OASIS Class 3

Home Health VNA
Merrimack Valley Hospice
HomeCare, Inc.

The Leaders in Home Health and Hospice Care

Oasis Class 3 Syllabus

- M2020 Medication management VBP
- 2015 **Drug Education**/VBP
- Pressure Ulcer/Injury
- Stasis Ulcer/Injury
- Surgical wounds

- *VBP Value Based Purchasing

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.) VBP

0 – Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

1 – Able to take medication(s) at the correct times if:

(a) individual dosages are prepared in advance by another person; OR

(b) another person develops a drug diary or chart.

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

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

NA – No oral medications prescribed.

Consider the following :

- All medications prescription and over the counter
- Ability not willingness or compliance
- On dc you must consider if the pt has the ability to take meds after all the intervention provided OR does the caregiver continued to administer out of convenience.
- Mental/Emotional status
- Cognitive function
- Activities permitted

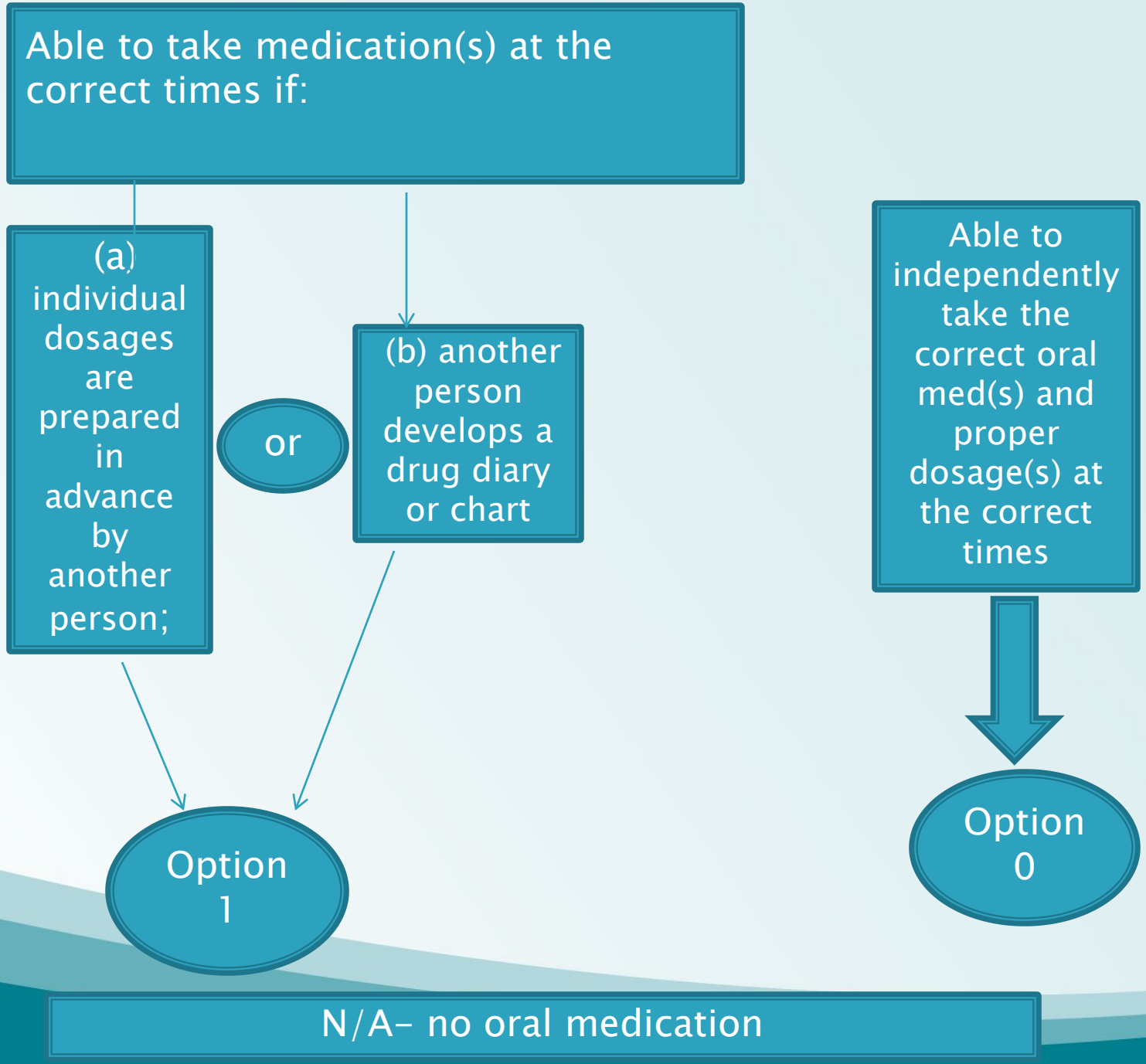
Unable to take medication unless administered by another person

Option 3

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

Option 2

N/A- no oral medication


Able to take medication(s) at the correct times if:
(a) individual dosages are prepared in advance by another person;
or
(b) another person develops a drug diary or chart
Able to independently take the correct oral med(s) and proper dosage(s) at the correct times
Option 1
Option 0
N/A- no oral medication

