

SAFE PRACTICES *in Patient Care*

Helping to promote a culture of safety

Home health care service covered under Medicare Part A consists of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician. The instrument/data collection tool used to collect and report performance data by home health agencies is called the Outcome and Assessment Information Set (OASIS). Since 1999, CMS has required Medicare-certified home health agencies to collect and transmit OASIS data for all adult patients whose care is reimbursed by Medicare and Medicaid. Beginning in January 2010, home health agencies have been required to collect a revised version of the OASIS data set (OASIS-C). OASIS-C includes data items supporting measurement of rates for use of specific evidence-based care processes. In her articles, Ms. Narayan, an expert in OASIS-C, explains how home health care nurses can use this tool to improve the outcomes of two common home health care conditions.

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Special Homecare Issue

Using OASIS to Improve Outcomes with Post-Stroke Patients

Mary Curry Narayan, MSN, RN, HHCNS-BC, COS-C

A stroke is devastating. Within minutes, life changes radically for the patient and family. "Time is brain" with strokes, so early pre-admission interventions can help ensure optimal outcomes. Timely CT scans, lab tests, and use of recombinant tissue plasminogen activator (rtPA) to treat ischemic strokes within 3 to 4.5 hours after symptom onset¹ can help reverse existing brain damage and prevent further damage.

The continuum of care for a stroke patient typically progresses from the ICU to a med-surg unit, rehabilitation center, then to home—all within a few weeks. After discharge to home, the patient still needs significant care, often the full spectrum of home health services: nursing care, physical therapy, occupational therapy, speech therapy, social work, nutrition therapy and home health aides.

Stroke rehabilitation is a prime example of how long-term care is shifting from acute and transitional care settings to home care. Because stroke is a complex condition that requires the skills of an interdisciplinary team,

the homecare nurse plays a major role in coordinating care² during recovery at home. An important care coordination tool is the OASIS (Outcome and Assessment Information Set). It is a significant contributor to the success of home care and is a key component of Medicare's partnership with the homecare industry to help ensure optimal home healthcare outcomes. Thus, OASIS not only helps the nurse perform an assessment to initially develop and communicate a plan of care, but it also serves as a vehicle for home health performance improvement and agency-level aggregate reporting.³

The OASIS includes assessments of patient demographics, support systems, health/functional status, health services utilization, and more. This article discusses the mechanics of and rationales for completing various portions of the OASIS on a stroke patient. It also recommends strategies for obtaining complete information, developing effective interventions, and cultivating a therapeutic relationship with the patient and family.



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Best Nursing Practices for Homecare Diabetes Patients

By Mary Curry Narayan, MSN, RN, HHCNS-BC, COS-C

D diabetes is a lifelong condition that requires more than medication compliance to optimize patient outcomes. Patients must adopt lifestyle behaviors that help prevent complications¹ and ensure their continuing health (Figure 1). Changing behaviors is not an easy task, so the homecare nurse plays a significant role in educating and coaching patients in this arena.

In the past two years, the American Diabetes Association and the American Association of Diabetes Educators have published new clinical practice recommendations² and evidence-based standards for educating patients with diabetes³ (Figure 2, page 6). AADE's standards focus on seven behaviors patients need to achieve optimal glucose control. Known as the AADE7 Self-Care Behaviors™, they underscore the need for “self-management support.”

This article focuses on key areas of the OASIS assessment, explaining how nurses should use it to assess patients referred to home care for diabetes, identify deficits, and use ADA and AADE guideline implications for care planning. To lay the groundwork for this shift in caregiving, self-management support—the basis for AADE's patient education model—is explained first. Discussion of self-management support strategies are integrated with the technical nursing interventions.

Self-Management Support

Self-management support is an evidence-based method of helping patients with chronic illnesses achieve optimal management of their diseases.⁴

For patients with diabetes, that includes strategies to help patients make the multiple long-term behavioral changes needed in order to achieve optimal glucose control, enabling them to avoid diabetes' many complications.¹

Change is hard—really hard. To achieve lasting change, patients need support, encouragement and self-efficacy (confidence in one's ability to succeed). Self-management support draws on the evidenced-based strategies that have grown out of learning self-efficacy and behavioral change theory.⁵ Knowing that one should change is not enough to enable people to change. Therefore, mere teaching of what should be done does not create behavioral change. Behavioral change requires learning *how* to change—employing strategies to overcome all the barriers and problems that make change difficult.⁶ This predicates a new patient education paradigm. Instead of nurses being “teachers,” nurses need to act more like “coaches”—running different scenarios with patients to help them choose correct actions in varied situations and reinforcing learning using the “teach-back” method. Asking the patient to “teach the nurse” after you explain to the patient what to do is one of the most effective ways to ensure patient understanding.

Most people go through “stages of change:” recognizing the need to change; then planning, making, and maintaining the change; finally, recovering from relapses should they occur.⁶ During this process, patients develop problem-solving and coping strategies—elements of the AADE7 self-management behaviors—with help

from an empathetic nurse who coaches the patient in these new behaviors.

OASIS Assessment

The comprehensive OASIS (Outcomes Assessment and Information Set)⁷ is among the first interventions that the home healthcare clinician performs. The OASIS is a set of questions that clinicians use to improve the patient's status. It has many uses; organizationally, it measures care outcomes, determines reimbursement, and compares the care of one agency to another. But clinically, it is an assessment tool. The OASIS tool used for start-of-care [admission] comprises approximately 100 questions. Here are some key portions for identifying the patient's care planning needs.

