

Clinical Record Items

(M0080) Discipline of Person Completing Assessment:

Enter Code	1 - RN
<input type="checkbox"/>	2 - PT
	3 - SLP/ST
	4 - OT

(M0090) Date Assessment Completed: / /
month day year

(M0100) This Assessment is Currently Being Completed for the Following Reason: Transfer to an Inpatient Facility

Enter Code	6 - Transferred to an inpatient facility—patient not discharged from agency [Go to M1041]
<input type="checkbox"/>	7 - Transferred to an inpatient facility—patient discharged from agency [Go to M1041]

Patient History and Diagnoses

(M1041) **Influenza Vaccine Data Collection Period:** Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 through March 31?

Enter Code	0 - No [Go to M1051]
<input type="checkbox"/>	1 - Yes

(M1046) **Influenza Vaccine Received:** Did the patient receive the influenza vaccine for this year's flu season?

Enter Code	1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
<input type="checkbox"/>	2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
	3 - Yes; received from another health care provider (for example, physician, pharmacist)
	4 - No; patient offered and declined
	5 - No; patient assessed and determined to have medical contraindication(s)
	6 - No; not indicated - patient does not meet age/condition guidelines for influenza vaccine
	7 - No; inability to obtain vaccine due to declared shortage
	8 - No; patient did not receive the vaccine due to reasons other than those listed in responses 4-7

(M1051) **Pneumococcal Vaccine:** Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?

Enter Code	0 - No
<input type="checkbox"/>	1 - Yes [Go to M1242]

(M1056) **Reason Pneumococcal Vaccine not received:** If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:

Enter Code	1 - Offered and declined
<input type="checkbox"/>	2 - Assessed and determined to have medical contraindication(s)
	3 - Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine
	4 - None of the above

Medications

(M2005) **Medication Intervention:** Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

Enter Code	0 - No
<input type="checkbox"/>	1 - Yes
	NA - There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

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

Enter Code	0 - No
<input type="checkbox"/>	1 - Yes
	NA - Patient not taking any drugs

Emergent Care

(M2301) **Emergent Care:** At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

Enter Code	0 - No [Go to M2401]
<input type="checkbox"/>	1 - Yes, used hospital emergency department WITHOUT hospital admission
	2 - Yes, used hospital emergency department WITH hospital admission
	UK - Unknown [Go to M2401]

(M2310) **Reason for Emergent Care:** For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? (Mark all that apply.)

- 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- 10 - Hypo/Hyperglycemia, diabetes out of control
- 19 - Other than above reasons
- UK - Reason unknown

Discharge

(M2401) Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?			
Plan / Intervention	No	Yes	Not Applicable
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

(M2410) To which **Inpatient Facility** has the patient been admitted?

Enter Code	<input type="checkbox"/> 1 - Hospital <input type="checkbox"/> 2 - Rehabilitation facility <input type="checkbox"/> 3 - Nursing home <input type="checkbox"/> 4 - Hospice <input type="checkbox"/> NA - No inpatient facility admission
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(M0906) **Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer, or death (at home) of the patient.

<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
month		day		year			

Section J: Health Conditions

(J1800) Any Falls Since SOC/ROC, whichever is more recent	
Enter Code	Has the patient had any falls since SOC/ROC, whichever is more recent?
<input type="checkbox"/>	0 - No → Skip J1900
<input type="checkbox"/>	1 - Yes → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

(J1900) Number of Falls Since SOC/ROC, whichever is more recent	
	Enter Code in Boxes
Coding: 0. None 1. One 2. Two or more	<input type="checkbox"/> A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	<input type="checkbox"/> B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	<input type="checkbox"/> C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma