

SUGGESTIONS FOR OBTAINING ASSESSMENT DATA
RE: OASIS ITEMS M1700-1750 NEURO/EMOTIONAL/BEHAVIORAL STATUS

M1700- (was M0 560)-Cognitive functioning-Relates to CURRENT DAY- The assessment process itself can be stressful, does patient need questions repeated?? Need instructions repeated i.e. “please remove your socks so I can check your feet”. Appropriate response selection should be apparent by the ***end of the visit***. Note distractibility, need to repeat directions and evidence of written notes/calendars for remembering. Alert/oriented is an aspect of responses 0-2. Many patients scoring as a #1 are probably a #2. Does the patient need reminders to take medications? Do they ask the same question many times? Are they easily distracted? Ask the patient to carry out a series of 2-3 simple instructions and observe the response and ability to stay focused on the conversation. Use the clock drawing task or MMSE. Ask if they remember your name after several minutes. Do not minimize the extent of the problem because the patient is elderly, has a pleasant disposition, or is apologetic for failing to remember correct answers. Most patients will be a “1” and possibly a “2” on admission due to the stressful/unfamiliar nature of the admission process

M1710-(was M0570)- No real changes, though again, the assessment process is a “new” situation for some patients. Focus on orientation. Interview the caregiver as needed. Ask place, year, address and birth date – validate. Does pt. seem confused by the admission process? Able to remain attentive to admission process? Ask patient about memory/confusion when they wake up in the morning or at night. “Do you know where you are when you wake up?” Mild confusion can be masked by patients with well-developed social skills.

M1720- (wasM0580)-Replace word “anxious” with “nervous, or restless” when questioning state of anxiety. Most patients will be a “1” on start of care due to admission process. Anxious feeling may be precipitated by apprehension about uncertain future, progression of disease process- real or imagined. There may be situations where there is a threat to personal safety and security. It can evolve from anything that makes life less predictable or causes one to feel less in control over the direction of one’s life. Check for anti-anxiety medications. Use word “nervous or worry”. Check respiratory or cardiac medications. What is response to the “Clock Drawing” task? Ask, “do you often worry about things?” Check medications for anti-anxiety i.e. (Xanax, Ativan, Klonopin), ask patient why and when they take the Rx.

M1730- (replaces M0590)-Asks if has been screened, NOT IF need screening or are depressed. If not psychiatric RN, suggest not using #2 or #3 answer as additional tools such as GDS-Geriatric Depression scale, Cornell scale, require additional instruction in use. If patient scores above 3, further action is indicated. Notify physician of results, may seek referral for MSW if do not have psychiatric RN on staff, or refer to outside agency. (Area Agency on Aging, Community Mental Health). Utilize Depression Intervention Plan developed by Psychiatric Sub-committee.

M1740-(was M0610)- Any patient that needs someone to fill a medication planner for them should be scored a “1”. Those who require supervision of ADL/IADL for **safe** performance or completion of task are at least a “1” if not lower. Those patients who demonstrate poor safety awareness (not using walker, smoking with O2), should be scored a “2”. Poor safety awareness/impaired decision making on day of assessment **and** recent past. Impaired decision making can include giving away money, not paying bills. Score as a “2”.

1. Validate with family re: memory, safety problems, safety concerns such as leaving stove on, or not taking meds correctly.
2. Is pt. able to cook? Use stove safely?
3. Seek clarification- use “what would you do if...?” examples.
4. Who you call/dial in an emergency? what is the phone number?
5. Ask for directions to the home.
6. Ask family re: how pt. is doing with ADLs, check condition of feet. Pt. may not indicate any problems with ADLs, but is always in pajamas.
7. Ask what was eaten night before. Don’t ask about breakfast, because you will likely get “cereal” as an answer. Validate food intake with family.
8. Determine ability to follow simple directions like, “squeeze my hand, roll up your sleeve”.

M1745- (was M0620)- This **includes** the behaviors in M1740 and also includes wandering, self abuse, verbal disruption, physical aggression. This also relates to the patient who forgets to use their walker, smokes with O2, and needs a medication planner filled. ***If M1740 is answered 1-6, then M1745 cannot be a 0.***

M1750- (was M0630)- If have orders at SOC for psychiatric nursing, even if Psych RN not doing opening, answer YES.

Remember, several of these data points are best answered at the end of assessment visit.

Prepared and developed by the MHHA Psychiatric Sub-committee, 10/00.
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