Critical OASIS Components

Diagnoses & Symptom Control (M1020 & M1022)

Assessment

- Identify diabetes mellitus on the list of diagnoses. Differentiate Type I or Type II, controlled or uncontrolled, and list its “manifestations” [complications].
- If the patient is taking insulin, identify “long-term insulin therapy” as a diagnosis.
- Identify complication(s) of diabetes for which the patient requires home care support (e.g., diabetic foot ulcer).
- Include in the diagnoses list any other diabetic complications or conditions that require ongoing

Figure 1: Building Blocks of Effective Diabetes Home Care

Nursing Responsibilities	Patient Self-Care Behaviors*
Assessment	Healthy Eating
Education	Being Active
Coaching	Monitoring
Prevention/Care of complications	Taking medications
Coordination of care/Referrals	Problem solving
	Healthy Coping
	Reducing Risk

* Listed behaviors are the AADE7 Self Self-Care Behaviors™

medication or treatment, even if the patient is independent in that care, and even if those conditions are not the main focus of care.

The nurse needs to monitor them and the effectiveness of the medication/treatment plan while the patient is in home care.

- Record symptom control of diabetes and its complications, remembering that most patients receiving home care for such complications have a symptom control level ≥ 2 . Patients with Hg A1C $> 7\%$ are “poorly controlled” and deserve a symptom control score > 3 .

Care Plan Interventions

The diagnosis of diabetes and/or its complications predicates including all of the following on the care plan, whether or not it is the main focus of care. Ensure that the patient can plan and eat a diabetes-appropriate diet.

- Ensure the patient knows what diet they are to follow and how to do so.
- Complies with aerobic exercise in daily routine or as prescribed. Consistently takes the correct medication, prescribed dose and at the right time.
- Demonstrates appropriate technique for monitoring and recording blood glucose (BG).
- Knows the signs and symptoms of hypo/hyperglycemia and appropriate actions to take should they occur.
- Knows appropriate care for sick days.
- Understands the principles of diabetic foot care.
- Has a “Personal Medical Record” in which they record their latest eye, dental, and monofilament foot exams; dates and results of the latest Hg A1C, lipid, and renal function tests; and pneumonia/flu vaccines.

The nurse should monitor the pa-

The comprehensive OASIS is among the first interventions that the home healthcare clinician performs.

tient’s daily BG levels to ensure the patient stays within ADA guidelines (fasting: 70–130mg/dL; postprandial: < 180 mg/dl at peak) unless the nurse has orders for different parameters (M2250). Address episodes of hyperglycemia because they exacerbate comorbidities such as delayed wound healing.

Risk Factors (M1034)

Assessment

- Assess for obesity and smoking. These risk factors can cause or exacerbate complications in patients with diabetes.

Care Plan Interventions

For overweight patients:

- Encourage and promote a healthy diabetic diet. Refer to dietitian for medical nutrition therapy and individualized care plan tailored to meet the patient needs.
- Encourage an exercise program and consider a referral to PT for an exercise program, with the goal of aerobic exercise for 30 minutes/day 5 days a week. Even homebound patients can exercise by stepping in place or using light hand weights to increase heart rate.
- Provide the patient with substantial support and encouragement. Reinforce recording their weight weekly. Praise the patient for every pound and/or inches lost.
- Help the patient discover personal barriers to losing weight and

identify ways to overcome the barriers.

For patients who smoke:

- Encourage them to quit. Help them choose a smoking cessation programs that meets their needs, and for which you can help coach the patient.
- If they are not ready to quit, ask them to identify why quitting is personally relevant, smoking’s potential positive benefits and negative consequences, and barriers or impediments to smoking. Repeat this process intermittently, but gently, until the patient expresses interest in quitting.

Vision (M1200)

Assessment

- Because high BG puts patients at high risk of diabetic retinopathy or blurred vision, assess carefully for visual impairment.

Care Plan Interventions

- Determine if the patient is due for an eye exam, which should be done annually. Encourage/facilitate regular exams.
- If the patient already has severely impaired vision, consider a referral to Occupational Therapy, as OTs have many strategies and devices that can enhance patient quality of life despite visual loss.

Integumentary Status (M1300–M1350)

Assessment

- Assess the patient’s skin, from head to toe, looking for pressure ulcers, stasis ulcers, surgical wounds, and all other skin abnormalities or lesions that need to be monitored or treated. Due to the increased risk that patients with diabetes have for delayed healing and complications when skin integrity is broken, list all lesions that could deteriorate (not just pressure/stasis ulcers and surgical wounds). Record them

in “Other Lesions” (M1350) and describe them in the wound/narrative section of the note.

- Especially assess lower extremities—lower legs and all surfaces of both feet. If the patient has foot ulcers, remember that diabetic foot ulcers caused by pressure are pressure ulcers on the OASIS. If not caused by pressure, they are captured as “Other Lesions” (M1350).

Care Plan Interventions

- Monitor all lesions and treat as needed.
- Assess all surfaces of the patient’s feet during each visit. This is now the standard of care.
- Teach the patient how to do the same, to avoid foot ulcers (unless the patient already verbalizes—and demonstrates—appropriate foot assessment and care). Foot care requires the patient to check all surfaces of both feet every day, to report all lesions as soon as they are noticed, and to always wear properly-fitted, comfortable socks/footwear free of pressure or chafing. Foot care also requires keeping feet clean and dry, cutting toenails straight across (or having them cut by a podiatrist), drying between toes after bathing and ensuring that feet are not exposed to very hot or cold water or surfaces. Nurses working for agencies without a patient education resource for foot care can use the resource from the National Diabetes Education Program, “Take Care of Your Feet for a Lifetime (http://ndep.nih.gov/media/feet_broch_eng.pdf).⁸
- Determine if the patient is due for a monofilament foot exam, which should be done annually, and encourage this. Add this exam to the patient’s home calendar. Place in “Personal Health Record.”

