inside home that are used by the patient (for example, to get to toileting, sleeping, eating areas, or laundry facilities)
- ☐ 2 - Stairs leading into home
- ☐ 3 - Narrow or obstructed doorways

PHYSIOLOGIC STATUS

Assessment Strategy | **Data Item**

27. Orientation to Place and Time

Patient-Response Item: Read each question to the patient. Allow the patient 10 seconds to respond to each question. Indicate whether the patient's response was correct or not.

Patient-Response Item:

PROVIDER: Tell the patient "I am going to ask you some questions. Please try to answer the best you can." Then read each question and record whether the answer was correct or not.

☐ Mark here if patient is nonresponsive **[Go to Item PS280]**

"Nonresponsive" means that the patient is unable to respond.

27. (PS260) Orientation to Place and Time

(Allow 10 seconds for each reply.)

		0 - Correct Response	**1 - Incorrect Response**
a.	**What year is this?** *(accept exact answer only)*	☐	☐
b.	**What month of the year is this?** *(on the first day of a new month, or last day of the previous month, accept either month)*	☐	☐
c.	**What is today's date?** *(accept previous or next date, for example, on the 7th accept the 6th or 8th, as well as the 7th)*	☐	☐
d.	**What day of the week is this?** *(accept exact answer only)*	☐	☐
e.	**What country are we in?** *(accept exact answer only)*	☐	☐
f.	**What state are we in?** *(accept exact answer only)*	☐	☐
g.	**What city/town are we in?** *(accept exact answer only)*	☐	☐

28. Patient's Perceived Health Status

Patient-Response Item: Read the item and the response options word-for-word to the patient. Record the response provided. If the patient does not use one of the response options provided, read the options again, and ask him/her to choose the appropriate option. Do not interpret the patient's answer and choose a response for him/her.

Patient-Response Item:

28. (PS270) Patient's Perceived Health Status: Compared to other people your age, how would you rate your overall health at the present time?

- ☐ 0 - Excellent
- ☐ 1 - Very Good
- ☐ 2 - Good
- ☐ 3 - Fair
- ☐ 4 - Poor

PHYSIOLOGIC STATUS

Assessment Strategy | **Data Item**

29. High Risk Factors

Interview the patient or caregiver for past health history. Observe the environment, current health status, and consider information that may be provided in response to other questions. Use clinical judgment in determining the best response(s). Choose option 3 and/or 4 only when the patient currently uses and is dependent on alcohol and/or drugs. If you choose "NA - None of the above" or "UK - Unknown," no other options should be marked.

29. (PS280) High Risk Factors characterizing the patient: **(Mark all that apply.)**

- ☐ 1 - Current or past smoker
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ NA - None of the above
- ☐ UK - Unknown

30. Oral Status

Ask the patient to open his/her mouth. Note whether there are sores on the gums, tongue, or mucous membranes; number of teeth missing; evidence of tooth decay; and whether the teeth present appear to be firmly implanted in the gums and free of debris. If the patient wears dentures, ask the patient if the dentures fit well or if they rub or cause any discomfort when worn. Does the patient have any mouth, tooth, or gum pain? Use clinical judgment to determine the best response. (This information also will be used in responding to Item PS350 part b.)

30. (PS290) Oral Status: How would you describe the health of the patient's teeth and gums?

- ☐ 0 - Excellent
- ☐ 1 - Very good
- ☐ 2 - Good
- ☐ 3 - Fair
- ☐ 4 - Poor

31. Vision

Ask the patient about a history of vision problems (for example, cataracts, glaucoma, need for glasses). You may recall the patient's ability to see the signature line on the consent form, or observe the patient's ability to count fingers at arm's length or to see the numbers on a prescription label. Observe whether the patient can differentiate between medications, especially if patient self-administers medications. Be sensitive about asking the patient to read, as the patient may not be able to read although vision is adequate.

31. (PS300) Vision <u>with corrective lenses</u> if the patient usually wears them:

- ☐ 0 - Normal vision: Sees adequately in most situations; can see medication labels, newsprint.
- ☐ 1 - Partially impaired: Cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- ☐ 2 - Severely impaired: Cannot locate objects without hearing or touching them.
- ☐ NA - Patient nonresponsive **[Go to Item PS320]**

"Nonresponsive" means that the patient is unable to respond.

32. Hearing

Assessment of this item begins at the start of the home visit, as the assessor begins communicating with the patient. If the patient uses a hearing aid or appliance, be sure that it is in place, has an effective battery, and is turned on.

For patients whose primary language differs from that of the nurse doing the assessment, differentiate between a need for repetition due to hearing difficulty and an inability to understand the language spoken by the assessor. If someone is providing language interpretation during the visit, document that information in the visit notes.

32. (PS310) Hearing ability <u>with hearing aids</u> if the patient usually uses them:

- ☐ 0 - Normal hearing: Hears adequately in most situations, in groups as well as one-on-one.
- ☐ 1 - Minimal difficulty: Hears adequately except in special situations, such as crowds; may need occasional repetition, extra time, or louder voice.
- ☐ 2 - Moderate difficulty: Hears with difficulty even in ordinary situations so that conversation is restricted; many misunderstandings occur; frequent failure to respond.
- ☐ 3 - Severe difficulty: No hearing that is useful for conversation or receiving information.

PHYSIOLOGIC STATUS

Assessment Strategy | **Data Item**

33. Dyspnea

During conversation, does the patient stop frequently to catch his/her breath? When you request to see the bathroom, ask the patient to walk with you. This provides an opportunity to observe and evaluate the occurrence of shortness of breath with a walk of a distance you can estimate (if less than 20 feet, ask the patient to extend the distance back to the chair). For the chairfast patient, use the examples provided in the response options to determine the exertion necessary to produce shortness of breath.

33. (PS320) Dyspnea: When is the patient dyspneic or noticeably **Short of Breath?**

- ☐ 0 - Never, patient is not short of breath
- ☐ 1 - When climbing stairs, walking more than 20 feet, or transferring into/out of wheelchair (if chairfast)
- ☐ 2 - With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (for example, while talking, eating, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

If the patient usually uses oxygen continuously, mark the response that best describes the patient's shortness of breath while using oxygen. If the patient uses oxygen intermittently, mark the response that best describes the patient's shortness of breath without the use of oxygen.

34. Activity Tolerance

The patient may mention information relevant to activity tolerance early in the assessment process. If not, begin by asking the patient if there have been changes in the past 14 days in his/her energy to do the things he/she usually is able to do. If the patient acknowledges changes, ask more specific questions to determine whether the decreased activity tolerance seems to be related to his/her physical status or emotional factors (i.e., differentiate decreased activity due to fatigue from that related to depression). Changes in activity tolerance due to emotional factors should not be included in responding to this item.

34. (PS330) Activity Tolerance: How often during the past 14 days has the patient decreased participation in his/her regular activities because of fatigue, shortness of breath, lack of stamina, or other physical problems?

- ☐ 0 - Never
- ☐ 1 - Sometimes
- ☐ 2 - About half of the time
- ☐ 3 - Most of the time
- ☐ 4 - All of the time

35. Patient Medications

Ask the patient to show you the bottles of medications he/she currently takes. Note whether they are current prescriptions. Count the total number of medications. Differentiate those medications taken daily or at specified frequencies (for example, every other day) from those taken as needed (i.e., PRN). Include vitamin, nutritional, and herbal supplements that are consumed by the patient. Over-the-counter medications and supplements not requiring a prescription should be listed as over-the-counter medications, even if recommended by the patient's physician. Include medications administered by any route (for example, oral, injected, inhaled, per NG, sublingual). Response must be a whole number (for example, 3, 7). If a patient takes no medications of a particular type (for example, daily over-the-counter medications), enter "0" in the space provided.

35. Patient Medications Enter "0" if none.

a. **(PS340)** How many prescription medications is the patient ordered to take?

Daily or at Specified Frequency_____

PRN_____

b. **(PS342)** How many over-the-counter medications does the patient take?

