The universal purpose of home care is to promote the patient’s optimal level of well being and function. The OASIS WALK® is designed to objectively evaluate the patient’s ability to safely interact with his/her environment given his/her physical and mental health status on the day of assessment. The information collected at the beginning of a quality episode (SOC/ROC) and at recertification provides the basis for care planning and the development of interventions to stabilize or improve the patient’s health status including functional ability to stay safely in their home and reduce his/her risk for emergent care and hospitalization. The degree to which the interventions and skilled care provided by each visiting clinician contributed to those goals is determined when the assessment and comparative OASIS WALK® is conducted at the end of the quality episode (transfer and discharge). This change in the patient’s health status is reported publicly as end result and utilization outcome measures on the CMS website Home Health Compare.

When conducting the OASIS WALK, lead the patient through this series of functional activities, real and/or simulated, observing for environmental barriers and the presence and use of assistive devices and adaptive equipment. “Test” the patient’s ability and evaluate whether the patient has both the cognitive and physical capacity to perform the tasks safely given their current health status, in their unique environment on this day of assessment. Using your clinical judgment, determine how much human intervention (cuing, supervision, contact guarding, assistance, etc.) is required and select the OASIS response that represents the current level of safe functioning the day of assessment (at the time of the visit and in the 24 hours that precedes the visit).

The care giving situation is not a consideration when scoring these items. Patients who have caregivers may be assessed to be independent or not. Patients who live alone may be determined to be independent or not. “Independent” includes ability and safety and is not defined by the availability of caregivers and/or living situation.

<table>
<thead>
<tr>
<th>OASIS Items</th>
<th>Patient Demonstration</th>
<th>Instructions</th>
<th>Ability Demonstrated/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>M2020/2030 Management of Oral/Injectable Medications</td>
<td>For oral medications, ask patient to retrieve medications from storage area, demonstrate how to open the bottle, pour the medication and explain when and how they remember to take medication and/or.</td>
<td>Observe balance, strength, ability to come to a standing position and ambulate as patient retrieves medications. Note such things as vision to read labels, cognition for remembering to take them and manual strength/dexterity to open containers, pour medicines, reach mouth and/or manipulate injection supplies and reach site of injection.</td>
<td><strong>Determine how much assistance (in person; cueing or physical contact) is required to set up or remember to take any or all medication doses safely. If ability varies among the medications, select a response for the medication requiring the most assistance.</strong>**</td>
</tr>
<tr>
<td>M2000 Drug Regimen Review</td>
<td>For medications that will be injected in the home, ask patient to retrieve injection supplies from storage area, demonstrate how to draw up medication, select site, explain how and when to take the medication and dispose of needles…</td>
<td>Reconcile medications and conduct a drug regimen review per agency policy. Determine if there are any potentially significant medication issues e.g. drug reactions, ineffective drug therapy, side effects, drug interactions, any discrepancies such as duplicate therapy, omissions, additions, dosage differences and dosage errors or non compliance.****</td>
<td>Identify high risk medications and provide/ensure instruction</td>
</tr>
</tbody>
</table>
| M1200 Vision | Ask the patient to visualize the words or numbers on medication bottles and syringe barrels and notice if he/she sees environment (e.g. objects in path, etc.) when retrieving medications from storage... on special precautions within assessment timeframe. 

Observe if the patient uses glasses (prescription or store bought) or other device to see and its effectiveness. Observe the patient visualize and navigate his environment. Determine if visual deficits for any reason (cataracts, macular degeneration, glaucoma, etc.) or physical deficits (inability to freely move head and neck due to cervical collar or halo traction, etc.) interfere with his/her ability to safely function visually in the home environment.

Score the patient’s ability to visually function with the vision he/she has using glasses if worn. Glasses include corrective lenses and drugstore reading glasses and exclude a magnifying glass. |
| --- | --- |
| M1860 Ambulation | ...walk a distance of at least 20 feet and to the bathroom... (If unable to ambulate, ask patient to propel manual or electric wheelchair once seated in it.) 