If the patient has a diabetic foot ulcer

Complications of Diabetes

Compared to the general public, patients with diabetes have

- 4x the risk for blindness
- 4x the risk of heart attack
- 19x the risk of end-stage renal disease
- 28x the risk for lower extremity amputation

They are at risk of developing other vascular problems, neuropathies, numerous eye diseases, and foot and skin problems.

1. Suter P, Hennessy B. Diabetes: Evidence-based self-management support. Integrated Chronic Care Course. Penta Health. 2010.
2. U.S. National Library of Medicine. Diabetes Complications. <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004667/>. Accessed September 26, 2011.

Foot ulcers are worthy of expanded discussion because they are prevalent and, if not treated correctly in a timely manner, can cause numerous complications. Many patients with diabetes have some degree of peripheral neuropathy (PN). PN is the most common contributor to neuropathic ulcers because they develop without the patient’s knowledge. The repetitive, painless trauma isn’t noticed because the patient has decreased sensation. Such neuropathic wounds (e.g., diabetic foot ulcer/DFU) are some of the most difficult to manage. They also cause significant morbidity and mortality. A recent study showed that diabetic patients with a history of a DFU have a 47% increased risk of mortality compared to those who did not.⁹

Assessment

- **History:** Include duration of diabetes, duration of the wound, level of BG control, smoking history and disease comorbidities
- **Pertinent labs:** Hg A1C to assess blood glucose control, H&H (hemoglobin/hematocrit); BUN and creatinine to assess renal function; WBC along with C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR), to screen for possible infection
- **Vascular Assessment:** Palpate

femoral, popliteal, dorsalis pedis and posterior tibial pulses. Obtain an ankle-brachial index (ABI). This can be done in the home with a handheld doppler, a sphygmomanometer, and a stethoscope. Ask the patient to lie quietly in supine position for 5 minutes. Then assess the blood pressure in bilateral arms, bilateral dorsalis pedis, and posterior tibial pulses. The highest pulse in each foot is divided by the highest brachial pulse for each lower extremity. The ABI is specific to each lower extremity, so record one number for each leg. Normal range for an ABI is 0.91 to 1.30. An ABI below 0.4 indicates severe obstruction and warrants immediate referral to a vascular surgeon. An ABI above 1.30 could indicate medial artery calcification and require laboratory assessment of vascular status. If a toe brachial index is indicated, it should be done in the vascular lab. Many patients with diabetes have coexisting vascular disease. If you suspect this due to clinical findings or delayed wound healing, do not hesitate to suggest a referral to a vascular surgeon.

- **Foot and Wound Evaluation:** Examine the patient’s shoes. What type of shoes is/was the patient wearing? Did they contribute to the development of the ulcer? Note wound location, size (L × W × D), wound bed, tunneling or undermining, including the ability to probe to bone (may indicate osteomyelitis), condition of wound edges, tissue type and quality of wound bed, periwound skin status, exudate, pain. Also note any foot deformities: hammer or claw toes, bunion, Charcot deformity. Assess foot temperature, ischemic changes such as loss of subcutaneous tissue, thin, shiny skin, hair loss, thickened toenails.

- **Signs/Symptoms of Infection:** Persons with diabetes may not mount a strong immune response, so the only signs of infection may be a faint halo of erythema surrounding the wound. Other signs of infection could include: change in amount or odor of exudate, delay in wound healing, poor quality wound tissue. In addition, infections from wounds can be occult. If you suspect infection, consider requesting screening tests as noted.

Putting it all Together

- **Offload:** Get the pressure off the ulcer; it's critically important to healing! The gold standard in offloading is the total contact cast (TCC).¹⁰ TCCs are available through some podiatrists, physicians, physical therapists, and nurses. Due to the expertise required to apply a TCC, it is not used as often as warranted. An alternative is custom felt with an offloading shoe. This low-cost option has been shown to be equivalent to the TCC in healing effectiveness.¹¹ Other offloading options include a removable cast walker, half shoe, and other specialty shoes. Some form of offloading **MUST** be utilized to heal the ulcer. Without offloading, no dressing will heal the wound. Offloading options vary with the patient's age and activity level, insurance coverage and knowledge of healthcare providers.
- **Debridement:** If devitalized tissue is present, debridement is essential to prevent infection and promote wound healing. Various debridement methods are available; a clinician who specializes in wound care can choose an appropriate method. Some studies suggest that early aggressive debridement of necrotic tissue increases rate of wound healing.¹²
- **Topical Treatments/Dressings:**

A variety of options exist
for treating infection
in a neuropathic ulcer,
including silver alginate,
silver hydrofiber,

Polyhexamethylene biguanide
(PHMB)-impregnated gauze,
and cadexomer iodine.

The principles of moist wound healing hold true for neuropathic ulcers, as with all wounds. If the wound is too moist, add an absorptive dressing; if it is too dry, add moisture. Cover with a protective dressing including antimicrobial-impregnated gauzes for both prevention and treatment. Infection is always a risk, due to the wound location and potentially elevated BG readings. A blood glucose level > 180 can render the patient vulnerable to wound infection. If the wound fails to respond to standard wound therapy, the wound may have an occult infection. A variety of wound dressing options exist for use in treating infection in a neuropathic ulcer, including silver alginate, silver hydrofiber, Polyhexamethylene biguanide (PHMB)-impregnated gauze, and cadexomer iodine. PHMB is bactericidal at low concentrations and is also fungicidal. PHMB-impregnated gauzes have been available for the past 10 years. These dressings are an effective microbial barrier to help to reduce overall infection rates when used with existing infection-control

practices. Consult a wound specialist for further direction.

