HOME HEALTH OASIS WALK SIMULATION NEW RESIDENT PROGRAM

Allina Health
HOME HEALTH

Allina Health New Graduate OASIS Walk® Simulation

Location of training

Two adjacent conference rooms.

- Conference room A- debriefing area, living room, and bedroom area
- Conference room B- bathroom

Subject Matter Experts (SME)

The following SME's are involved with the simulation:

- Quality and Compliance Coordinators/Manager
- Clinical Managers – nursing and rehab
- Learning and Development

Purpose

To increase the comfort level of the new graduate RN or PT with different aspects of the OASIS walk®.

Learning Objectives

After completion of the OASIS Walk Simulation, the participant will:

1. Demonstrate all components of the OASIS walk® (e.g. bathroom and bedroom transfers).
2. Demonstrate and document the MACH-10 Falls Assessment.
3. Understand how to answer selected questions of OASIS C2.
4. Demonstrate awareness of the Allina Health pet policy.

Audience

New graduate RN and/or PT.

Supplies etc. for this low-fidelity simulation

1. The "patient" will be dressed in a robe, TED hose with foam under to simulate swelling. Stage 2-pressure ulcer/injury on elbow (Picture attached to elbow). Glasses. Simulated incision on hip.
2. Family- dressed in street clothes.
3. Bed (lawn chair if needed)
4. Commode (simulating toilet)
5. Sink (picture on table)
6. Shower (lip of shower simulated by a cardboard 4 inches high).
7. Shower chair
8. Shower head and grab bar pictures
9. Pill bottles labeled (we use fake names like Fluidia for a Lasix-type med)

Allina Health New Graduate OASIS Walk® Simulation

10. Smart phone app with dog sounds
11. Stuffed animals to simulate dogs.
12. OASIS C2 and MACH-10 documents.

Patient Description

The patient is a 90-year-old status post hospitalization for CHF. Patient also fractured their hip 5 weeks ago. The patient is also a diabetic taking an oral hypoglycemic. Patient is incontinent but denies.

The patient will be slightly HOH with mild-moderate cognitive issues. The patient is anxious. The participants are not made aware of this.

Social

Family is present (compliance people, Learning, managers). They are slightly dysfunctional. The patient had previously lived alone. Family is unsure who will be looking out for parent now.

Prebrief and Scenario:

The employee(s) are prebriefed with the PMH and are told that they will have twenty minutes to complete the OASIS walk® components and fall assessment. They are instructed to enter the "home" the way they would normally (knock on door). Expectation is that the employees will introduce themselves and ask the patient their preferred name. The patient will get off the chair slowly in obvious pain, but will deny when asked. Demonstrates HOH and forgets things throughout (e.g., that they had a broken hip, that they were in the hospital). The employee/patient walk to the "bedroom" and complete transfers to and from bed. They then move into the "bathroom" and complete "toilet" and "shower" transfers. It is expected the skin inspection will occur here. They then go back to the "living room" and finish with the falls assessment. The employee is expected to complete the OASIS as they are moving around, but may also complete after their session.

Debrief

After all participants have completed the scenario, all come back into the "living room". Quality and Compliance go through all questions on the OASIS and Mach-10 to first see how the participants answered, and then what the true answer would be. The participants are encouraged to ask any questions they may have. There is about 40 minutes allotted for this part. The participants are then asked to fully reflect on how they felt with doing this and what they have learned and will put into immediate practice.

OUR MISSION
We serve our communities by providing exceptional care, as we prevent illness, restore health and provide comfort to all who entrust us with their care.