- Can they get to the meds, can they get to the water?
- Pt has to be able to get the medication, read or identify medication, open the container select measure liquid/pick up the pill and take the medication
- PO meds =placed in mouth and swallowed
- Does not include inhalers or swish and expectorate
- Report was is true on day of assessment
- If ability varies from med to med consider the medication that takes the most assistance

- If the patient is missing a medication use your judgement if they would be able to take it if it were in the home

- If PRN medication is ordered and needed on day of assessment and pt needed reminders to take the medication, the score would be a 2, needs reminders

- If pt lives in an ALF you must use clinical judgment to determine if the pt is able to get to the medication and take correctly, proper dosage at the correct time

- **Bubble packs**-If the pt receives bubble packs and they can take them independently, the pt is independent with medication management if all other criteria are met.

APPLY WHAT YOU LEARN

At SOC MRS Jones has 3 oral meds prescribed daily. She has been safely taking her antihypertensive and stool softener for years at the appropriate times and dose. She is not taking her tapering dose of steroids as she doesn't understand which dose she should take or when to take it. The SN established a drug chart and educated Mrs. Jones regarding dose and frequency of the steroid.

0 – Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

1 –Able to take medication(s) at the correct times if:

(a) individual dosages are prepared in advance by another person; OR

(b) another person develops a drug diary or chart

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

3 – Unable to take medication unless administered by another person

NA – No oral medications prescribed

M2030 Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.

0 – Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

1 – Able to take injectable medication(s) at the correct times if:

(a) individual syringes are prepared in advance by another person; and/OR

(b) another person develops a drug diary or chart.

2 – Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection

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

NA – No injectable medications prescribed.

- Patients' current ability to prepare all injectable medications reliably and safely excludes IV meds
- Includes obtaining, drawing up, aseptic technique, and disposing of needle properly
- If the ability varies between 2 medications, consider the one that takes the most assistance
- PRN injections, even if not used on day of assessment are considered, use your clinical judgment, have the patient explain the procedure they would use
  - i.e. epi pens

- Include medication ordered even if not administered on day of assessment
- Vitamin B 12 for example that is not due on day of assessment but ordered monthly
- You may make inferences based on the patients cognitive and physical status

- Unable to take injectable medication unless administered by another person.

Option 3

-Able to take med(s) at the correct times if given reminders by another person based on the frequency of the injection

Option 2

Able to take injectable medication(s) at the correct times if:
(a) individual syringes are prepared in advance by another person; and/or
(b) another person develops a drug diary or chart.

Option 1

Able to independently take the correct med(s) and proper dosage(s) at the correct times.

Option 0

No injectable medications prescribed =N/A

Apply What You Learn

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

How would you score the oasis?

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

1– Able to take injectable medication at the correct time if:

a) individual syringes are prepared in advance by another person OR

b) another person develops a drug diary or chart

2– Able to take medication at the correct time if given reminders by another person based on the frequency of the injection

