Clarification to OASIS QUESTIONS

CMS states that the OASIS questions need to be answered with the safety of the patient and the efficiency of the task in mind. This means that if the patient is not safe performing the task/movement, or they are not efficient in performing the task/movement, then they cannot be considered independent, even if they live alone and/or perform these items alone.

CMS also states that we are not required to record the patient’s answer to any OASIS item if there is evidence to the contrary. We are to use clinical judgment and observation in addition to information gathered from the patient or caregivers.

When O C-1 goes into effect, on January 1, 2015, there will need to be even more consistency and accuracy between the diagnosis, the OASIS assessment items and the subsequent interventions. Any discrepancy between any of these will be grounds for auditors to deny episodes.

With that in mind, here are some of the most frequent errors that are seen, leading to lower HHRG scores than are accurate as well as poor outcomes, when discharge oases are compared to SOCs:

1. **PAIN:**
   a. This question should be “in the last 24 hours, have you had any pain while moving?”
   b. If the patient is sitting still, you need to ask them to move (get up, etc) since the question has to do with pain while moving.
   c. The patient who is sitting quietly, having taken hers/his pain medication may very well not have any pain, so you need to explore what happens when she/he don’t take her/his pain meds, or when she/he are due for the next dose.

2. **INCONTINENCE:**
   a. Even if the patient tells you they are continent, consider this: is she/he sitting on a chair with a towel or chux?
   b. When you check his/her skin for pressure ulcers, is she/he wearing a diaper or pad? These are clues that the patient is incontinent, even occasionally, has stress incontinence or cannot get to the bathroom on time.
   c. The patient who is chairbound is almost certainly incontinent, since they are unable to get up independently and must wait for assistance, which may not be timely in coming.

3. **COGNITION:**
   a. If a patient wants to be sure his/her family member is there before she/he sees the clinician for the first time, or constantly looks to the family member to answer questions, that can be a good clue that the patient is having difficulty with memory, or anxiety.
b. Remember that patients who have just had surgery often have temporary memory or cognitive issues due to the anesthesia or sedatives.

4. **MEDICATIONS:**
   a. Even if the patient has not had surgery, medications are one of the most confusing issues for patients.
   b. She/he often do not know if she/he are suppose to resume the medications she/he had before hospitalization, and there are frequently new medications that need to be picked up from the pharmacy, or medication refills that came due while she/he were in the hospital that didn’t get filled.
   c. If even one Rx has not been picked up, CMS directs us that that patient is a 3 (cannot take medications without someone providing) since you cannot assess medications that are not in the home, *whether the patient intends to pick them up or not.*
   d. The patient who cannot get up independently cannot be independent in their medications. If the patient has cognitive issues, it is also unlikely she/he is independent in her/his medications.

5. **SHORTNESS OF BREATH:**
   a. If the patient is on continuous oxygen, this question includes the use of oxygen, but many patients who are short of breath when up and active are not short of breath while sitting still.
   b. Therefore, it is imperative that you have a patient get up.
   c. Having the patient stand up and sit down 5 times without stopping and marching in place can help mimic stairs if there are none, and will give you a reasonable idea of their status if you do not feel safe having them walk away from her/his chair.

6. **FALLS ASSESSMENT :**
   a. This is another example of using clinical judgment and observation.
   b. If you assess a patient as being at risk for falls, it is not possible for them to then be independent in transfers and gait, as the safety issue is in play.
   c. If the patient is a fall risk, you need to do the TUG (Timed get Up and Go).
   d. If you feel that the patient is too unsafe for you to do the TUG, you can put the highest score in (greater than 3 minutes).

7. **UPPER BODY DRESSING:**
   a. If the patient cannot walk to the closet, she/he are a 1.
   b. If she/he cannot manage buttons, cannot pull something over her/his head, or do not have the ROM to put on a sweater or shirt, she/he are at least a 2.
c. The patient who takes 90 minutes to dress themselves, due to fatigue, SOB, etc, is not independent, even if she/he are doing it alone. This is where the efficiency question comes in.

8. LOWER BODY DRESSING:
   a. If the patient has had a total hip replacement, she/he cannot bend over to put on shoes, and would be a 2.
   b. Someone with impaired balance who is at risk to fall when she/he stands to pull up his/her pants is a 2.
   c. The patient who is wearing slip-on shoes because she/he cannot get her/his usual shoes on, or is wearing a robe because she/he cannot dress without help, is a 2, or even a 3.

9. BATHING:
   a. The patient is a 1 if she/he can get into and out of the shower or bathtub all by themselves.
   b. She/he is a 2 if she/he needs assist to get in/out of the tub but does not need ongoing supervision.
   c. If she/he needs someone standing by throughout to ensure that she/he are safe, they are a 3.
   d. Ask yourself, “would I be comfortable walking away and leaving this person in the shower/bathroom all by themselves throughout the entire bathing process?”

10. TOILET TRANSFERRING:
    a. A patient who cannot use the toilet without an assistive device over it (either a raised toilet seat or commode) cannot use “the toilet” which means the toilet as it came from Home Depot!

11. TOILETING HYGIENE:
    a. If the patient has difficulty with lower body dressing (unless it is an otherwise high-level hip replacement) she/he is probably going to have difficulty with her/his lower body clothing in the toileting process.

12. TRANSFERRING:
    a. The patient that needs the chair to be raised, or uses the arms on the chair for support, or pulls up using the walker, but can do that independently, is a 1.
    b. A patient who needs someone to remind her/him to lean forward, or to be careful of the oxygen tubing, but who can otherwise get up from a chair even without arms, is a 1.
    c. If a patient needs both an assistive device AND reminders, cues, etc, they are a 2.
d. The patient who needs more assistance than verbal cues, stand by assist, or light touch (the patient who needs someone to actually help pull them up) is a 2.

13. AMBULATION:
   a. If the patient can walk independently and without an assistive device indoors, outdoors, up and down stairs without a handrail, on hills, and over uneven surfaces like railroad tracks, gravel or sand, they are a 0.
   b. If she/he can do all that with a cane, she/he is a 1. (We would be hard-pressed to convince CMS that either of these is homebound! If he/she is homebound the documentation must clearly support the homebound status.)
   c. If the patient is safe (there’s that word, again) indoors with a walker, then they are a 2, even if she/he needs assist to walk outside, or to get up and down stairs.
   d. If she/he is not safe to walk alone (regardless of what kind of assistive device she/he uses, she/he is a 3.
   e. The patient who uses the furniture or wall to get around the house is not a 1 or a 2, but a 3, since they are unsafe.