- Other considerations for stalled wounds include hyperbaric oxygen, growth factors, or engineered tissue replacement therapy. Referral to a wound center is helpful in assessing the need for these options when standard therapy fails.

Medications (M2000 – M2040)

Assessment

- During the telephone call to schedule the first care visit, ask the patient to gather all medications being taken, including inhaled, injectable, and topical meds; herbs, vitamins, minerals, and other supplements. Stress that you also need to see over-the-counter meds that the patient takes as needed. Explain that this is to ensure all the medications are safe when taken with one another. Ask if the patient has any prescription orders that have not yet been filled. All this is part of the drug regime review (M2000).
- During the first care visit, compare the medications the patient has in the home to the medications list provided by the referral source (usually the hospital Discharge Medication List).
- Ask the patient about any side effects, concerns or troubles the patient has taking the medications as ordered (to assess compliance). Check for drug interactions and effectiveness. Are the medications controlling the signs and symptoms they were prescribed to address?
- Ensure that the patient can identify medications taken for diabetes—insulin and other hypoglycemics—as these are high-risk medications (M2010). Determine if the patient knows the signs/symptoms of hypoglycemia and actions to take for such reactions.

Figure 2: AADE7: The Seven Healthy Behaviors

Healthy eating

- No foods are “off limits,” including sweets
 - *Skills needed:*
 - Reading food labels
 - Identifying high carbohydrate, fat and protein foods
 - Identifying “one serving”
 - Planning meals
 - Counting carbohydrate
- Methods for healthy eating
 - *Plate method (easiest to learn)*
 - Divide a 9-inch plate into quarters
 - Fill ½ of the plate with non-starchy vegetables (greens, broccoli, carrots, sprouts, any vegetable with less than 5 g/carbohydrate per servicing).
 - Fill ¼ of the plate with starchy foods (grains, beans, starchy vegetables [potatoes, peas, corn]).
 - Fill ¼ of the plate with a lean meat, fish, eggs, tofu, or low-fat cheese.
 - Add an 8 oz glass of low-fat milk or another carb.
 - Add a fruit or an occasional sweet.
- Carbohydrate counting
 - *Most people need 45–60 carbs/meal, individualized to each patient.*
 - *Only foods high in carbs are counted (starchy or sugary foods)*
 - Bread, cereal, rice and crackers
 - Fruit and juice
 - Milk and yogurt
 - Beans and soy products
 - Starchy vegetables like potatoes and corn
 - Sweets and snack foods (sodas, cake, cookies and candy)

Being active

- Some exercise is better than none.
- Choose an enjoyable activity, such as walking or using an exercise bike while watching a favorite TV program.
- 10 minutes of exercise 3x a day is as good as 30 minutes at one time.
- Check BG before/after exercise to ensure BG is high enough to exercise and to see response to exercise.

Monitoring

- Monitor feet, checking for lesions each day.
- Monitor BG with a meter as often as recommended by physician.
- Monitor for feelings of hypo- or hyperglycemia and correlate with BG readings.
- Keep a record of BG readings, sharing with healthcare provider at each visit.
- Monitor BG to check how your medicines, meals, activity or illness affect your BG and use these results to help manage BG.
- Demonstrate correct use of the glucose meter.
- Determine if cost of replacement is a problem that needs to be resolved.

Taking medication

- Know the purpose and side effects of each medication, and when to notify the physician about its effects.
- Develop a plan that prevents forgetting medications or accidentally taking the wrong medication/amount.
- Demonstrate administration of the right medication/right dose/right time through demonstration
- If taking insulin, rotate sites.

Problem solving

Use scenarios to practice problem solving for:

- What to do when BG is high or low?
- What to do when getting sick, vomiting, have an infection, or other illness?
- What to eat when out to dinner at a restaurant or when a guest?
- What to do about monitoring BG/taking medication when traveling?
- What to do if you are in a traffic jam and it is time for you to eat?
- What other situations require problem-solving?

Healthy coping

- Negative emotions are normal but coping with those emotions can be “healthy” or “unhealthy.”
- Recognize negative emotions and figure out healthy ways of coping.
- Healthy coping includes faith-based activities, exercise, enjoyable hobbies, talking with friends, joining a support group. (Unhealthy coping includes smoking, overeating, avoiding people, drinking alcohol).
- Discuss feelings of discouragement or depression with a healthcare provider.

Reducing risk

- Keep regular doctor’s appointments, at least every 3 to 6 months.
- Stop smoking. Ask for help from healthcare provider for smoking cessation programs that work.
- Learn the principles of keeping feet healthy. Keep feet clean and dry. Do not go barefoot. Wear only shoes that fit well.
- Keep your blood pressure lower than 130/80.
- Keep your cholesterol lower than 200.

American Association of Diabetic Educators website. AADE7 Self-Care Behaviors. <http://www.diabeteseducator.org/ProfessionalResources/AADE7/>. Accessed July 13, 2011.

- Ask the patient to demonstrate taking oral medications. Determine if the patient has a good plan for taking the right med/right dose/right time, demonstrating management of oral medications (M2020).
- If the patient takes insulin or other injectable meds (includes subcutaneous pump), ask the patient to demonstrate proper dosing, administration, and management of injectable medications (M2030), as well as safe disposal of sharps.
- Assess if there are barriers to compliance due to financial, delivery, cognitive, or cultural issues.

