OASIS NP Scenarios: September 2012

Our focus this month will be specific to process measure OASIS items. As such, there will be a series of small targeted scenarios as opposed to one longer one. Although the format will be different, the intent remains to provide an educational resource for OASIS NP participants.

Depression Screening (M1730)

When the speech pathologist administers the PHQ-2 to screen for depression, Mr. Adams responds to both questions with “Not at all”. He is tearful during the assessment visit and his wife reports he stopped taking his antidepressant last week without telling the doctor.

During the admission visit, the nurse attempts to administer the PHQ-2 to screen for depression but the patient refuses to answer. She has no cognitive issues and states “this is none of your business”..

Fall Risk Assessment (M1910)

Mr. Parker is able to complete the Timed Up and Go (TUG) in 12 seconds without assistance. His home is cluttered, he is taking several strong pain medications, there is no railing on the stairs to access the bedroom and he is incontinent.

Mrs. Ermine has very limited mobility. She has fallen 3 times in the last week, is confused when she first wakes up, forgets to use her walker consistently and has very limited caregiver support. She is unable to get up from a chair without moderate assistance and is so unsteady when attempting the Timed Up and Go (TUG) that the physical therapist provides assistance while walking.

Mr. Geller lives in a home free of obstacles, does not use an assistive device, takes only 2 medications and has had no falls in the last year. When the nurse administers the Timed Up and Go (TUG), the score is 19 seconds.

Pain Assessment (M1240)

When asked to rate her pain using the 0 to 10 scale, Mrs. Jeanette reports “0”. She goes on to say that over the last 24 hours it has been as high as 8 especially when she is active.

Mr. Walters is asked if he is having pain in his left knee which was replaces less than 48 hours prior to the home health admission. He says “no”. He is happy with the pain medications he has been sent home with and is taking them as instructed.

Mrs. Brooks is asked to rate her pain using the 0 to 10 pain scale. She smiles broadly and states “9” and proceeds to get up from her chair and walk with no grimacing or distress noted.

Pressure Ulcer Risk Assessment (M1300)

Mr. Willis is being admitted to home health following a hip replacement. The physical therapist used the Braden tool to assess for pressure ulcer risk but is not comfortable with the entire form. She decides to skip a couple of the items but completed the rest confirming her suspicion that he is at risk for developing pressure ulcers.

When completing the resumption of care, the occupational therapist notes Mrs. Drake is spending most of her waking hours sitting in her wheelchair which lacks a cushion. The skin assessment locates a Stage 2 pressure ulcer on her left buttock in an area often wet due to urinary incontinence. He concludes there is a significant risk for pressure ulcers based on these facts.

Drug Education Intervention (M2015)

While completing the transfer OASIS for Mrs. Sessions, the physical therapist finds in the documentation from nursing that the patient was taught how to manage their oxygen correctly.

The discharge visit is being completed by a clinician who has not seen the patient before. She is confident that medication teaching was done as this is agency policy. She cannot locate orders for this or any documentation within the record showing it was completed.