Daily or at Specified Frequency_____

PRN_____

PHYSIOLOGIC STATUS

Assessment Strategy

36. Nutritional Risk

Answers to these questions can be obtained by asking the patient to describe his/her food intake over the past 24 hours. (This is often considered a food diary.) Answer items based on the patient's intake over the past 24 hours, regardless of whether that intake was typical. Information obtained about fluid intake will be used in responding to Item PS360.

a. Over the past 24 hours, did the patient need to modify/adapt or limit his/her food intake due to a medical condition or illness? If the patient should eat a special diet, even if he/she does not, answer "yes."
b. Use the results of your inspection of the patient's oral status (Item PS290) to further investigate the possibility of mechanical problems affecting food intake. Ask about problems chewing or problems with dentures over the past 24 hours. Use your clinical judgment to determine whether a problem exists.
c. Has the patient had any problems swallowing food over the past 24 hours?
d. You will have obtained this information in Item PS340.
e. Ask the patient how often he/she has had an alcoholic drink over the past 24 hours.
f. How many meals did the patient eat over the past 24 hours?
g. Review the food diary. Consuming less than two servings of fruit over the past 24 hours requires a "yes" response.
h. Review the food diary. Consuming less than two servings of vegetables over the past 24 hours requires a "yes" response.
i. Review the food diary. Consuming less than two servings of milk products over the past 24 hours requires a "yes" response.
j. If the cost of food has not yet been discussed, ask if the patient has been able to buy the food needed over the past 24 hours. If patient's meals are provided by his/her place of residence, answer should be "no."
k. If someone cooked for the patient or delivered meals, did that person also eat with the patient?
l. Ask the patient about weight loss or gain in the past six months. Follow up to determine amount of loss/gain and whether this was unwanted or not.

Data Item

36. (PS350) Nutritional Risk: Place a checkmark in the appropriate box next to each question.

		0 - No	1 - Yes
a.	In the past 24 hours, did medical conditions or illnesses limit or change the amount or type of food the patient ate?	☐	☐
b.	In the past 24 hours, did the patient experience dental problems that made eating difficult?	☐	☐
c.	In the past 24 hours, did the patient experience swallowing difficulties that made eating difficult?	☐	☐
d.	In the past 24 hours, did the patient take more than three prescription drugs?	☐	☐
e.	In the past 24 hours, did the patient consume more than two alcoholic drinks?	☐	☐
f.	In the past 24 hours, did the patient eat fewer than two meals?	☐	☐
g.	In the past 24 hours, did the patient eat fewer than two servings of fruit?	☐	☐
h.	In the past 24 hours, did the patient eat fewer than two servings of vegetables?	☐	☐
i.	In the past 24 hours, did the patient eat fewer than two servings of milk products?	☐	☐
j.	In the past 24 hours, has the patient lacked the funds to purchase food?	☐	☐
k.	In the past 24 hours, did the patient eat alone at any time?	☐	☐
l.	In the past six months, has the patient had an unwanted loss or gain of 10 or more pounds?	☐	☐

PHYSIOLOGIC STATUS

Assessment Strategy | **Data Item**

37. Hydration

From Item PS350, you should have knowledge of what the patient drank with meals and at other times during the past 24 hours.

37. (PS360) Hydration: In the past 24 hours, the patient's approximate **Oral Fluid Intake** was:

- ☐ 0 - 6 cups or more (more than 1400 cc or 48 oz.)
- ☐ 1 - 2-5 cups (480-1400 cc or 16-48 oz.)
- ☐ 2 - Less than 2 cups (less than 480 cc or 16 oz.)
- ☐ NA - Unable to drink fluids

38. Skin Turgor

Skin turgor decreases with age and in the presence of dehydration, which is the rationale for performing the assessment on the chest wall. You should pick up a fold of skin one inch below the patient's clavicle between your thumb and forefinger or you could ask the patient to pick up a fold of his/her own skin in the same location. Observe how rapidly the skin returns to its original configuration.

38. (PS370) Skin Turgor: Pick up a fold of skin approximately 1 inch below the patient's clavicle. When released, note what happens to the skin.

- ☐ 0 - Skin returns to place immediately upon release
- ☐ 1 - Skin returns slowly to place within 5 seconds
- ☐ 2 - Skin remains in pinched position for more than 5 seconds

39. Presence/Severity of Pain

Presence/ Severity of Pain - Start/Resumption of Care

Information about the presence or severity of pain may have arisen when discussing medical conditions, assistance provided by others, and activity tolerance (Items PS170-PS202, PS234, and PS330). Refer to the responses to those items as a starting point for additional discussion of pain.

39. Presence/Severity of Pain

Presence/Severity of Pain

Presence/ Severity of Pain - Reassessment/ Follow-up

Information about the presence or severity of pain may have arisen when discussing medical conditions, assistance provided by others, structural barriers in the home, and activity tolerance (Items PS180-PS202, PS234, PS250, and PS330). Refer to the responses to those items as a starting point for additional discussion of pain.

Presence/Severity of Pain

PHYSIOLOGIC STATUS

Assessment Strategy | **Data Item**

39. Presence/Severity of Pain

Presence/ Severity of Pain - Discharge

Information about the presence or severity of pain may have arisen when discussing medical conditions, assistance provided by others, and activity tolerance.

a. **Frequency of Pain**
Responses are arranged in order of lowest to highest frequency. Refer to the 14-day period precisely; orient the patient to this interval by referring to a specific date or day of the week. If the patient's pain is well controlled by medication, the frequency of pain will be lower than that of a patient whose pain is inadequately controlled.

b. **Severity of Pain**
This item should be answered based on the patient's worst level of pain, whether or not the patient has taken medication.
Patient-Response Item: Read the item and the response options word-for-word to the patient. Record the response provided. If the patient does not use one of the response options provided, read the options again, and ask him/her to choose the appropriate option. Do not interpret the patient's answer and choose a response for him/her.

c. **Pain Interfering with Daily Activities**
Note that this item asks only how often the pain has interfered with the patient's normal activities. Pain that is well controlled by medication may not be considered severe enough to produce alteration in the patient's usual routine. Refer to the 14-day period precisely; orient the patient to this interval by referring to a specific date or day of the week.

Presence/Severity of Pain

a. **(PS380) Frequency of Pain**: During the past 14 days, how much of the time has the patient been troubled by pain?

- ☐ 0 - Never **[Go to Item PS400]**
- ☐ 1 - Rarely
- ☐ 2 - Some of the time
- ☐ 3 - Most of the time
- ☐ 4 - All of the time

Patient-Response Item:

b. **(PS382) Severity of Pain**: When the pain was at its worst, would it be described as:

- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe
- ☐ 4 - Unbearable
- ☐ NA - Patient nonresponsive

"Nonresponsive" means that the patient is unable to respond.

c. **(PS384) Pain Interfering with Daily Activities**: How much of the time over the past 14 days has pain interfered with the patient's normal routine? (Note: If the patient's level of pain has changed over the period, answer should be based on the most recent level of pain.)

- ☐ 0 - Pain did not get in the way of normal routine
- ☐ 1 - At times, but not every day
- ☐ 2 - Every day, but not constantly
- ☐ 3 - All of the time

PHYSIOLOGIC STATUS

Assessment Strategy

40. Presence/Severity of Pressure Ulcers

a. **Presence of Pressure Ulcer**

This item requires a visual examination of the patient's skin. Inspect the skin over bony prominences carefully. Pressure ulcers occur more often in patients who are very elderly, inactive, cognitively impaired, incontinent, have impaired circulation, and/or have poor nutritional status.

b. **Number of Pressure Ulcers at Each Stage**

Recognizing erythema (a Stage 1 ulcer) in darker-skinned individuals requires close examination. Inspect for change in texture, a bluish/purplish skin tone, or extremely dry skin over bony prominences. Palpate for warmth, tissue consistency (firm or boggy feel), or slight edema in these areas. Interview for sensation changes (pain, itching).

The bed of the ulcer must be visible to determine the stage accurately. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed.

Reverse staging of granulating pressure ulcers is <u>not</u> an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). Therefore, an ulcer should always be staged according to the wound at its worst. For example, a healing Stage 3 pressure ulcer continues to be listed as Stage 3 and the degree of healing would be identified in part c. The clinician may need to contact previous providers (including the patient's physician) to determine the stage of the wound at its worst.