Care Plan Interventions

- Alert the physician to any medication issues, including reconciliation of discrepancies between the “official list” and the medications the patient has in the home.
- Discuss any concerns related to apparent medication ineffectiveness, reported side/adverse effects, potential drug interactions, and barriers to compliance. Ensure that the physician responds to issues within 24 hours (M2002).
- Because hypoglycemics are high-risk medications (M2010), ensure that the patient can identify signs of hypoglycemia (signs of BG < 70) and what to do should it occur; check BG; take 15–20 g of a simple carbohydrate (e.g., 4 oz. fruit juice or soda or 8 oz. of milk); check BG again in 15 minutes.
- During each visit, assess for changes or problems with medications. Check for effectiveness, side effects, and compliance problems.
- Resolve barriers to compliance, such as setting up a pill box and reminder system for patients who

forget to take medications.

- Using teach-back and demonstration methods, ensure that the patient can identify the correct dose, time, and potential side effects for each medication taken. Give the patient a medication sheet for each med being taken, ensuring the information is at a 5th-grade reading level or lower. (TIP: Print medication education sheets from the National Library of Medicine's Medline website <http://www.nlm.nih.gov/medlineplus/druginformation.html>.)¹³ Ask the patient to familiarize him/herself with one medication per visit, using the NLM sheets, and give a "teach-back" about the medication at the next visit.
- Use problem-solving exercises to ensure that the patient can distinguish between expected side effects (e.g. shakiness prior to a late meal) and how they can be mitigated (eating meals at regular times, grabbing a small snack if meal will be late) versus problems that must be reported to their doctor (e.g. fasting BG levels > 130 several times in a week).
- If the patient has financial barriers, get a social work referral for medication assistance programs.

Bringing it back to the AADE7

In each of the seven areas that AADE has defined as healthy behaviors, the clinician needs to incorporate self-management support strategies with the nursing process:¹⁴

- Assess the patient's knowledge frequently, at regular intervals.
- Build confidence and skills in achieving the seven behaviors.
- Identify long-term goals and set achievable short-term goals that are likely to promote success and self-management.

- Use action plans to help the patient move toward better self-management.
- Implement the action plan over a specific or limited time period.
- Evaluate how well the action plans work by helping the patient identify successes, barriers to success, and ways to overcome the barriers.

Conclusion

Today, one-half of the U.S. population has at least one chronic illness, such as diabetes.¹⁵ A plethora of research studies indicate that, to reduce the rising costs of chronic illnesses, new ways of treating and managing those illnesses are needed.^{4,16} Patients with diabetes require ongoing support if they are to self-manage their illness and prevent complications and hospitalizations.

Clinicians who keep current with the evidence-based guidelines produced by the ADA and the AADE can help patients with diabetes—even those previously considered non-compliant—to achieve better health and well-being. Through good OASIS assessments and care planning using ADA and AADE guidelines to address deficits discovered on the OASIS, home healthcare nurses can help patients master the self-management behaviors advocated by the ADA and AADE.

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Using OASIS to Improve Outcomes with Post-Stroke Patients—Continued from page 1

Patient Profile

Fifteen days ago, 65 year-old Mr. Jones had a stroke, causing right-arm hemiplegia, right-leg hemiparesis, and dysphagia. He was hospitalized for 3 days, then treated at a rehab facility for 10 days. His dysphagia and failure to pass swallowing tests put him at high risk for aspiration. He was fed through an NG tube until 3 days ago, when a percutaneous gastric feeding tube (G tube) replaced the NG tube. Upon discharge, he was referred to home healthcare for nursing and therapy services. Comorbidities include atrial fibrillation, hypertension, hyperlipidemia, and a deep vein thrombosis (DVT) diagnosed 10 days ago. He has a hemi-walker and is on 8 medications, including warfarin. Prior to his stroke, Mr. Jones and his wife were preparing for a 3-month tour of Europe, a trip they had been planning for years to celebrate his retirement.

1st VISIT: Homecare Admission

The visiting nurse who admits Mr. Jones to home healthcare services is making a very complex visit. She needs to assess the patient and address his urgent nursing and safety needs. Mr. Jones has significant comorbidities along with his stroke. In addition, his wife (his main caregiver) is overwhelmed with the task at hand. Family members greatly influence a patient's recovery, so it's important to address patient/caregiver concerns first.

For patients like Mr. Jones, dividing the OASIS assessment into two or more visits may be the best way to ensure patient safety and establish the rapport and trust necessary to begin a therapeutic relationship. So the nurse decides to limit her first visit to completing 4 assessments (Medication, Physical, Functional, Falls) and teaching G-tube care and use. By prioritizing this way, the nurse is better able

to meet the patient's immediate needs and perform an accurate, in-depth OASIS assessment that ensures the best care planning and therapeutic interventions.

Medication Assessment

The nurse starts with reviewing and reconciling all the patient's medications (M2000, M2002). A medication review usually alerts the nurse to almost all the patient's comorbidities (M1020–1024), even if some were omitted from the referral. The nurse asks Mr. and Mrs. Jones when each medication was started and why. This helps her simultaneously glean medical history, assess the patient's/family's medication knowledge, and uncover potential medication problems. This is an opportune time to evaluate the patient's (or, in this case, the caregiver's) ability to administer the right medication at the right time (M2020, M2030). It's not enough to hear the person recite the correct times and dosages of medications; ask for a demonstration—actually watch the person measure and deliver the right medication/right dose. This helps ensure safe medication management. Because all of Mr. Jones' medicines are delivered enterally, the nurse checks Mrs. Jones' medication skills as they work with the G tube (detailed in the following discussion of the Physical Assessment).