Allina Health
HOME CARE SERVICES

OUR VALUES
- INTEGRITY
- RESPECT
- TRUST
- COMPASSION
- STEWARDSHIP

Home Health New Resident
OASIS Walk®
Simulation

Time	Topic	Presenter(s)
5 minutes	What is Simulation at Allina Health, Rules	Lynn
	Pre-brief/Questions: *This patient is s/p hospitalization for CHF exacerbation. Hip fracture 4 weeks ago. Wears glasses. Lives alone but family may help. Family is present for the SOC.* *Perform the SOC-OASIS walk components; including the MACH-10, medications, integumentary.* *PMH – DM controlled by Metformin. May not be taking as ordered. Lasix, Oxycodone, Ativan.*	Lynn
20 minutes	Simulation Activity	Group A
20 minutes	Simulation Activity	Group B
45 minutes	Debrief	Group
10 minutes	Wrap-up and Takeaways	Lynn

Prebrief Template- New Grad OASIS Walk® Simulation

Preparation of Participants			
Goals and Objectives 1. Demonstrate all components of the OASIS walk® (e.g. bathroom and bedroom transfers). 2. Demonstrate and document the MACH-10 Falls Assessment. 3. Understand how to answer selected questions of OASIS C2. 4. Demonstrate awareness of the Allina Health pet policy.	**Prep time** 5 minutes	**Simulation time** 20 minutes	**Debrief time** 40-45 minutes
Level of fidelity for simulation: Low	Confederates (actors) needed: yes If yes, how many – patient, family, facilitator at the minimum		
◆ Assess participants experience level with simulation: no experience, some, extensive			
◆ Review guidelines for safe learning environment-"Simulation provides experiential learning in a controlled, safe learning environment. The safe learning environment provides an opportunity for participants to practice assessments and skills without fear of harming a patient, allowing for skill enhancement, process improvement and team communication training."			
◆ Video recording (video deleted after debrief) – we do not do this at this time			

Introduction to simulation procedures
◆ **No food, drink in the simulation area**
◆ Expectations– treat as real scenario; full participation is expected
◆ Infection control (wear gloves, other PPE as appropriate for scenario
◆ Use of medications- must be labeled "Simulated medication"
◆ Equipment protection (i.e. May apply Lucas but not turn on)

Orientation to environment
◆ What will be "real" and what will be" fake" in the scenario
◆ Role assignments
◆ There will be confederates (actors)

Scenario Development

The following documents are to be utilized as tools in the scenario planning, design and implementation process of simulation. Below is the Scenario Planning Template which contains the details required in the planning process as well as questions that should be considered when creating a simulation. The Scenario Template is for your use in the planning process as well as in running the scenario. As noted, key components such as time frame, triggers, patient state (mannequin settings), expected actions/interventions, and facilitator notes are included.

Scenario Planning Template

Location of training: *River Room Westgate*

Clinical Subject Matter Experts: *Sarah Rynkiewich, Sandra Pierce, Lynn Miller*

Purpose (outcomes) of scenario: *Standardization and completion of the OASIS walk by New Home Health Residents*

Learning Objectives:

At the completion of this scenario

The learner will

Demonstrate the components of the OASIS walk

Demonstrate the MACH 10

Discuss the importance of both in the accuracy of documentation

Audience:

Home Health New Graduate Residents

Proposed Delivery Dates: each cohort

Simulation Equipment/set up:

Hospital Bed

Commode

Walker

Shower Chair

Med Bottles (from CPT kit)

Patient Description: *Patient story*

This patient will have a dx of CHF, SOB with min exertion- SOB going to door, slow gait. Wears glasses and has slight cognitive issues. History of Hip Fracture 5 weeks ago.