Consult published guidelines of NPUAP (www.npuap.org) for additional clarification or resources for training.

Data Item

40. Presence/Severity of Pressure Ulcers

a. **(PS400)** Does the patient have a **Pressure Ulcer**?

☐ 0 - No **[Go to Item PS410]**
☐ 1 - Yes

A pressure ulcer is defined as any lesion caused by unrelieved pressure resulting in tissue damage. Pressure ulcers most often occur over bony prominences that are subjected to pressure or friction (for example, sacrum, coccyx, occiput, heels, elbows). Answer "yes" if the patient has a pressure ulcer at any stage, even if healed.

b. **(PS402)** Current **Number of Pressure Ulcers** at each stage: **(Circle one response for each stage.)**

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

If there are no ulcers at a given stage, circle "0" for that stage. A pressure ulcer should be staged at its greatest level of tissue destruction. Therefore, the stage of any ulcer can progress from Stage 1 to Stage 4. The reverse is not true. Even after a pressure ulcer begins to heal, it should always be staged according to the wound at its worst.

A pressure ulcer covered by eschar (necrotic tissue) or a nonremovable dressing or cast cannot be staged because it cannot be observed adequately.

PHYSIOLOGIC STATUS

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c. **Status of Most Problematic (Observable) Pressure Ulcer**
Visualize the wound to identify the degree of healing evident in the "most problematic" ulcer. The "most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.

c. **(PS404) Status of Most Problematic (Observable) Pressure Ulcer**:

- ☐ 0 - Re-epithelialized
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing

Re-epithelialized means that the wound bed is completely covered with new epithelium; there are no openings in the wound.
Fully granulating means that the wound bed is filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no necrotic tissue; no signs or symptoms of infection; wound edges are open.
Early/partial granulation means that at least 25% of the wound bed is covered by granulation tissue; no necrotic tissue; may be dead space; no signs or symptoms of infection; wound edges may be open.
Not healing means that a Stage 1 pressure ulcer or an infected pressure ulcer is not healing. A pressure ulcer that is covered by necrotic tissue (eschar) cannot be staged, but its status is not healing, because it cannot heal while covered by necrotic tissue.

41. Presence/Severity of Surgical Wounds
Item identifies the presence, number, and severity of surgical wounds.

a. The following are considered surgical wounds: Orthopedic pin sites; central line sites; stapled or sutured incisions; debrided graft sites; wounds with drains; surgical incisions with approximated edges and scabs; Medi-port sites and other implanted infusion devices or venous access devices; and muscle flaps performed to surgically replace pressure ulcers. "Old" surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds. A pressure ulcer that has been surgically debrided remains a pressure ulcer. It does not become a surgical wound. A PICC line is not a surgical wound, as it is peripherally inserted.

b. Count the number of visible wounds. A wound is not observable if it is covered by a dressing (or cast) which is not to be removed per physician's orders. Each opening in a single surgical wound is counted as one wound. Suture or staple insertion sites are not considered to be separate wounds.

41. Presence/Severity of Surgical Wounds

a. **(PS410)** Does this patient have a **Surgical Wound?**

- ☐ 0 - No **[Go to Item PS420]**
- ☐ 1 - Yes

b. **(PS412) Current Number of (Observable) Surgical Wounds:** (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)

- ☐ 0 - Zero
- ☐ 1 - One
- ☐ 2 - Two
- ☐ 3 - Three
- ☐ 4 - Four or more

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c. This item identifies the presence of a surgical wound that is covered by a dressing (or cast) that is not to be removed, per physician's orders. Answer "yes" if there is a wound for which the dressing cannot be removed by home care clinicians (for example, a plastic surgeon may order that he/she be the only one to remove the dressing over a new skin graft).

d. If there is more than one wound, determine which is the most problematic. The "most problematic" wound is the one that may be complicated by the presence of infection, location of wound, large size, difficult management of drainage, or slow healing. Visualize this wound to identify the degree of healing.

42. Urinary Incontinence or Urinary Catheter Presence

Review the urinary elimination pattern as you assess the patient. Urinary incontinence may result from multiple causes, including physiologic reasons, cognitive impairments, or mobility problems. Does the patient admit having difficulty controlling urine? Is a catheter present? Be alert for an odor of urine, which might indicate a problem with bladder sphincter control. Ask for input from the aide/personal care aide when subsequent assessments are done. A leaking urinary drainage appliance is <u>not</u> incontinence.

43. Urinary Incontinence Frequency

Once the existence of incontinence is known, ask when the incontinence occurs.

Data Item

c. **(PS414)** Does this patient have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?

- ☐ 0 - No
- ☐ 1 - Yes

d. **(PS416) Status of Most Problematic (Observable) Surgical Wound:**

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable surgical wound

42. (PS420) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[Go to Item PS440]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[Go to Item PS440]**

Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type.

If the patient is incontinent <u>at all</u> (for example, "occasionally," "only once in a while," "sometimes I leak a little bit"), mark option 1.

If the patient requires the use of a urinary catheter for any reason, mark option 2. If the patient is both incontinent and requires a urinary catheter, mark only option 2.

43. (PS430) Urinary Incontinence Frequency: When does urinary incontinence occur?

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

PHYSIOLOGIC STATUS

Assessment Strategy | **Data Item**

44. Bowel Incontinence Frequency

Bowel incontinence is the involuntary passing of stool. Review the bowel elimination pattern as you assess the patient. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if he/she has difficulty controlling bowels, has problems with soiling clothing, uncontrollable diarrhea, etc. The patient's responses to these questions may make you aware of a previously unidentified problem, which can be addressed in the care plan. On subsequent assessments, ask the aide/personal care aide about evidence of bowel incontinence.

44. (PS440) Bowel Incontinence Frequency: How often does the patient experience bowel incontinence?

- ☐ 0 - Never has bowel incontinence
- ☐ 1 - Once a week or less
- ☐ 2 - Two to six times each week
- ☐ 3 - At least once a day
- ☐ NA - Ostomy present

Refers only to the frequency of the symptom.

Use option "NA" if the patient has an ostomy for bowel elimination.

45. Constipation Frequency

Constipation is a change in bowel habits, with decreased frequency of stools, often associated with increased difficulty in passing stools. Interview patient regarding bowel habits, use of over-the-counter laxatives/enemas, use of dietary or "natural" laxatives, etc. Frequency of stools is no different in <u>active</u> elderly people than in those who are younger (the normal range is generally considered to be 3 times daily to 3 times weekly). If medications or foods are used regularly to prevent constipation, note the frequency of constipation while these interventions are being used.

45. (PS450) Constipation Frequency: During the <u>past 14 days</u>, how many times has the patient been constipated?

- ☐ 0 - Not at all
- ☐ 1 - Once
- ☐ 2 - Twice
- ☐ 3 - Three or more times

46. Presence of UTI

Interview for symptoms and treatment while assessing the patient. Question the patient about any new medications and call the physician if necessary. This item asks only about UTIs that have been treated in the <u>past 14 days</u>. If the patient had symptoms of a UTI or a positive culture for which the physician did not prescribe treatment, or the treatment ended more than 14 days ago, mark option 0. If the patient is on prophylactic treatment and develops a UTI, mark option 1.

46. (PS460) Presence of UTI: Has the patient been treated for a **Urinary Tract Infection** in the <u>past 14 days</u>?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment
- ☐ UK - Unknown

47. Respiratory Treatments

Interview patient or caregiver about whether such treatments are ordered/received. Review medications. Look for the presence of such equipment in the home.

47. (PS470) Respiratory Treatments utilized at home: **(Mark all that apply.)**

- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continuous or at night)
- ☐ 3 - Continuous positive airway pressure
- ☐ NA - None of the above

Identify any of the listed respiratory treatments used by the patient in the home. <u>Exclude</u> any respiratory treatments that are not listed here.

FUNCTIONAL STATUS

The following items address the patient's functional status. Level of functioning is an important indicator of the patient's ability to remain at home, even with assistance. Included in the functional status items are basic self-care activities (for example, bathing, grooming, dressing, eating, mobility) and other activities needed to support independent living (for example, meal preparation, medication management, shopping).