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

NA – no injectable medication

Star Rating/VBP – Drug Education on All Medications M2016

(M2016) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

0 – No

1 – Yes

NA – Patient not taking any drugs

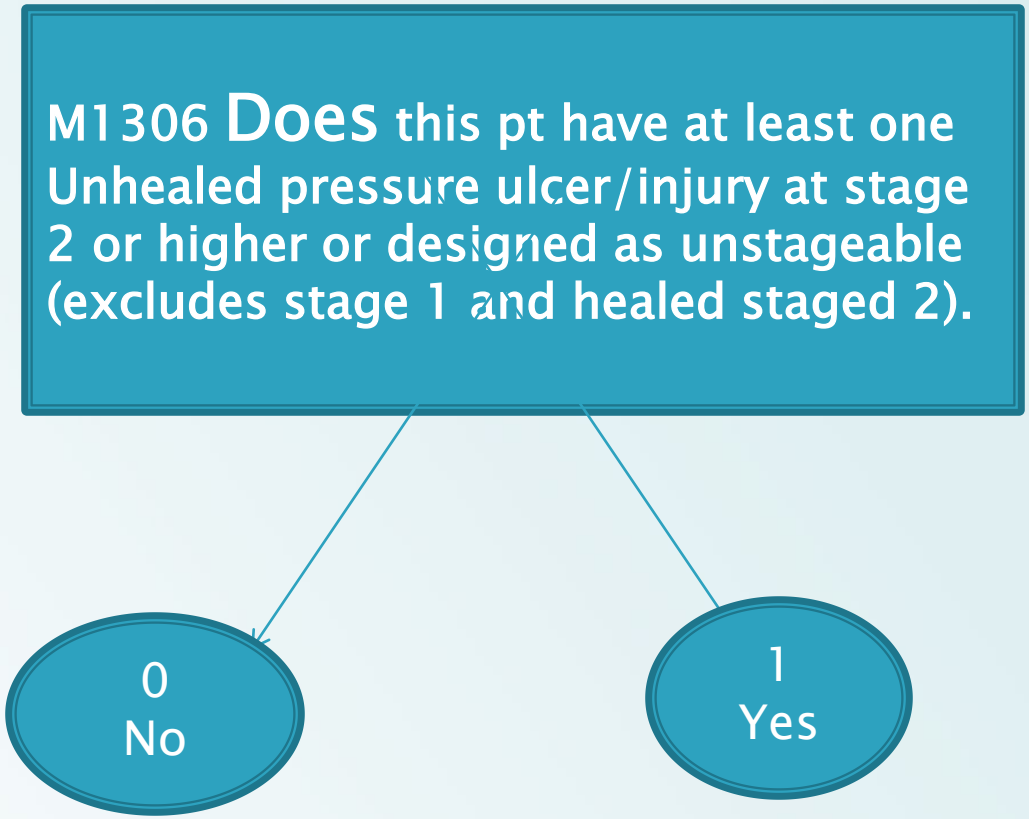
OASIS Time Points Completed

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

Item Intent

- Identifies if clinician instructed the patient/caregiver about how to manage medications effectively and safely. Drug education interventions for M2016 should address all medications the patient is taking – prescribed and over-the-counter – by any route
- Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment.

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



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

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

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

1 Was present at the most recent SOC /ROC assessment

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

N/A

The intent is to :

- Identify the oldest stage 2 pressure ulcer/injury that is present at d/c and is not fully epithelialized, assess the length of time this ulcer remained unhealed while the patient received care from the home health agency

- And to identify patient who developed stage 2 pressure ulcer/injury while under the care of the HHA

SOC/ROC

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**	☐
B1. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers**	☐
C1. **Stage 4:** Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers**	☐
D1. Unstageable: **Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**	☐
E1. Unstageable: **Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

F/U

Follow-Up

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**	☐
B1. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers**	☐
C1. **Stage 4:** Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers**	☐
D1. **Unstageable: Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**	☐
E1. **Unstageable: Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1. **Unstageable: Deep tissue injury** **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

D/C

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 – Go to M1311B1, Stage 3]	☐
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 – Go to M1311C1, Stage 4]	☐
B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 – Go to M1311D1, Unstageable: Non-removable dressing/device]	☐
C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** [If 0 – Go to M1311E1, Unstageable: Slough and/or eschar]	☐
D2. Number of <u>these</u> unstageable pressure ulcers/injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 – Go to M1311F1, Unstageable: Deep tissue injury]	☐
E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury** [If 0 – Go to M1324]	☐
F2. Number of <u>these</u> unstageable pressure injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

- A pressure ulcer/injury treated with a muscle/rotational flap or a skin graft is a surgical wound

- A pressure ulcer/injury that has been surgically debrided remains a pressure ulcer and should not be reported as a surgical wound on M1342
- If all the damaged tissue of a pressure ulcer/injury is excised and no flap is used it should still be considered a sx wound as all the damaged tissue from pressure was removed .

M1322–M1342

(M1322)	**Current Number of Stage 1 Pressure Injuries:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
Enter Code ☐	0 1 2 3 4 or more
(M1324)	**Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:** (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries
(M1330)	Does this patient have a **Stasis Ulcer?**
Enter Code ☐	0 No **[*Go to M1340*]** 1 Yes, patient has BOTH observable and unobservable stasis ulcers 2 Yes, patient has observable stasis ulcers ONLY 3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[*Go to M1340*]**
(M1332)	**Current Number of Stasis Ulcer(s) that are Observable:**
Enter Code ☐	1 One 2 Two 3 Three 4 Four or more
(M1334)	**Status of Most Problematic Stasis Ulcer that is Observable:**
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1340)	Does this patient have a **Surgical Wound?**
Enter Code ☐	0 No **[*Go to M1400*]** 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device **[*Go to M1400*]**
(M1342)	**Status of Most Problematic Surgical Wound that is Observable**
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

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

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

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

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

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

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

- Since a suspected Deep Tissue Injury in evolution does not granulate and would not be covered with new epithelial tissue, the only appropriate response for a suspected Deep Tissue Injury is

- (3)– Not Healing.

Suspected Deep Tissue Injury

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

Stage I

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

Stage II

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

Stage III

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

Stage IV

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

Unstageable

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

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

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

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

- Report only current stasis ulcers
- If completely epithealialized, no longer a stasis ulcer
- Select 0-no if all stasis ulcers are completely healed
- You cant reverse stage pressure ulcers stage for example stage 4 to a stage 3
- If Braden is 18 or less you need an intervention to prevent pressure ulcers on POC

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

- See attached sheet

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

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

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

Scab does not automatically mean non healing

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

Date of complete epithelialization:

- Consider date of surgery, any reported wound healing progress/complications and clinical assessment findings

- If the incision could have been epithelialized for 30 days, wound is considered healed and not considered here

- Is the incision line completely re-epithelialized with no signs or symptoms of infection (if completely closed, re-epithelialization generally takes place with hours to 3 days)

- If the incision has been newly epithelialized for 30 days then it's considered a scar

- If a scab is adhering to incisional tissue and /or s/s infection then =non healing

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

Apply What you Learned

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

0 -Newly epithelialized

1 -Fully granulating

2 -Early/partial granulation

3 -Not healing