Social/Family History-

Lives alone, but daughters involved in various degrees

Background/setting:

In the home- living room, bedroom

Scenario Template

Time Frame (Aprox.)	Triggers: (Changes in Pt. Condition)	Patient State/ Mannequin Settings	Patient Comments/Script (including actors)	Expected Actions/ Interventions	Simulation Facilitator Notes
	EE knocks at the door	Pt takes a bit to get there, demonstrates SOB, confused as to who the ee is	"Who are you?" "I don't remember making that appointment, but come in"		
	EE and patient sit in living room- EE starts components of the OASIS walk		Medications scattered, forgets walk/furniture walks- If questioned- "it's a nuisance, I am fine", then slight trip		
	EE should then take into bedroom	Slight SOB	Struggles to stand up Uses chair to help get out of bed		
	EE should take to the bathroom/shower	Slight SOB	Slight trip into shower Struggle to get off toilet (multiple attempts or pull self up)		
	EE (switch to the other) perform MACH-10	Proper Instruction	Patient slow		

MAHC 10 - Fall Risk Assessment Tool

Click here to review the Validation Study of the Missouri Alliance for Home Care's fall risk assessment tool.

Conduct a fall risk assessment on each patient at start of care and re-certification.

Patient Name:_____

(Circle one) SOC or Re-certification Date:_____

Required Core Elements **Assess one point for each core element "yes".** *Information may be gathered from medical record, assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment.*	**Points**
Age 65+	
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis	
Prior history of falls within 3 months An unintentional change in position resulting in coming to rest on the ground or at a lower level	
Incontinence Inability to make it to the bathroom or commode in timely manner Includes frequency, urgency, and/or nocturia.	
Visual impairment Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	
Impaired functional mobility May include patients who need help with IADLS or ADLS or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	
Environmental hazards May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	
Poly Pharmacy (4 or more prescriptions – any type) All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	
Pain affecting level of function Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	
Cognitive impairment Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patients ability to adhere to the plan of care.	
A score of 4 or more is considered at risk for falling **Total**	

Clinician's signature_____

Missouri Alliance for **HOME CARE**
2420 Hyde Park, Suite A, Jefferson City, MO 65109-4731 ▪ (573) 634-7772 ▪ (573) 634-4374 Fax

Want resources to reduce your falls rate & compare yourself with other home care agencies? Join MAHC's Falls Reduction Benchmark Project – contact us today for more information!

(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions – Check all that apply See OASIS Guidance Manual for a complete list of relevant ICD-10 codes**.**

☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)

☐ 2 - Diabetes Mellitus (DM)

(M1060) Height and Weight – While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up

a. ☐☐ Height (in inches). Record most recent height measure since the most recent SOC/ROC

b. ☐☐☐Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

SENSORY STATUS

(M1200) Vision (with corrective lenses 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, or patient nonresponsive.

(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used):

☐ 0 - Adequate: hears normal conversation without difficulty.

☐ 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.

☐ 2 - Severely Impaired: absence of useful hearing.

☐ UK - Unable to assess hearing.

(M1220) Understanding of Verbal Content in patients own language (with hearing aid or device if used):

☐ 0 - Understands: clear comprehension without cues or repetitions.

☐ 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.

☐ 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.

☐ 3 - Rarely/Never Understands.

☐ UK - Unable to assess understanding.

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).

☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.

☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.

☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).

☐ 5 - Patient nonresponsive or unable to speak.

(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

☐ 0 - No standardized, validated assessment conducted

☐ 1 - Yes, and it does not indicate severe pain

☐ 2 - Yes, and it indicates severe pain

(M1242) Frequency of Pain Interfering with patient's activity or movement:

☐ 0 - Patient has no pain

☐ 1 - Patient has pain that does not interfere with activity or movement

☐ 2 - Less often than daily

☐ 3 - Daily, but not constantly

☐ 4 - All of the time

INTEGUMENTARY STATUS

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?

☐ 0 - No assessment conducted [Go to M1306]

☐ 1 - Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool

☐ 2 - Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?

☐ 0 - No

☐ 1 - Yes

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as Unstageable? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

☐ 0 - No [Go to M1322]

☐ 1 – Yes

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage

A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured 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: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers 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: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	

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

☐ 0 - Newly epithelialized

☐ 1 - Fully granulating

☐ 2 - Early/partial granulation

☐ 3 - Not healing

☐ NA - No observable pressure ulcer

(M1322) Current Number of Stage I Pressure Ulcers: Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

☐ 0

☐ 1

☐ 2

☐ 3

☐ 4 or more

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

☐ 1 - Stage I

☐ 2 - Stage II

☐ 3 - Stage III

☐ 4 - Stage IV

☐ NA - Patient has no pressure ulcers or no stageable pressure ulcers

(M1330) Does this patient have a **Stasis Ulcer**?