Most of the functional status items address two aspects of functioning: (a) the patient's ability to perform the specified activity independently, and (b) the degree to which the activity is successfully accomplished with any assistance provided by agency staff and informal caregivers, and the use of assistive devices.

Direct observation, supplemented by interview, is the preferred method for assessing functional status. If direct observation is not possible, responses should be based on all observed and reported information. All items present the most independent (least impaired) level first, then proceed to the most dependent (most impaired). If a patient's level of functioning appears to fluctuate, choose the option that reflects his/her worst or most dependent level of functioning. Except where otherwise indicated, functional status items should be answered based on the patient's condition over the past week.

FUNCTIONAL STATUS

Assessment Strategy	Data Item
48. Grooming This item measures (a) the degree to which the patient is able to groom independently and (b) the frequency with which grooming tasks are successfully completed considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. Observe the patient gathering equipment needed for grooming. The patient can verbally report the procedure used for grooming and demonstrate the motions utilized in grooming (for example, hand to head for combing, hand to mouth for teeth care). You also should observe the general appearance of the patient to assess grooming deficiencies and verify upper extremity strength, coordination, and manual dexterity to determine if the patient requires assistance with grooming. If the patient requires hands-on assistance, choose option 3 or 4 for PS480A, depending on the level of assistance required.	**48. Grooming:** Grooming refers to washing of hands and face, hair care, shaving or make up, teeth or denture care, and fingernail care. a. **(PS480A) Grooming Ability:** Indicate the patient's ability to groom independently. ☐ 0 - Patient is able to groom independently without human assistance or assistive devices ☐ 1 - Patient is able to groom independently using assistive devices ☐ 2 - Patient is able to groom with intermittent supervision and/or verbal cueing (patient may require assistive devices as well) ☐ 3 - Patient is able to groom with intermittent human assistance (patient may require assistive devices as well) ☐ 4 - Patient requires human assistance throughout the grooming process b. **(PS480P) Grooming Performance:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how much of the time is the patient well groomed? ☐ 0 - All of the time ☐ 1 - Most of the time ☐ 2 - About half the time ☐ 3 - Sometimes ☐ 4 - Rarely, if ever

FUNCTIONAL STATUS

Assessment Strategy

49. Bathing

This item measures (a) the degree to which the patient is able to bathe independently and (b) the frequency with which bathing tasks are successfully completed considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance to determine if the patient has been bathed as needed. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. If the patient requires hands-on assistance, choose option 3 or 4 for PS490A, depending on the level of assistance required.

50.-51. Dressing Upper Body/Lower Body

These items measure (a) the degree to which the patient is able to dress upper and lower body independently and (b) the frequency with which dressing tasks are successfully completed considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. Dressing tasks include the ability to obtain, put on, and remove upper and lower body clothing (including any lower-extremity prosthesis). A combined observation/interview approach with the patient or caregiver is required to determine the most accurate responses for these items. Observe the patient's general appearance and clothing and ask him/her about any difficulty 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 Item

49. Bathing

a. **(PS490A) Bathing Ability:** Indicate the patient's ability to wash hair and body independently.

- ☐ 0 - Patient is able to wash hair and body independently without human assistance or assistive devices
- ☐ 1 - Patient is able to wash hair and body independently using assistive devices
- ☐ 2 - Patient is able to bathe with intermittent supervision and/or verbal cueing (patient may require assistive devices as well)
- ☐ 3 - Patient is able to bathe with intermittent human assistance (patient may require assistive devices as well)
- ☐ 4 - Patient requires human assistance throughout the bathing process

b. **(PS490P) Bathing Performance:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how much of the time are the patient's hair and body clean?

- ☐ 0 - All of the time
- ☐ 1 - Most of the time
- ☐ 2 - About half the time
- ☐ 3 - Sometimes
- ☐ 4 - Rarely, if ever

FUNCTIONAL STATUS

Assessment Strategy

50. Dressing Upper Body

Opening and removing upper body garments during the physical assessment of the heart and lungs provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing.

Data Item

52. Dressing Upper Body: Dressing upper body refers to all tasks related to dressing the upper body, including the management of undergarments, pullovers, front-opening shirts, zippers, buttons, and snaps.

a. **(PS520A) Ability to Dress Upper Body:** Indicate the patient's ability to dress his/her upper body independently.

- ☐ 0 - Patient is able to dress upper body independently without human assistance or assistive devices
- ☐ 1 - Patient is able to dress upper body using assistive devices
- ☐ 2 - Patient requires human assistance to dress upper body (patient may or may not require assistive devices as well)

b. **(PS520P) Performance in Dressing Upper Body:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how much of the time is the patient's upper body appropriately clothed?

- ☐ 0 - All of the time
- ☐ 1 - Most of the time
- ☐ 2 - About half the time
- ☐ 3 - Sometimes
- ☐ 4 - Rarely, if ever

FUNCTIONAL STATUS

Assessment Strategy | **Data Item**

51. Dressing Lower Body

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. If the patient requires hands-on assistance, choose option 3 or 4 for PS530A, depending on the level of assistance required.

51. Dressing Lower Body: Dressing lower body refers to all tasks related to dressing the lower body, including the management of undergarments, slacks, socks, and shoes.

a. **(PS530A) Ability to Dress Lower Body:** Indicate the patient's ability to dress his/her lower body independently.

- ☐ 0 - Patient is able to dress lower body independently without human assistance or assistive devices
- ☐ 1 - Patient is able to dress lower body independently using assistive devices
- ☐ 2 - Patient is able to dress lower body with intermittent supervision and/or verbal cueing (patient may require assistive devices as well)
- ☐ 3 - Patient is able to dress lower body with intermittent human assistance (patient may require assistive devices as well)
- ☐ 4 - Patient requires human assistance throughout the process of dressing lower body

b. **(PS530P) Performance in Dressing Lower Body:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how much of the time is the patient's lower body appropriately clothed?

- ☐ 0 - All of the time
- ☐ 1 - Most of the time
- ☐ 2 - About half the time
- ☐ 3 - Sometimes
- ☐ 4 - Rarely, if ever

52. Toileting

This item measures (a) the degree to which the patient is able to toilet independently and (b) the frequency with which toileting tasks are successfully completed considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. Observe the patient transferring to the toilet or commode with whatever assistance he/she usually uses. Observation may be combined with an interview approach with the patient or caregiver to determine the most accurate response for this item.

52. Toileting: Toileting refers to transferring to bedside commode or toilet; use of toilet, bedside commode, bedpan, or urinal; and management of hygiene and clothes after toileting.

a. **(PS540A) Toileting Ability:** Indicate the patient's ability to toilet independently.

- ☐ 0 - Patient is able to toilet independently without human assistance or assistive devices
- ☐ 1 - Patient is able to toilet independently using assistive devices
- ☐ 2 - Patient is able to toilet with intermittent supervision and/or verbal cueing (patient may require assistive devices as well)
- ☐ 3 - Patient is able to toilet with intermittent human assistance (patient may require assistive devices as well)
- ☐ 4 - Patient requires human assistance throughout the toileting process
- ☐ NA - Patient has catheter for urinary elimination and ostomy for bowel elimination **[Go to Item PS550A]**

FUNCTIONAL STATUS

Assessment Strategy

Data Item

b. **(PS540P) Toileting Performance:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how much of the time is the patient toileted as needed?

- ☐ 0 - All of the time
- ☐ 1 - Most of the time
- ☐ 2 - About half the time
- ☐ 3 - Sometimes
- ☐ 4 - Rarely, if ever

53. Transferring

This item measures (a) the degree to which the patient is able to transfer independently and (b) the frequency with which the patient transfers safely considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. Observe the patient transferring between the bed and chair with whatever assistance the patient usually uses. Determine whether the transfer is done safely. This may be observed at the same time you observe the patient's ambulation/locomotion or toileting transfers. Observation may be combined with an interview approach with the patient or caregiver to determine the most appropriate response to this item. If the patient requires hands-on assistance, choose option 3 or 4 for PS550A, depending on the level of assistance required.

