CMS states that answering the OASIS questions need to be with the safety of the patient and the efficiency of the task in mind. This means that if the patient is not safely performing the task/movement, or not efficient in performing the task/movement, then the patient 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.

With OASIS C-2, there is a need to be even more consistent and accurate 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 seen, leading to lower HHRG scores that are inaccurate as well as poor outcomes, when discharge OASIS are compared to the SOC:

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 his/her pain medication, may very well not have any pain, so you need to explore what happens when s/he does not take her/his pain medications, or when s/he is due for the next dose.

2. **INCONTINENCE:**
   a. Even if the patient tells you they are continent, consider this: Is the patient sitting on a chair with a towel or under pad?
   b. When you check the patient’s skin for pressure ulcers, is the patient 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 chair bound 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 a family present before s/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. The patient often does not know if s/he is supposed to resume the prehospitalization medications; there are frequently new medications that need to be picked up from the pharmacy; or medication refills came due while the patient was in the hospital that did not get filled.
   c. If even one prescription has not been picked up, CMS directs us that the 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 is unable to get up independently cannot be independent in their medications. If the patient has cognitive issues, the patient is also unlikely to be independent in taking 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 the patient’s status if you do not feel safe having the patient walk away from the 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 then to 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, the patient is a 1.
   b. If the patient cannot manage buttons, cannot pull something over his/her head, or does not have the ROM to put on a sweater or shirt, the patient is at least a 2.
   c. The patient who takes 90 minutes to dress themselves, due to fatigue, SOB, etc., is not independent, even if the patient is 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, the patient cannot bend over to put on shoes, and would be a 2.
   b. The patient with impaired balance who is at risk to fall when stands to pull up pants is a 2.
   c. The patient who is wearing slip-on shoes because s/he cannot put on her/his usual shoes, or is wearing a robe because s/he cannot dress without help, is a 2, or even a 3.

9. BATHING:
   a. The patient is a 1 if can get into and out of the shower or bathtub without assistance.
   b. The patient is a 2 if needs assistance to get in/out of the tub but does not need ongoing supervision.
   c. If the patient needs someone standing by throughout to ensure safety, the patient is a 3.
   d. Ask yourself: “Would I be comfortable walking away and leaving this person in the shower/bathroom all by him/herself 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), the patient is probably going to have difficulty with lower body clothing in the toileting process.
12. TRANSFERRING:
   a. The patient, who 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 to be reminded 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 the patient can do all that with a cane, the patient is a 1. (We would be hard-pressed to convince CMS that either of these is homebound! If the patient is homebound, the documentation must clearly support the homebound status.)
   c. If the patient is safe (there is that word, again) indoors with a walker, then the patient is a 2, even if the patient needs assistance to walk outside, or to get up and down stairs.
   d. If the patient is not safe to walk alone (regardless of what kind of assistive device used), the patient 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.