☐ 0 - No [Go to M1340]

☐ 1 - Yes, patient has BOTH observable and unobservable stasis ulcers

☐ 2 - Yes, patient has observable stasis ulcers ONLY

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

(M1340) Does this patient have a **Surgical Wound?**

☐ 0 - No [Go to M1350]

☐ 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 M1350]

(M1342) Status of Most Problematic Surgical Wound that is Observable

☐ 0 - Newly epithelialized

☐ 1 - Fully granulating

☐ 2 - Early/partial granulation

☐ 3 - Not healing

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

☐ 0 - No

☐ 1 – Yes

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?

☐ 0 - Patient is not short of breath

☐ 1 - When walking more than 20 feet, climbing stairs

☐ 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 eating, talking, or performing other ADLs) or with agitation

☐ 4 - At rest (during day or night)

ELIMINATION STATUS

(M1600) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

☐ 0 - No

☐ 1 - Yes

☐ NA - Patient on prophylactic treatment

☐ UK - Unknown

(M1610) Urinary Incontinence or Urinary Catheter Presence:

☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620]

☐ 1 - Patient is incontinent

☐ 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) [Go to M1620]

(M1615) When does **Urinary Incontinence** occur?

☐ 0 - Timed-voiding defers incontinence

☐ 1 - Occasional stress incontinence

☐ 2 - During the night only

☐ 3 - During the day only

☐ 4 - During the day and night

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700) Cognitive Functioning: Patient's current (day of assessment) 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 (cuing, 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.

(M1710) When Confused (Reported or Observed Within the Last 14 Days):

☐ 0 - Never

☐ 1 - In new or complex situations only

☐ 2 - On awakening or at night only

☐ 3 - During the day and evening, but not constantly

☐ 4 - Constantly

☐ NA - Patient nonresponsive

(M1720) When Anxious (Reported or Observed Within the Last 14 Days):

☐ 0 - None of the time

☐ 1 - Less often than daily

☐ 2 - Daily, but not constantly

☐ 3 - All of the time

☐ NA - Patient nonresponsive

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?

☐ 0 - No

☐ 1 - Yes, patient was screened using the PHQ-2©* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐NA
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐NA

☐ 2 - Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.

☐ 3 - Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week **(Reported or Observed): (Mark all that apply.)**

☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required

☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions

☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.

☐ 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)

☐ 6 - Delusional, hallucinatory, or paranoid behavior

☐ 7 - None of the above behaviors demonstrated

ADL/IADLs

(M1800) Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).

☐ 0 - Able to groom self-unaided, with or without the use of assistive devices or adapted methods.

☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.

☐ 2 - Someone must assist the patient to groom self.

☐ 3 - Patient depends entirely upon someone else for grooming needs.

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.

☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.

☐ 2 - Someone must help the patient put on upper body clothing.

☐ 3 - Patient depends entirely upon another person to dress the upper body.

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.

☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.

☐ 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.

☐ 3 - Patient depends entirely upon another person to dress lower body.

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

☐ 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.

☐ 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.

☐ 2 - Able to bathe in shower or tub with the intermittent assistance of another person:

(a) For intermittent supervision or encouragement or reminders, OR
(b) To get in and out of the shower or tub, OR
(c) For washing difficult to reach areas.

☐ 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.

☐ 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.

☐ 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.

☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

☐ 0 - Able to get to and from the toilet and transfer independently with or without a device.

☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.

☐ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).

☐ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.

☐ 4 - Is totally dependent in toileting.