53. Transferring: Transferring refers to all tasks associated with transferring between bed and chair.

a. **(PS550A) Transferring Ability:** Indicate the patient's ability to transfer independently.

- ☐ 0 - Patient is able to transfer independently without human assistance or assistive devices
- ☐ 1 - Patient is able to transfer independently using assistive devices
- ☐ 2 - Patient is able to transfer with intermittent supervision and/or verbal cueing (patient may require assistive devices as well)
- ☐ 3 - Patient is able to transfer with intermittent human assistance (patient may require assistive devices as well)
- ☐ 4 - Patient requires human assistance throughout the transferring process
- ☐ NA - Patient is bedbound **[Go to Item PS570]**

b. **(PS550P) Transferring Performance:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how much of the time does the patient safely transfer between bed and chair?

- ☐ 0 - All of the time
- ☐ 1 - Most of the time
- ☐ 2 - About half the time
- ☐ 3 - Sometimes
- ☐ 4 - Rarely, if ever

FUNCTIONAL STATUS

Assessment Strategy	Data Item
54. Ambulation/Locomotion This item measures (a) the degree to which the patient is able to ambulate/wheel independently and (b) the circumstances under which the patient ambulates/wheels safely considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. Observe the patient ambulating or wheeling with whatever assistance the patient usually uses and on the surfaces to which the patient has access. Determine whether the activity is done safely. Note if the patient uses furniture or walls for support. Observation may be combined with an interview approach with the patient or caregiver to determine the most appropriate response to this item. If the patient requires hands-on assistance, choose option 3 or 4 for PS560A, depending on the level of assistance required.	**54. Ambulation/Locomotion:** Ambulation/locomotion refers to getting to a standing position, walking, or using a wheelchair once seated. a. **(PS560A) Ambulation/Locomotion Ability:** Indicate the patient's ability to ambulate/wheel independently. ☐ 0 - Patient is able to ambulate/wheel independently without human assistance or assistive devices ☐ 1 - Patient is able to ambulate/wheel using assistive devices ☐ 2 - Patient requires human assistance to ambulate/wheel (patient may or may not require assistive devices as well) b. **(PS560P) Ambulation/Locomotion Performance:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, under what circumstances is the patient able to safely ambulate or wheel? ☐ 0 - In all situations inside and outside the home, including on ramps or stairs ☐ 1 - Inside and outside the home, except for ramps or stairs ☐ 2 - Inside the home, but not outside the home ☐ 3 - Only for limited distances within the home ☐ 4 - Does not ambulate/wheel safely anywhere
55. Bed Mobility This item measures the patient's ability to move in bed. Observe the patient moving in bed with whatever assistance he/she usually uses. Observation may be combined with an interview approach with the patient or caregiver to determine the most appropriate response to this item. If the patient requires supervision or verbal cues, choose option 1; if the patient requires human assistance to position limbs or roll, choose option 2; and if the patient is totally dependent on another person to move in bed at all, option 3 is appropriate.	**55. (PS570) Bed Mobility:** Can the patient move to and from a lying position, turn from side to side, and position his/her body while in bed? ☐ 0 - Able to move independently while in bed ☐ 1 - Able to move in bed with minor assistance ☐ 2 - Able to move in bed only with assistance ☐ 3 - Unable to move in bed

FUNCTIONAL STATUS

Assessment Strategy	Data Item

56. Feeding/Eating

This item measures (a) the degree to which the patient is able to feed/eat independently and (b) the frequency with which feeding/eating tasks are successfully accomplished considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. Ask the patient about the frequency of food consumption over the past 24 hours and any difficulties he/she has encountered in eating or being fed. In some cases, it may be necessary to obtain additional information from the caregiver about this activity. This information should have been discussed in answering Item PS350. If the patient requires hands-on assistance, choose option 3 or 4 for PS580A, depending on the level of assistance required.

56. Feeding/Eating: Feeding/eating refers to taking in nutrients orally and/or by nasogastric or gastrostomy tube. It does not include food preparation.

a. **(PS580A) Feeding/Eating Ability:** Indicate the patient's ability to feed/eat independently.

- ☐ 0 - Patient is able to feed/eat independently without human assistance or assistive devices
- ☐ 1 - Patient is able to feed/eat independently using assistive devices
- ☐ 2 - Patient is able to feed/eat with intermittent supervision and/or verbal cueing (patient may require assistive devices as well)
- ☐ 3 - Patient is able to feed/eat with intermittent human assistance (patient may require assistive devices as well)
- ☐ 4 - Patient requires human assistance throughout the feeding/eating process

b. **(PS580P) Feeding/Eating Performance:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how often did the patient consume food or nutrients over the past 24 hours?

- ☐ 0 - More than three times
- ☐ 1 - Three times
- ☐ 2 - Two times
- ☐ 3 - One time
- ☐ 4 - Never

57. Meal Preparation

This item measures (a) the degree to which the patient is able to prepare meals independently and (b) the frequency with which meals are successfully prepared considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. This may have been discussed earlier while assessing caregiver support or nutrition. If not, ask the patient how frequently meals were available over the past 24 hours and who prepared these meals. If the patient has help intermittently, ask how he/she manages to obtain/prepare meals when alone. It may be necessary to ask the caregiver about this activity.

57. Meal Preparation: Meal preparation refers to light meals, full meals, reheating of delivered meals, or nutritional supplements.

a. **(PS590A) Meal Preparation Ability:** Indicate the patient's ability to prepare meals independently.

- ☐ 0 - Patient is able to prepare meals independently without human assistance or assistive devices
- ☐ 1 - Patient is able to prepare meals using assistive devices
- ☐ 2 - Patient requires human assistance to prepare meals (patient may or may not require assistive devices as well)

FUNCTIONAL STATUS

Assessment Strategy

58. Medication Management

This item measures (a) the degree to which the patient is able to manage medications independently and (b) the frequency with which medications are successfully managed considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. Ask the patient if anyone helps him/her with any part of taking medications (for example, knowing when to take each medicine and remembering to take medicine at the right time). Does someone help by setting up medicines in pillboxes periodically? Ask the patient if he/she ever has trouble remembering when pills were taken last, especially medications taken only as needed (for example, pain medications). If patient denies memory problems, ask him/her to tell you when he/she should take the various medications. If patient self-administers medications, how does he/she know which pill is which? Ask patient to demonstrate. If patient must remove the medications from a pill box or medication bottle independently, ask him/her to demonstrate that task. This item relates to Item PS740.

Data Item

b. **(PS590P) Meal Preparation Performance:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how often were meals prepared and accessible to the patient over the past 24 hours?

- ☐ 0 - More than three times
- ☐ 1 - Three times
- ☐ 2 - Two times
- ☐ 3 - One time
- ☐ 4 - Never

58. Medication Management: Medication management refers to administration of current dosage at appropriate times/intervals.

a. **(PS600A) Medication Management Ability:** Indicate the patient's ability to manage medications independently.

- ☐ 0 - Patient is able to manage medications independently without human assistance or assistive devices
- ☐ 1 - Patient is able to manage medications independently using assistive devices
- ☐ 2 - Patient is able to complete some, but not all medication management activities without human assistance (patient may or may not require assistive devices as well)
- ☐ 3 - Patient is physically or cognitively unable to manage medications; all medication management activities must be completed by others
- ☐ NA - Patient takes no medications **[Go to Item PS500A]**

b. **(PS600P) Medication Management Performance:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how much of the time are medications prepared and taken reliably and safely?

- ☐ 0 - All of the time
- ☐ 1 - Most of the time
- ☐ 2 - About half the time
- ☐ 3 - Sometimes
- ☐ 4 - Rarely, if ever

FUNCTIONAL STATUS

Assessment Strategy	Data Item

59. Laundry

This item measures (a) the degree to which the patient is able to independently launder his/her clothing and linens as needed and (b) the frequency with which laundry tasks are successfully completed considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. Ask the patient about his/her ability to do laundry, even if this task is not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other activities of daily living (ADLs) to assist in determining the best response to this item. Awareness of the location of laundry facilities (from the environmental assessment) also is needed.