Observe environment. Observe physical ability, cognition and note medical restrictions. Determine the level of human intervention and/or type of assistive device required to safely ambulate across surfaces through the house and move around in the bathroom. This item also includes safely negotiating surfaces outside the home the patient routinely accesses to obtain medical treatment and attend church.

Select the response reflecting the patient’s ability to safely ambulate the day of assessment (take more than the 1-2 steps it takes to transfer to a wheelchair). Even if a patient has a limited ability to ambulate and uses a wheelchair more than he/she walks, score the ability to walk.

Select “0” if able to safely ambulate on ALL surfaces routinely accessed at ALL times without human intervention or assistive device.

Select “1” if able to safely ambulate on ALL surfaces routinely encountered with a one handed device and without human intervention.

Select “2” if able to safely ambulate with human intervention on uneven surfaces and/or a two handed device on level surfaces.

If the patient does not require human intervention but safely ambulates with a walker on some surfaces and cane on others, select the score reflecting the device supporting safe... |
| M1200 Vision | Ambulation on all surfaces.  
Score “3” if requires human intervention at ALL times for safe ambulation regardless of care giving situation and use of devices.  
If patient has no ability to ambulate, select “4” or “5” depending on ability to propel self in any kind of wheelchair.  
****  
Observe ability to visualize environment and see objects in path as patient walks or wheels to the bathroom. |
|---|---|
| M1840 Toilet Transfer | ...and get to bathroom toilet...  
...sit on the toilet and get off...  
**OR**  
*(If bathroom toilet not accessible)*  
...get to the Bed Side Commode (BSC)...  
...sit on and get off...  
Locate the bathroom, placement, type and height of toilet.  
Observe ambulation, physical ability and cognition, note medical restrictions and determine the amount of assistance required to safely **get to and from AND on and off** the bathroom toilet.  
If unable to get to the bathroom toilet AND transfer safely, determine if able to **get to and from AND on and off** the bedside commode safely OR position the urinal and get on/off the bedpan by his/her self OR needs to be scored as dependent in toileting.  
Note: This item is about access and transfer. Scoring does not include cleaning and wiping self or managing clothing. Assess ability to **get to and from AND on and off** toilet/BSC even if catheter or “ostomies” present.  
A patient who can safely access the bathroom toilet some hours of the day and must use the bedside commode at night for reasons of safety has a varying ability within the 24 hr period. Select the OASIS response that that reflects what is true the majority of the time/day of assessment.  
****  
Observe patient’s physical ability and cognition, note medical restrictions and determine how much assistance is required to manage **both hygiene AND clothing**. Toileting hygiene includes cleansing around the stoma for ostomy patients and perineal/catheter care when a urinary catheter is in place.  
Select 0 if he/she can manage both tasks safely and without need of human intervention.  
Select 1 if he/she can manage both tasks safely once the... |
| M1845 Toileting Hygiene | ...reach perineal area to cleanse self, conduct perineal hygiene AND manage clothing...  
Select 0 if he/she can manage both tasks safely and without need of human intervention.  
Select 1 if he/she can manage both tasks safely once the... |
<table>
<thead>
<tr>
<th>M1800 Grooming</th>
<th>...stand in front of the sink, wash hands... supplies are laid out. Select 2 if he/she needs some human intervention (more than a supply set up) with either or both activities. Select 3 if dependent for both tasks. **** Locate grooming items. Observe physical ability and cognition, note medical restrictions and determine how much assistance is required for collecting and using utensils used in grooming tasks (i.e. washing face and hands, hair care, shaving or make up, teeth or denture care, finger nail care). If ability varies among the grooming tasks, select the response best describing level of ability for the majority of the tasks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1830 Bathing</td>
<td>...step in and out of the tub/shower... ...while in shower/tub reach as if washing feet and back (hard to reach places)... Locate tub/shower and note presence of supportive, adaptive/safety equipment and assistive devices. Observe physical ability and cognition, note medical restrictions and determine the amount of human intervention required to safely get in and out of the tub/shower AND wash entire body this day of assessment. Select from response 0-3. Select 0 - able to both transfer AND bath self safely without human intervention and equipment/devices. Select 1 - able to both transfer AND bath self safely with the equipment/devices present AND without human intervention. Select 2 - able to transfer and bath safely with intermittent human intervention. Select3 - able to transfer and bath safely with constant human intervention. If unable to access the tub/shower by any safe means, the tub/shower is not accessible or if there is a medical restriction to not shower or tub bathe, select from responses 4 - 6. Select 4 - able to bathe safely at the sink, in a chair or on commode without human intervention. Select 5 - able to bathe safely at the sink, in a chair or on commode with some human intervention. Select 6- dependent in bathing (e.g. can't participate effectively, must be bathed in bed, etc.). Note: Preference, habit and care giving situation is not scored here.</td>
</tr>
<tr>
<td>M1200 Vision</td>
<td>...walk to bedroom.... Observe ability to visualize environment, transition floor surfaces and see objects in path as patient walks or wheels to</td>
</tr>
<tr>
<td>M1860</td>
<td>Ambulation</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>M1850</td>
<td>Transferring</td>
</tr>
</tbody>
</table>