Mr. Jones is on the anticoagulant warfarin, a high-risk drug⁴ (M2010). So the nurse teaches (1) proper dosing, (2) warning signs of bleeding, (3) prevention strategies (use a soft toothbrush, shave with an electric razor, avoid falls, etc.), and (4) what to do if the patient exhibits any sign of bleeding. Ensuring that warfarin can be administered safely is essential during the first visit.

Families are frequently on "information overload" and are overwhelmed with adjustments to make when they bring their loved one home, so discussing new information during this first visit needs to be reinforced. The nurse gives the Joneses a simple, one-page

handout that outlines "need-to-know" information about warfarin. The nurse asks them to review the handout and keep it handy so they can check it quickly and often. The nurse will instruct on each of the other 7 medications over the course of Mr. Jones' recuperation at home. Both patient and caregiver need to become effective partners in Mr. Jones' medication management program.

Physical Assessment

Because the homecare referral and the medication review highlight Mr. Jones' multiple health conditions—stroke, DVT, atrial fibrillation, and hypertension—the nurse performs a more in-depth exam than the basic homecare admission head-to-toe assessment. Specifically, she includes neurological and cardiovascular assessments to establish baselines for future comparison. She also notes the patient needs in-depth skin and GI/nutrition assessments, due to the patient's mobility problems and G-tube feedings.

Neurological Assessment

To establish the neurological baseline, the nurse assesses pupil constriction/accommodation, extraocular movements and performs multiple comparisons: the sides of the face when raising eyebrows/puffing cheeks/smiling, symmetrical rise of soft palate on saying "ah," finger-nose-finger test, shrugging shoulders, strength of hand grips, pronator drift, and ability to raise each leg. She also performs the heel-shin test. She evaluates the patient's speech throughout the physical assessment (M1230) and the patient's balance during the functional assessment. On future visits, she will compare this baseline information to Mr. Jones' progress.

Cardiovascular Assessment

The nurse also performs an in-depth cardiovascular exam, including atrial/radial pulses (with special attention to an irregular heartbeat or pulse deficit), heart sounds, peripheral pulses, ortho-

static blood pressure, pulse oximetry and measurement of leg edema. Cardiac abnormalities are prevalent among stroke patients, and they often can cause a stroke. For example, a myocardial infarction can lead to stroke. Cardiac arrhythmias are fairly common with ischemic strokes, and Mr. Jones' atrial fibrillation can precipitate a stroke. Stroke also can cause or exacerbate cardiac abnormalities, such as myocardial ischemia,⁵ so an in-depth cardiac exam is an essential element of stroke home care.

Skin Assessment

The nurse performs a complete skin assessment (M1306–M1350), especially of all bony prominences and peristomal skin, and performs a Braden Scale assessment to determine risk for pressure ulcers (M1300). The nurse notes that Mr. Jones' Braden Score is 17 (Mild Risk). Inactivity, immobility, excessive moisture from sweating, and the use of incontinence briefs for intermittent urinary and fecal “accidents” contribute to his risk of developing pressure ulcers (M1302). He already has a Stage 1 pressure ulcer on his coccyx (M1322).

To address the pressure ulcer, the nurse instructs Mr. Jones to shift his weight at least hourly when sitting and to turn from side to side when in bed, to keep weight off his coccyx. The nurse explains that excess moisture over his coccyx could cause the pressure area to turn into a “sore.” Excess moisture “hyperhydrates” the epidermis, impairing the skin's barrier qualities, raising the skin's pH, and increasing the risk of infection (because bacteria thrive in more alkaline environments). The nurse instructs Mr. Jones to change his briefs whenever damp or soiled, and advises using disposable incontinence cleansing/barrier wipes. These promote an acidic pH while protecting the skin with a breathable dimethicone barrier that allows sweat to escape.⁶ She shows Mrs. Jones how to use the cleanser/barrier without massaging the coccyx (which

can exacerbate underlying tissue damage) and steers her away from “non-breathable” petroleum and zinc oxide products. Perineal skin is particularly susceptible to damage associated with incontinence, so it's important to implement a system that includes cleansing, moisturizing, protection and treatment.⁶

Elimination Assessment

The nurse asks Mr. Jones about his previous and current elimination status (M1600–M1630), including bladder and bowel frequency and accidents. She discovers that he has functional urinary incontinence related to his slowness at getting to the bathroom and preparing to toilet. It humiliates him. The nurse tells him that, with the

occupational therapist's (OT) recommendations for assistive devices and a timed voiding program she will teach him, these problems likely will resolve.

As part of the physical assessment, the nurse includes the new gastrostomy in “Other Lesions” (M1350), documenting the condition of the peristomal skin and the tube length. While examining the 9-tube, the nurse instructs Mrs. Jones on its care and how to check gastric residuals to assess tube feeding tolerance prior to each bolus feeding.