59. Laundry

a. **(PS500A) Laundry Ability:** Indicate the patient's ability to wash clothing and linens independently.

- ☐ 0 - Patient is able to wash clothing and linens independently without human assistance or assistive devices
- ☐ 1 - Patient is able to wash clothing and linens independently using assistive devices
- ☐ 2 - Patient is able to complete some, but not all activities related to laundry without human assistance (patient may or may not require assistive devices as well)
- ☐ 3 - Patient is physically or cognitively unable to wash clothing and linens; all laundry-related activities must be completed by others

b. **(PS500P) Laundry Performance:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how much of the time are the patient's clothing and linens well laundered?

- ☐ 0 - All of the time
- ☐ 1 - Most of the time
- ☐ 2 - About half the time
- ☐ 3 - Sometimes
- ☐ 4 - Rarely, if ever

60. Housekeeping

This item measures (a) the degree to which the patient is able to complete housekeeping chores independently and (b) the frequency with which housekeeping chores are successfully completed considering all assistance provided by agency staff, informal caregivers, and the use of assistive devices. Ask the patient about his/her ability to complete housekeeping tasks, even if these tasks are not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other activities of daily living (ADLs) to assist in determining the best response to this item.

60. Housekeeping

a. **(PS510A) Housekeeping Ability:** Indicate the patient's ability to complete housekeeping chores independently.

- ☐ 0 - Patient is able to complete housekeeping chores independently without human assistance or assistive devices
- ☐ 1 - Patient is able to complete housekeeping chores independently using assistive devices
- ☐ 2 - Patient is able to complete some, but not all housekeeping chores without human assistance (patient may or may not require assistive devices as well)
- ☐ 3 - Patient is physically or cognitively unable to complete housekeeping chores; all housekeeping activities must be completed by others

FUNCTIONAL STATUS

Assessment Strategy | **Data Item**

b. **(PS510P) Housekeeping Performance:** Considering any assistance currently received from agency staff and/or informal caregivers as well as the use of assistive devices, how much of the time is the patient's home clean and orderly?

- ☐ 0 - All of the time
- ☐ 1 - Most of the time
- ☐ 2 - About half the time
- ☐ 3 - Sometimes
- ☐ 4 - Rarely, if ever

61. Obtaining Needed Items
Ask the patient if he/she shops independently or if someone else helps. "Assistance" in obtaining needed items might involve someone else doing the shopping, arranging for delivery, etc. Personal supplies refers to toiletries, cosmetics, etc. Identify the frequency with which necessary items are obtained, regardless of how they are obtained.

61. (PS610) Obtaining Needed Items: How much of the time is the patient able to obtain the following necessary items with currently available human assistance, agency care, and assistive devices?

		0 - Always	1 - Most of the time	2 - Some-times	3 - Never
a.	Groceries and personal supplies	☐	☐	☐	☐
b.	Clothing	☐	☐	☐	☐
c.	Household items	☐	☐	☐	☐
d.	Medications	☐	☐	☐	☐

☐ NA - No medications needed

62. Functional Potential
Based on the preceding assessment items, the patient's past health history, medical diagnoses, and your observations of the patient's current functional status, make an informed judgment regarding expectations for the patient's functional status during the next two months.

62. (PS620) Functional Potential: What is the best description of the patient's likely functional potential over the next two months?

- ☐ 0 - Excellent: Marked improvement in functional status is anticipated
- ☐ 1 - Moderate: Maintenance of current functional status is likely
- ☐ 2 - Guarded: Maintenance of current functional status is questionable
- ☐ 3 - Poor: Decline in functional status is likely

COGNITIVE/MENTAL STATUS

The objective of this portion of the assessment is to evaluate those mental or psychological processes that affect the individual's ability to function independently. This assessment includes observation of the patient throughout the entire assessment visit, as well as interview strategies to obtain more specific information. In addition to the patient, the family, caregiver, physician, and past health history all are important data sources for the assessment of cognitive/mental status.

Throughout the visit, carefully observe the patient's (1) posture and motor behavior, (2) manner of dress, (3) facial expressions, (4) grooming and personal hygiene, (5) affect, and (6) manner of speech. All are indicators of the patient's mental status.

Interviewing the patient or others involves a combination of asking open-ended questions and waiting while the patient answers in his/her own words. Based on the patient's responses, the clinician can proceed to more specific questions. The clinician should attempt to explore the patient's own perception of his/her emotional status. In addition to questions about mood or feelings, other information collected during the assessment process concerning appetite and weight changes also is relevant to the mental status assessment. If a patient's level of functioning appears to fluctuate, choose the option that reflects his/her worst or most dependent level of functioning.

COGNITIVE/MENTAL STATUS

Assessment Strategy | **Data Item**

63. Cognitive Functioning

The patient's description of current illnesses, past health history, and performance of self-care activities allows the clinician to make meaningful observations related to cognitive function. If the patient is having trouble remembering questions or the topic of conversation, ask if this is usual or related to a strange or novel situation. Has there been a change in the patient's attention span? If there is a caregiver in the home, gather information from that person also.

63. (PS630) Cognitive Functioning: Record patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

64. When Confused (Reported or Observed)

Information can be collected by observing the patient throughout the visit and by report from the patient or others. Ask the patient whether or not he/she ever feels somewhat confused (for example, "you don't know where you are or how you got there") and determine under what circumstances that occurs. Mild confusion can be masked in patients with well-developed social skills, so careful assessment is needed. If a caregiver or family member is present, they also may be able to provide information.

64. (PS640) When Confused (Reported or Observed):

- ☐ 0 - Never
- ☐ 1 - In new or unstructured situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive **[Go to Item PS680]**

If it is reported that the patient is "occasionally" confused, identify the situation(s) in which confusion occurs.

"Nonresponsive" means that the patient is unable to respond.

65. Depressive Symptoms

Patient-Response Item: Read each question word-for-word to the patient. Indicate whether the patient responds "yes" or "no" to each question.

Patient-Response Item:

65. (PS650) Depressive Symptoms

		0 - No	1 - Yes
a.	Are you basically satisfied with your life?	☐	☐
b.	Are you less interested in activities you used to enjoy?	☐	☐
c.	Do you often get bored?	☐	☐
d.	Do you often feel helpless?	☐	☐
e.	Do you often feel worthless?	☐	☐

COGNITIVE/MENTAL STATUS

Assessment Strategy | **Data Item**

66. Socialization/Isolation

Assess the patient's sense of loneliness or isolation.

Patient-Response Item: Read the item and the response options word-for-word to the patient. Record the response provided. If the patient does not use one of the response options provided, read the options again, and ask him/her to choose the appropriate option. Do not interpret the patient's answer and choose a response for him/her.

Patient-Response Item:

66. (PS660) Socialization/Isolation: Sometimes people don't have as much contact with other people as they would like. How often do you feel lonely or isolated?

- ☐ 0 - Never
- ☐ 1 - Not very often
- ☐ 2 - About half the time
- ☐ 3 - Most of the time
- ☐ 4 - Always

67. Frequency of Anxiety (Reported or Observed)

Information can be collected by observation throughout the visit or by report of the patient or others. Observe posture, motor behavior, facial expressions, affect, and manner of speech. Ask the patient if he/she ever has episodes of feeling anxious. Does the patient wake up at night feeling fearful and anxious and possibly unable to go back to sleep? Has there been an increase in irritability or restlessness? Anxiety is common in patients with chronic respiratory disease, so increased respiratory difficulty also can increase anxiety. Refer to the 14-day period precisely; orient the patient to this interval by referring to a specific date or day of the week.

67. (PS670) Frequency of Anxiety (Reported or Observed) in the past 14 days: (Anxiety can be manifested in tension, nervousness, apprehension, and/or verbal expressions of distress.)

- ☐ 0 - Rarely, if ever
- ☐ 1 - Sometimes
- ☐ 2 - About half of the time
- ☐ 3 - Most of the time
- ☐ 4 - All of the time

68. Ability to Express Own Needs

This information can be determined by careful observation throughout the visit or by report of the patient or others. If patient is cognitively impaired or if speech is compromised by a medical condition, is the patient able to communicate needs to a caregiver by any method?