### Get into bed…get from bed to chair…
*If bedfast ask patient to turn and position self.*

### Dressing Upper and Lower body

Ask patient to take off shirt to check vital signs, listen to heart and lung sounds. Ask patient to remove shoes to inspect feet and heels, note edema and palpate pulses.

- **the bedroom.***
  - Locate bed. Notice placement, height and presence of rails/adaptive/safety equipment and assistive devices. Observe physical ability and cognition, note medical restrictions and determine the amount of human intervention required to move safely in an out of bed to a chair or surface applicable to the patient's environment (e.g., BSC, chair in another room, bench, etc.).

Select 0 - If transfer occurs safely without human intervention or assistive device
Select 1 - if transfer occurs safely with minimal human intervention OR use of an assistive device. If requires both intervention and device, this is not the answer.
Select 2 - if able to **bear weight AND pivot** when assisted with the transfer
Select 3 - if only able to **bear weight OR pivot** when transferred; OR cannot bear weight and pivot but is transferred by mechanical or human means from bed to another surface

Select either response 4 or 5 (bedfast) if the patient is not able to get to another surface from the bed and therefore confined to bed.

- **Locate where clothing items are stored and what style of clothing the patient routinely wears. If patient is dressed in clothing to accommodate current limitations and conditions and these are not like the patient's usual wardrobe, the assessment would not be made considering these items as they are not the ones **routinely worn**.**

Clothing routinely worn also includes supportive and protective devices such as sling, compression stockings, prosthesis, ankle foot orthosis, immobilizer, air casts, etc. when applicable.

Observe physical ability and cognition, note medical restrictions and determine the amount of human intervention required to safely gather and dress in the clothing items that are **routinely worn**, managing zippers, buttons and snaps if they are a method of closure for clothes routinely worn.

*If there is varying ability to safely don/doff the clothing items, score the amount of human intervention required for the...*
**M1306-1350 Integument Assessment**

**M1350 Skin Lesion**

- Inspect patient's skin, especially pressure points of heels, hips, sacrum, elbows and back of head for presence of wounds, lesions or ulcers.

Classify, determine and document the degree of healing for any observed wounds/lesions requiring clinical intervention (e.g., observation/assessment/treatment) using the WOCN Guidance on OASIS C Integumentary Items (www.wocn.org) and NPUAP pressure ulcer staging definitions (www.npuap.org).

### Skin lesion:
- Area of pathologically altered tissue
- Primary lesions (arising from previously normal skin) such as vesicles, pustules, weals
- Secondary lesions (resulting from changes in primary lesions) such as crusts, ulcers, scars
- Changes in color or texture such as maceration, scale, lichenification (thickening and hardening)
- Changes in shape of skin surface such as edema, cyst, nodule
- Breaks in skin surfaces such as abrasion, excoriation, fissure, incision
- Vascular lesions such as petechiae, ecchymosis

Includes (when requires clinical intervention) but not limited to:
- Arterial wounds, diabetic ulcers, rashes, crusts, bruises, sores
- Skin tears
- Burns
- PICC lines
- Non bowel ostomy

Excludes:
- Bowel ostomies
- Peripheral IV sites
- Pressure ulcers, stasis ulcers, surgical wounds

Note: While all patients have some lesion that is an alteration in skin integrity it is not included as a skin lesion if they do not require continued observation or care.