GI/Nutritional Assessment

Before coaching Mrs. Jones through a feeding and flushing, the nurse reviews the physician's orders and calculates Mr. Jones' hydration needs.⁷ (see Figure 1)

Figure 1. Tube-feeding Prescription

	Volume	References
Mr. Jones Height: 177.8 cm Weight: 80 kg BMI: 25.3 kg/m ²		
Est. daily kilocalorie needs	2,400–2,800	30–35 kcal/kg (1)
Est. daily protein needs	96–120 g	1.2–1.5 g/kg (2)
Est. daily fluid needs	2,448 mL	1mL/Kcal
Product: 1.2 high-protein, fiber-containing, 80% water formula	2,040 mL	Dietitian recommendation based on clinical judgment
Bolus Feeding	340 mL 6x/day	Dietitian recommendation based on clinical judgment
Minimum water flush pre/post bolus Medications (8 total)	720 mL	30 mL pre/post bolus (3)
6 meds 1x/day	(Given with bolus flushes of 720 mL)	15 mL pre/post medication delivery with one-time final flush of 15 mL (3)
2 meds 2x/day	90 mL	
Additional water flush to meet fluid needs	None	

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Mr. Jones' orders are for six 340-cc feedings/day, a total of 2,040 cc/day. His orders also include 30-cc water flushes pre- and post-feedings (720 cc/day). In addition, he is to receive 8 medications, 2 of which will be given twice a day. Because each should be flushed with 15 cc water before giving the next medication, Mr. Jones will receive his medication simultaneously with each of the 6 bolus flushes, and additional flushes for the remaining 2 medications. Then the nurse coaches Mrs. Jones in how to use a 60-cc catheter-tipped syringe to administer the feedings and the water flushes via gravity. Although the speech-language pathologist (SLP) should be able to teach Mr. Jones to safely swallow again so that a G-tube is not necessary, a more convenient method, particularly for homecare patients facing long-term enteral nutrition, is the automatic flush bags that are part of an enteral pump delivery system. The bag is filled with water and attached to a pump programmed to deliver periodic, regulated water flushes.

Fall Risk Assessment (M1910)

The Functional and Fall Risk assessments go hand in hand. Mr. Jones "fails" the Timed Up and Go (TUG) Test, taking 22 seconds to complete the 20-foot ambulation with its turn (passing score is < 14 seconds),⁹ putting him at risk for falls. The nurse demonstrates how Mrs. Jones can hold Mr. Jones' gait belt during ambulation and transfers. The nurse gives Mrs. Jones a handout on preventing falls in the home, making a note for the PT to visit for fall prevention as early as possible the next day. The nurse closes the visit by encouraging the Joneses to call the agency's 24/7 line if they have questions or concerns, especially about G-tube care and feedings.

2nd VISIT: Completing the OASIS

The nurse visits the next afternoon. Both the PT and SLP have evaluated Mr. Jones earlier in the day and start-

A more convenient method, particularly for homecare patients facing long-term enteral nutrition, is the automatic flush bags that are part of an enteral pump delivery system.

ed their treatment plans. The OT and HHA are due to start the next day. Mr. Jones is encouraged that the SLP will teach him to swallow safely, allowing him to eat and drink again.

After the nurse performs a brief head-to-toe physical assessment as required by her agency's visit policies and watches Mrs. Jones administer Mr. Jones' feeding and medications with nearly flawless technique, she attends to the remainder of the OASIS questions.

Sociodemographic and Medical History

She sits down with Mr. and Mrs. Jones and completes the OASIS demographic information (M0066–M0150). Although she learned much of Mr. Jones' medical history yesterday, the nurse needs to fill in some gaps in the history (M1000–M1100, M1900, M2100). So she gives both spouses a chance to "tell their story," asking open-ended questions to prompt a discussion about their understanding of the stroke, its prognosis, treatment plan, and their long-term goals.

The nurse fills in the final gaps by asking a few closed-ended questions (those that elicit a yes/no response). For example, she asks if Mr. Jones has had the recommended pneumonia and flu immunizations (M1040–M1055).¹⁰

He has not, so she adds their administration to the Plan of Care (POC).

Pain Assessment

Although she informally evaluated Mr. Jones for pain during his ADLs "walk-through," the nurse performs a standardized pain assessment (M1240) today, using the Numeric Pain Scale. Mr. Jones denies pain, but he is at risk for developing painful hemiparetic shoulder. Spasticity of the paralyzed shoulder muscles and subluxation of the shoulder joint usually start 2 weeks to 2 months after a stroke.¹¹ It can be prevented with passive range-of-motion exercises and positioning, so the nurse notes to discuss these preventive measures with the OT at the first interdisciplinary conference.

Depression Assessment

The nurse then asks Mr. Jones the PHQ-2, the standardized depression screening tool that is part of OASIS (M1730). He screens positive for depression, (as approximately 40% of stroke survivors do),¹² so she performs the PHQ-9, which measures the extent/severity of 9 symptoms that the DSM-IV lists for major depressive disorder.¹³ Depression can rob the patient of the physical and emotional energy needed to maintain the rigors of a therapy program, so addressing depression is crucial to treatment compliance,¹⁴ functional recovery, and well-being. The nurse contacts the doctor and makes a referral to the social worker for coping strategies and a support group. She also notes to retest Mr. Jones in about 4 weeks.

Finishing the Plan of Care

The nurse completes the OASIS, leaving the number of ordered therapy visits (M2200) open until the OT evaluates and determines the treatment plan. The nurse reviews the OASIS, noting each deficit. Then she discusses her findings with Mr. and Mrs. Jones, suggesting strategies to improve Mr. Jones' status and function. Together they complete a "mutually agreeable"

POC. Interventions include those already discussed and others, such as bimonthly PT/INR levels to track warfarin dosing, and ensuring Mr. Jones knows the signs/symptoms of stroke, because patients who have had one stroke are more likely to have a second one.¹⁵

Mr. Jones' Stay in Home Care

Over the next 2 months, the nurse sees Mr. Jones 3x/wk for first 2 weeks, then 2x/wk for the next 10 weeks, until he is no longer homebound. During that time, with help from the interdisciplinary team, the nurse teaches Mr. and Mrs. Jones about home safety, preventing complications, managing medications and strategies for ensuring continence and increasing functional independence. The nurse monitors Mr. Jones' cardiopulmonary status, skin condition, and PT/INR results. When the SLP and physician advance Mr. Jones' diet to foods and thickened fluids, she obtains orders for Diet training (especially identifying foods high in vitamin K and how to keep them in daily balance to avoid inhibiting warfarin's anticoagulant effect). The nurse monitors the G-tube site closing when it is no longer needed.