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

☐ 0 - Able to manage toileting hygiene and clothing management without assistance.

☐ 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.

☐ 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.

☐ 3 - Patient depends entirely upon another person to maintain toileting hygiene.

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

☐ 0 - Able to independently transfer.

☐ 1 - Able to transfer with minimal human assistance or with use of an assistive device.

☐ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.

☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.

☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(GG0170C) Mobility

Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason.
Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

Coding:	1. SOC/ROC Performance	2. Discharge Goal	
Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activity may be completed with or without assistive devices.*	↓Enter Codes in Boxes↓		
6 **Independent** – Patient completes the activity by him/herself with no assistance from a helper.	☐☐	☐☐	**Lying to Sitting on Side of Bed**: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.			
04 **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.			
03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.			
02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.			
01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.			
If activity was not attempted, code reason:			
07 **Patient refused**			
09 **Not applicable**			
88 Not attempted due to **medical condition or safety concerns**			

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).

☐ 1 - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.

☐ 2 - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.

☐ 3 - Able to walk only with the supervision or assistance of another person at all times.

☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.

☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.

☐ 6 - Bedfast, unable to ambulate or be up in a chair.

(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)	☐0	☐1	☐2
b. Ambulation	☐0	☐1	☐2
c. Transfer	☐0	☐1	☐2
d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)	☐0	☐1	☐2

MEDICATIONS

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?

☐ 0 – No- No issues found during review [Go to M2010]

☐ 1 – Yes- Issues found during review

☐ 9 - Patient is not taking any medications [Go to M2040]

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

☐ 0 - No

☐ 1 – Yes

(M2010) Patient/Caregiver High-Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

☐ 0 - No

☐ 1 - Yes

☐ NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medication

(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.)

☐ 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; 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

Allina Health

OASIS WALK® SIMULATION

What is the first thing that comes to mind about this experience? How did it make you feel?

What went right and why?

What did you learn?

What is one thing you will immediately put into your practice as a result of this experience?

Debrief Template

Debriefing is the most important part of simulated learning events. The debrief is one of the things that separates simulation from a return demonstration of skills. Debriefing is a dialogue amongst the participants and the facilitator to review the simulated event or activity. In the debrief the activity participants analyze and synthesize their emotions, actions, and thought processes. High participant engagement is a good sign of a strong debriefing and can lead to deeper levels of learning and increases the potential for transfer to work setting. An effective debriefing has a logical sequence through the phases of reaction, analysis, and summary. The debrief is the time to verify that the simulation learning objectives were achieved.

Phases of the Debrief	Suggested Questions	Comments and Examples
Phase One – Reaction	1.) How did it make you feel? 2.) Was it what you expected? 3.) What surprised you?	Get the feelings out so they can focus on the learning. Look for use of adjectives or descriptors. Getting all the participants to share their reactions helps to keep them engaged.
Phase Two – Analysis	1.) What went well? 2.) What was your immediate concern about assessing the patient? 3.) What cues were you picking up on? 4.) What critical decisions or interventions did you make? 5.) What were the pros and cons of critical actions or interventions? 6.) What was your thought process? 7.) What were the roles participants assumed (if not reassigned) ? 8.) Was there an identified leader? 9.) Did the leadership role change? 10.) Was the team communication effective? 11.) What would you have changed? 12.) What other kinds of choices could you have made? 13.) What are the procedures of policies that relate to this event? 14.) Was SBAR utilized? 15.) Was the communication loop closed with each critical action?	Ask questions and provoke discussion. “What were you thinking when…?” Looking to understand thought process behind decisions making. “I noticed…?” here you can call out incorrect practice. Strike a balance between issues raised and the objectives of the scenario
Phase Three – Summary Reflecting on our practice	1.) What did you learn? 2.) What would you do differently next time? 3.) How will your practice be impacted by this experience? 4.) What other kinds of choices could you have made?	For example: Policies to review Workflow changes Team communication Escalation process – chain of command