68. (PS680) Ability to Express Own Needs: Identify the patient's ability to express his/her needs relating to health, safety, and welfare.

- ☐ 0 - Good: Is able to express those needs that must be met for self-maintenance and personal safety
- ☐ 1 - Fair: Sometimes has difficulty expressing needs that must be met
- ☐ 2 - Poor: Is not able to express needs that must be met

COGNITIVE/MENTAL STATUS

Assessment Strategy

69. Presence and Frequency of Behavior Problems (Reported or Observed)

The specific behaviors noted may be observed by the clinician or reported by the patient or others and may indicate alterations in a patient's cognitive or mental/emotional status. Be alert for the presence of these behaviors throughout the visit. If present, discuss the frequency of their occurrence. All behavioral problems should be noted, regardless of their cause. Consult with family members or a caregiver familiar with the patient's behavior. Note the time interval of 30 days.

Data Item

69. (PS690) Presence and Frequency of Behavior Problems (Reported or Observed): In the past 30 days, how often has the patient experienced or exhibited any of the following behaviors? **(Respond for each item below.)**

	0 - Never	1 - Once	2 - Several times	3 - Several times a week	4 - At least daily
a. Verbal disruption: Yelling, threatening, excessive profanity, sexual references, etc.	☐	☐	☐	☐	☐
b. Physical aggression: Aggressive/ combative to self or others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)	☐	☐	☐	☐	☐
c. Disruptive, infantile, regressive, or socially inappropriate behavior (other than above)	☐	☐	☐	☐	☐
d. Delirium, confusion, delusions, hallucinations, or paranoia	☐	☐	☐	☐	☐
e. Agitated: Pacing, fidgeting, argumentative	☐	☐	☐	☐	☐
f. Wandering (straying or becoming lost in the community as a result of impaired judgment)	☐	☐	☐	☐	☐
g. Withdrawn	☐	☐	☐	☐	☐

FALLS/FALLS RISK

Assessment Strategy

70. Falls

a. Ask the patient or caregiver about all falls, even those that resulted in only very minor or no apparent injuries.

b. Ask the patient or caregiver if any medical attention was required as a result of any fall that occurred in the past two months.

Data Item

70. Falls

a. **(PS700)** Has the patient fallen in the past two months?

☐ 0 - No **[Go to Item PS710]**
☐ 1 - Yes

b. **(PS702)** When the patient fell, did he/she sustain an injury that required medical attention (for example, he/she went to see a doctor or other health care provider)?

☐ 0 - No
☐ 1 - Yes

FALLS/FALLS RISK

Assessment Strategy	Data Item
71. Falls Risk Complete this item after Items PS170-PS202, PS300, PS310, PS550A, PS550P, PS560A, PS560P, PS630, PS670, and PS690 are assessed and completed. Review the responses to these items to determine if impairments exist. Mark all characteristics that make a patient at risk for falling, regardless of the underlying diagnosis (for example, arthritis or CVA might result in a patient being unable to ambulate or transfer safely). Dizziness includes but is not limited to lightheadedness with sudden position changes. Mark "NA" if the patient has no risk factors that could lead to a fall.	**71. (PS710) Falls Risk:** Does the patient have any of the following characteristics? **(Mark all that apply.)** ☐ 1 - Confusion ☐ 2 - Impaired judgment ☐ 3 - Sensory deficit with corrective lenses or hearing aid, if normally used ☐ 4 - Unable to ambulate independently and safely (with or without assistive devices) ☐ 5 - Unable to transfer independently and safely (with or without assistive devices) ☐ 6 - Needs assistive devices to ambulate and/or transfer ☐ 7 - Anxiety/emotional lability ☐ 8 - Cardiac/respiratory disease affecting perfusion and oxygenation ☐ 9 - Dizziness ☐ 10 - Other (specify) _____ ☐ NA - None of the above

KNOWLEDGE AND ADHERENCE

Assessment Strategy	Data Item
72. Knowledge of Emergency Procedures Information relevant to answering this item may be gathered as a part of the preceding assessment items, and based on your observations and reports of the patient or others. Present the patient with a hypothetical situation and ask the patient what he/she would do (for example, "If a fire started in your kitchen, what would you do?"). Probe to determine if the patient would know what to do if leaving the residence became necessary. Assess the patient's knowledge of how to summon help and of how to use the telephone to summon help in an emergency situation.	**72. (PS721) Knowledge of Emergency Procedures:** Please indicate the patient's knowledge of how to implement emergency procedures. a. Patient knows how to exit residence (for example, home or apartment building) in an emergency situation — ☐ 0-No ☐ 1-Yes b. Patient knows how to summon help in an emergency situation — ☐ 0-No ☐ 1-Yes c. Patient knows how to use the telephone to summon help in an emergency situation — ☐ 0-No ☐ 1-Yes
73. Ability to Implement Emergency Procedures Based on the your observations of the patient as well as the reports of the patient or others, determine whether the patient is capable of independently exiting the building, summoning help, and using the telephone to summon help in an emergency situation.	**73. (PS723) Ability to Implement Emergency Procedures:** Please indicate the patient's ability to implement emergency procedures. a. Patient is able to exit residence independently in an emergency situation — ☐ 0-No ☐ 1-Yes b. Patient is able to summon help in an emergency situation — ☐ 0-No ☐ 1-Yes c. Patient is able to use the telephone to summon help in an emergency situation — ☐ 0-No ☐ 1-Yes

KNOWLEDGE AND ADHERENCE

Assessment Strategy	Data Item
74. Adherence to Medication Regimen Ask the patient (or caregiver, if appropriate) about any difficulties remembering to take medications or accessing the medications. Option 0 would be appropriate if the patient adheres 4 out of 5 times each day, option 1 if he/she adheres 2-4 out of 5 times, and option 2 if less than 2 out of 5 times. For schedules of different frequencies (for example, 7 times, 4 times), compute the percentage of adherence and mark the appropriate response. This item relates to Items PS600A and PS600P.	**74. (PS740) Adherence to Medication Regimen**: With the help of the aide/personal care aide, family members/friends, unpaid caregivers, etc., how closely has the patient adhered to his or her prescribed medication regimen over the <u>past 7 days</u>? ☐ 0 - Adheres completely (more than 80% of the time) ☐ 1 - Fair adherence (40-80% of the time) ☐ 2 - Poor adherence (less than 40% of the time) ☐ NA - Patient does not take prescription medications

PATIENT NEEDS

Assessment Strategy

75. Patient Needs

This item is meant to capture the patient's needs for different types of health-related assistance, whether or not those needs are met adequately by the assistance currently being received. The clinician should consider all assistance being received by the patient, not just assistance provided by agency staff. Responses to this item should be based on all information collected during the assessment using the clinician's observations and reports from the patient or others. The clinician or the patient or caregiver can identify a particular need. Based on the assessment data, the clinician should determine whether the assistance the patient currently receives adequately meets these needs and whether the patient will accept additional assistance.

Data Item

75. (PS750) Patient Needs: Please make a checkmark in the appropriate boxes to identify the skilled care, personal care, and other health services for which the patient requires assistance, regardless of whether assistance currently is being provided by the agency, informal caregivers, or other sources. Describe the status of the need.