### M1630 Bowel Ostomy

- Note presence of bowel ostomy.
| M1610  | Urinary Incontinence | Observe for signs of urinary and bowel incontinence in the bathroom, bedroom, on clothing and during skin inspection and presence of urinary catheters. | Observe for odors. Notice condition of clothing, use of pads/briefs condition of furniture, bathroom and presence of catheter and/or incontinence supplies. | Urinary incontinence includes:  
• Incontinence for any reason in any amount which occurred in the relevant past  
Excludes:  
• Leaking urinary catheter  
*** When “incontinence” is selected in M1610, determine when/how often urinary incontinence occurs for M1615.  
Select “0” time voiding defers when the patient is actively following a time voiding schedule and because they are it is completely effective (the patient has not experienced an episode of incontinence in the relevant past).  
Score “2” when incontinence occurs day and night OR day only.  
*** Determine how often bowel incontinence occurs.  
Note: Response selection for bladder and bowel incontinence should include information reported about the recent past and not just the day of assessment. |
| M1615  | When Incontinent |  |  |  |
| M1620  | Bowel Incontinence |  |  |  |
| M1240  | Pain Assessment | During the OASIS WALK®, observe for occurrence of pain (acute or chronic) which interferes with activity or movement as he/she performs above tasks. Ask patient to “rate” their pain. | Assess for acute and chronic pain using a standardized and validated pain assessment tool. Determine how often pain interferes with functional activity. Consider neoplasms, orthopedic procedures, musculoskeletal disorders, surgical interventions, paresthesia and neuropathy, etc. as sources of pain. Evaluate effectiveness of medication regimen and other treatment modalities. Pain medications might be taken regularly but pain could still interfere in normal life routine and relationships.  
*** Interfering pain causes an activity to take longer to complete, results in an activity being performed less often than desired, requires the patient to have additional assistance of a person or device or prevents the activity from occurring.  
Note: Response selection for this item should include |  |
<table>
<thead>
<tr>
<th>Observation</th>
<th>Description</th>
</tr>
</thead>
</table>
| **M1400** Dyspnea | **Observe for shortness of breath as patient demonstrates above tasks wearing O2 only if used constantly.**  
(If unable to ambulate, assess for shortness of breath during any activity such as transfers or bed mobility.)  
Determine what **level of exertion** produces shortness of breath; rest, talking, ambulating + 20 ft, doing ADL. Probe further to determine if the patient experienced dyspnea at time of sleep. Anxiety, fear and annoyance can cause shortness of breath as well as body type.  
Note: Response selection for this item should include dyspnea experienced at the time of the visit and the 24 hours preceding the visit.  
***  
Note presence of O2, Ventilator, C-PAP and Bi PAP equipment. Determine if there are physician orders for use. |
| **M1410** Respiratory Treatments |  |
| **M1700** Cognition | **Observe how patient follows directions and sequences tasks while demonstrating all of above tasks.**  
Assess level of comprehension, distractibility, ability to follow through, need for repeated directions, cues or reminders on the day of assessment.  
“Alert and oriented” is a component of scores “0”, “1”, **and “2.”**  
Score “1” when the patient needs clues and reminders in new situations. Score “2” when the patient needs reminders and clues in routine situations like bathing, ambulating and taking medications.  
***  
Determine ability follow directions and understand conversation.  
Patients who lip read have the capacity to understand the spoken word.  
***  
Assess for presence of hearing aids and to what degree hearing interferes with receiving directions, understanding them and then performing.  
Some one who reads lips because of profound deafness does not hear.  
**  
Determine how effectively the patient uses speech to answer questions and make needs known. |
| **M1220** Understanding Verbal Content |  |
| **M01210** Hearing | **Observe for presence of hearing loss while taking direction to perform above tasks and answer interview questions.**  
Observe verbal response to questions and during conversation.  
Assess for presence of hearing aids and to what degree hearing interferes with receiving directions, understanding them and then performing.  
Some one who reads lips because of profound deafness does not hear.  
**  
Determine how effectively the patient uses speech to answer questions and make needs known. |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1740</td>
<td>Cognitive, behavioral, psychiatric symptoms.</td>
<td>Observe for comprehension, safety awareness, attitude and behavior as patient demonstrates all of above tasks. Score “7” only when there is no evidence of memory problems or behaviors of such magnitude to interfere with patient’s ability to reach optimum level of function or require consideration when planning and delivering care. Someone requiring supervision of medications or prompting to perform tasks may have memory deficits which require additional strategies to gain compliance and reliability. Someone identified as a fall risk, with poor safety awareness, impulsive behaviors or leaves assistive device behind because they “don’t need it” may have impaired decision making. Note: Response selection for behaviors should include information reported about the recent past as well as the day of assessment. Observe condition of environment. Probe for feelings of sadness and worry and observe emotional/behavioral reactions to questions and assessment process.</td>
</tr>
<tr>
<td>M1710</td>
<td>Confused</td>
<td>Observe mood, affect, and signs of self neglect and ability to cope.</td>
</tr>
<tr>
<td>M1720</td>
<td>Anxious</td>
<td>Observe level of cooperation and orientation during OASIS Walk.</td>
</tr>
<tr>
<td>M1730</td>
<td>Depression Screening</td>
<td></td>
</tr>
</tbody>
</table>
Response Selection Tips for OASIS Functional Activity ITEMS M1800-1900