The main goal of nursing care is enabling Mr. and Mrs. Jones to return to as normal a life as possible, using self-management support strategies to achieve that goal. During each visit, the nurse allotted time to discover any new problems Mr. and Mrs. Jones were encountering, brainstorm solutions with them, and empower them to choose action strategies to meet their goals. The nurse focused on rapport, the therapeutic relationship—providing coaching and encouragement, and ensuring Mr. Jones had the outpatient and community support he needed.

Improvement in functional ability can continue for a year or so with good therapy and a motivated patient. Currently, about a third of patients recover completely or nearly completely from cerebrovascular accidents by one year.²

After 4 months of help from PT and OT, Mr. Jones finally could get up and down the stairs to his home and in/out of a car with his cane and his wife's assistance. At that time, arrangements were made for outpatient therapy, and Mr. Jones was discharged from home care.

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Upon completion of this offering, the learner will be able to:

1. Describe which assessments are critical to complete in the initial homecare visit for stroke and diabetes patients.
2. Explain the importance of skin assessments in diabetes and stroke patients.
3. Describe how to help patients and their families on the details of optimal oral and enteral nutrition.
4. Explain why pain and depression assessments are often minimized but important parts of a comprehensive OASIS.

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- 1. The presence of a diabetic foot ulcer should prompt**
 - a. Ordering of pertinent blood chemistries
 - b. Offloading the pressure
 - c. A vascular assessment
 - d. All the above
- 2. The AADE7 is**
 - a. Nutritional guidelines for diabetics
 - b. A form of self-management support
 - c. A set of new OASIS standards being tested for homecare
 - d. Part of IHI's next Forum on Quality and Safety in Healthcare
- 3. Two of the biggest risk factors for people with diabetes are**
 - a. Hypertension and myopia
 - b. Pancreatitis and diuresis
 - c. Obesity and smoking
 - d. Ascites and dysphagia
- 4. Insulin and other hypoglycemics are considered high-risk medications.**
 - a. True
 - b. False
- 5. Diabetic foot ulcers are insidious because**
 - a. They develop without the patient's knowledge
 - b. They are hard to treat
 - c. They cause significant morbidity and mortality
 - d. They look atypical
- 6. If a stroke patient is motivated and has a good therapy program, approximately how long can he or she expect to keep gaining improvements in functionality?**
 - a. Six months after the stroke
 - b. One year after the stroke
 - c. Two years after the stroke
 - d. Indefinitely
- 7. What conditions can contribute to the development of a pressure sore?**
 - a. Inactivity and excessive moisture from sweating
 - b. Incontinence and anorexia
 - c. Immobility and using a dimethicone skin barrier
 - d. All the above
- 8. When is an in-depth cardiovascular assessment an important element of stroke homecare?**
 - a. It's not
 - b. Only when a stent, valve replacement, or coronary artery bypass predates the stroke
 - c. Whenever atrial fibrillation predates the stroke
 - d. All the time: stroke can cause or exacerbate a number of cardiac abnormalities
- 9. Because warfarin is a high-risk drug, the nurse should coach the patient and family on how to minimize bleeding risks. Which of the following is not included in that coaching?**
 - a. Using a soft toothbrush
 - b. Avoiding falls
 - c. Using a straight-edge razor
 - d. Dosing the warfarin properly
- 10. The medication review helps the nurse**
 - a. Determine the extent of the family's medication knowledge
 - b. Collect medical history, including comorbidities
 - c. Observe the family's technique and expertise in medication administration
 - d. All the above

		Mark your answers with an X in the box identifying the correct answer(s).																																										
<p>What is the highest degree you have earned? (circle one)</p> <p>1. Diploma 2. Associate 3. Bachelor's 4. Master's 5. Doctorate</p> <p>Indicate to what degree did this program meet the objectives: Using 1 = strongly disagree to 6 = strongly agree rating scale, please circle the number that best reflects the extent of your agreement with each statement.</p> <p>At the end of the session the participant will be able to:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td style="text-align: center; width: 10%;">Strongly Disagree</td> <td style="width: 10%;"></td> <td style="text-align: center; width: 10%;">Strongly Agree</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> <tr> <td>1. 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Explain why pain and depression assessments are often minimized but important parts of a comprehensive OASIS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> <td style="text-align: center;">6</td> <td></td> </tr> </table> <p>Name & Credentials _____</p> <p>Position/Title _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Phone _____ Fax _____</p> <p style="text-align: center;">For immediate results, take this test online at www.saxetesting.com</p>		Strongly Disagree		Strongly Agree					1. Describe which assessments are critical to complete in the initial homecare of stroke and diabetes patients	1	2	3	4	5	6		2. Explain the importance of skin assessments in diabetes and stroke patients	1	2	3	4	5	6		3. 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<p>or Mail to: Saxe Communications, PO Box 1282, Burlington, VT 05402 Fax: 802.872.7558</p>		<p>Safe Practices. V.5 No.3</p>	<p>Score _____</p>	<p>10</p>																																								