Service Need	Patient Needs Assistance 0-No	Patient Needs Assistance 1-Yes	Current Assistance Not Adequate	Patient Will Accept Additional Assistance
Personal Care				
1. Grooming	☐	☐	☐	☐
2. Dressing	☐	☐	☐	☐
3. Bathing	☐	☐	☐	☐
4. Feeding or eating	☐	☐	☐	☐
5. Toileting	☐	☐	☐	☐
6. Bowel program	☐	☐	☐	☐
7. Transferring	☐	☐	☐	☐
8. Ambulation/locomotion	☐	☐	☐	☐
9. Medication management	☐	☐	☐	☐
10. Meal preparation	☐	☐	☐	☐
11. Housekeeping	☐	☐	☐	☐
12. Laundry	☐	☐	☐	☐
13. Shopping	☐	☐	☐	☐
Skilled Care				
14. Skilled nursing care	☐	☐	☐	☐
15. Physical or occupational therapy	☐	☐	☐	☐
16. Speech therapy	☐	☐	☐	☐
17. Social work	☐	☐	☐	☐
Other Health Services				
18. Case management	☐	☐	☐	☐
19. Caregiver support or respite	☐	☐	☐	☐
20. Community-based food program	☐	☐	☐	☐
21. Home-delivered meals	☐	☐	☐	☐
22. Hospice	☐	☐	☐	☐
23. Mental health services	☐	☐	☐	☐
24. Nutrition counseling	☐	☐	☐	☐
25. Personal emergency response system	☐	☐	☐	☐
26. Adult protective services	☐	☐	☐	☐
27. Transportation	☐	☐	☐	☐
28. Pain management	☐	☐	☐	☐
29. Other (specify) _____	☐	☐	☐	☐

QUALITY OF LIFE

Assessment Strategy | **Data Item**

76. Self-rated Quality of Life

Patient-Response Item: Read the item and the response options word-for-word to the patient. Record the response provided. If the patient does not use one of the response options provided, read the options again, and ask him/her to choose the appropriate option. Do not interpret the patient's answer and choose a response for him/her.

Patient-Response Item:

76. (PS760) Self-rated Quality of Life: Think about all the parts of your life - your health, your happiness, and other feelings. Considering all of these things, how would you rate your quality of life overall?

- ☐ 0 - Excellent
- ☐ 1 - Very Good
- ☐ 2 - Good
- ☐ 3 - Fair
- ☐ 4 - Poor
- ☐ NA - Patient nonresponsive

"Nonresponsive" means the patient is unable to respond.

SATISFACTION WITH CARE

Assessment Strategy | **Data Item**

77.-78. Overall Satisfaction and Willingness to Refer

PS790 - Satisfaction Form for Current Patients

Patient-Response Items: Read each item and its response options word-for-word to the patient. Record the responses provided. If the patient is nonresponsive, please obtain this information from the primary caregiver. If the patient/caregiver does not use one of the response options provided, read the options again, and ask him/her to choose the appropriate option. Do not interpret the patient's/caregiver's answer and choose a response for him/her.

Patient-Response Items:

77. (PS790) Overall Satisfaction: All things considered, how much of the time have you been satisfied with the care you received from *(agency or facility)* over the past two months?

- ☐ 0 - Never
- ☐ 1 - Not very often
- ☐ 2 - Sometimes
- ☐ 3 - Most of the time
- ☐ 4 - Always

SATISFACTION WITH CARE

Assessment Strategy | **Data Item**

PS790 - Satisfaction Form for Discharged Patients

Overall Satisfaction and Willingness to Refer

Patient-Response Items: Read each item and its response options word-for-word to the patient. Record the responses provided. If the patient is nonresponsive, please obtain this information from the primary caregiver. If the patient/caregiver does not use one of the response options provided, read the options again, and ask him/her to choose the appropriate option. Do not interpret the patient's/caregiver's answer and choose a response for him/her.

Patient-Response Items:

(PS790) Overall Satisfaction: All things considered, how much of the time were you satisfied with the care you received from *(agency or facility)* over the last two months before your discharge?

- ☐ 0 - Never
- ☐ 1 - Not very often
- ☐ 2 - Sometimes
- ☐ 3 - Most of the time
- ☐ 4 - Always

78. (PS800) Willingness to Refer: Would you recommend *(agency or facility)* to your best friend or a close family member?

- ☐ 0 - Yes, definitely
- ☐ 1 - Yes, probably
- ☐ 2 - No

UTILIZATION OF SERVICES

Assessment Strategy | **Data Item**

PS810 – Transfer/ Death at Home

79. Emergent Care

Ask the patient or caregiver if the patient has had any services for emergent care since the last assessment. Reviewing the patient's medical record also may provide the information needed to answer this item. Emergent care reflects all unscheduled visits for medical care as well as medical appointments that occur within 24 hours of scheduling. Care could have been received in settings other than an emergency room. Services provided by the home care agency are not considered emergent.

79. (PS810) Emergent Care: Since the last time assessment data were collected, has the patient utilized any emergency services?

- ☐ 0 - No **[Go to Item PS830]**
- ☐ 1 - Yes

Emergency services are defined as unscheduled medical visits or services provided within 24 hours of scheduling.

UTILIZATION OF SERVICES

Assessment Strategy | **Data Item**

PS810 – Reassessment/ Follow-up, Discharge

Emergent Care
Ask the patient or caregiver if the patient has had any services for emergent care since the last assessment. Reviewing the patient's medical record also may provide the information needed to answer this item. Emergent care reflects all unscheduled visits for medical care as well as medical appointments that occur within 24 hours of scheduling. Care could have been received in settings other than an emergency room. Services provided by the home care agency are not considered emergent.

79. (PS810) Emergent Care: Since the last time assessment data were collected, has the patient utilized any emergency services?

- ☐ 0 - No **[Skip Remainder of Form]**
- ☐ 1 - Yes

Emergency services are defined as unscheduled medical visits or services provided within 24 hours of scheduling.

80. Emergent Care Reason
Ask the patient or caregiver to state all the symptoms and reasons for which he/she sought emergent care. A phone call to the doctor's office or emergency room may be required to clarify the reason(s) for emergent care.

80. (PS820) Emergent Care Reason: For what reason(s) did the patient or family seek emergent care? **(Mark all that apply.)**

- ☐ 1 - Acute mental/behavioral health problem
- ☐ 2 - Hypo/hyperglycemia, diabetes out of control
- ☐ 3 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- ☐ 4 - Injury caused by fall or accident at home
- ☐ 5 - Injury while straying unsupervised from a protective environment
- ☐ 6 - Nausea, dehydration, malnutrition, constipation, impaction
- ☐ 7 - Pneumonia
- ☐ 8 - Pressure ulcer (new or deterioration)
- ☐ 9 - Respiratory problems (for example, shortness of breath, respiratory infection other than pneumonia, obstruction)
- ☐ 10 - Uncontrolled pain
- ☐ 11 - Urinary tract infection
- ☐ 12 - Wound or tube site infection, deteriorating wound status, new wound (other than pressure ulcer)
- ☐ 13 - Other (specify) _____
- ☐ UK - Reason unknown

81. Inpatient Facility
Often the family or medical service provider informs the agency that the patient has been admitted to an inpatient facility. Clarify with this informant as to which type of facility the patient has been admitted. You may have to contact the facility to determine how it is licensed.

81. (PS830) To which **Inpatient Facility** has the patient been admitted?

- ☐ 1 - Hospital
- ☐ 2 - Rehabilitation facility
- ☐ 3 - Nursing home
- ☐ 4 - Hospice

UTILIZATION OF SERVICES

Assessment Strategy	Data Item
82. Reason(s) for Hospitalization Interview the patient, family, or medical service provider to determine the conditions requiring acute hospital admission.	**82. (PS840) Reason(s) for Hospitalization: (Mark all that apply.)** ☐ NA - Patient has not been hospitalized ☐ 1 - Acute mental/behavioral health problem ☐ 2 - Bowel/intestinal obstruction ☐ 3 - Hypo/hyperglycemia, diabetes out of control ☐ 4 - Improper medication administration, medication side effects, toxicity, anaphylaxis ☐ 5 - Injury caused by fall or accident at home ☐ 6 - Injury while straying unsupervised from a protective environment ☐ 7 - Pneumonia ☐ 8 - Pressure ulcer (new or deterioration) ☐ 9 - Respiratory problems (for example, shortness of breath, respiratory infection other than pneumonia, obstruction) ☐ 10 - Scheduled surgical procedure ☐ 11 - Unscheduled or emergency surgery ☐ 12 - Scheduled non-surgical procedure (for example, chemotherapy, diagnostic tests) ☐ 13 - Uncontrolled pain ☐ 14 - Urinary tract infection ☐ 15 - Wound or tube site infection, deteriorating wound status, new wound (other than pressure ulcer) ☐ 16 - Other (specify) _____ ☐ UK - Reason unknown