Complete OASIS items M1800-1900 according to patient’s “ability” which may not be how patient routinely performs the activity. To determine “ability” requires interview strategies combined with observation of the patient’s demonstration of task and then making a clinical judgment to factor out “willingness” or “compliance.”

“Ability” encompasses patient performance that is safe considering the patient’s:
- current physical condition (strength, flexibility, ROM, dexterity, balance, etc.)
- current clinical condition (pain, edema, obesity, presence of wounds, dressings, VAD, etc.)
- mental/emotional/cognitive status
- activity limitations/medical restrictions
- environment

Ability can be temporarily or permanently limited by:
- physical impairments (e.g., limited range of motion, impaired balance, presence and location of wound, etc.)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear, etc.)
- sensory impairments (e.g., pain, impaired vision or hearing)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry, etc.)

The patient’s ability may change as the patient’s condition improves or declines, as medical restrictions are lifted or imposed or as the environment is modified. After evaluating all these factors, choose the response that reflects what the patient is “ABLE” to do on the day of the assessment (the time of the visit and the 24 hr preceding the visit) regardless of what he is or is not actually doing or who may or may not be available to provide assistance on a routine basis.

To select the most accurate response reflecting ability, ask yourself the question, “Now that I have observed the patient perform, what kind and how much assistance are required to do this task safely?” If the patient has varying levels of ability with in the 24 hour period of assessment, the clinician must decide which response reflects the patient’s ability to perform the task more than 50% of the time. If there is a varying level of ability with a data item that has several components (i.e. grooming tasks, articles of clothing, etc.), report the patient’s ability for the majority of the tasks.

INDEPENDENCE. The selection of response 0 in these functional data items varies by OASIS item. In some, it means “safely without human intervention.” In others it means “safely without human intervention and without adaptive equipment or devices.” Assess all tasks considering the patient’s, cognition, emotional and behavioral status, physical function, medical restrictions, environment and ability to complete safely. If the assessing clinician determines that the patient needs human intervention by supervision (prompting, cueing, reminders or standby) or assistance (touching, contact guarding or participation) for safe and effective completion of the task, regardless of whether a care giver is present or not, the standard of “independence” is not met.