Oklahoma State Department of Health
Creating a State of Health

News You Can Use

Oklahoma State Department of Health
Quality Improvement & Evaluation Service (405) 271-5278
Nancy Atkinson, Service Director

MDS

Special points of interest:

- Falls
- MDS Coding Tips
- Automation Tips, Reminders & Updates

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Fall Prevention

– Wanda Roberts, RN

Fall prevention has been a distinct area of concern for over 50 years. Numerous studies focusing on falls, fall prevention, and fall outcomes have been completed. Methods have been researched and changes made. Quality improvement measures have been put in place. Nevertheless, fall-related injuries are the most common cause of accidental death in those over the age of 65.[1]To date, a *universal* fall and injury prevention strategy has yet to be established.[1]

Nursing home residents are at an even greater risk for falling than elderly in the community. In fact, nursing home residents fall at twice the rate.[2] 75% of residents are reported to fall at least once a year.[3]There are multiple reasons why our elders in long term care facilities fall more often than those in the community. Research suggests that the main reason is they are generally in poorer health than those individuals in the community. They may also be in greater cognitive decline and need more help in caring for themselves. Falling can also be an indication of other health problems-often referred to as intrinsic factors.

Effective interventions assume that falls are not the result of random accidents but are the result of the presence of numerous risk factors and a compromised medical condition.[5]

There are multiple common intrinsic (related to the resident) and extrinsic (related to the environment) factors that impact a resident's fall risk. Some intrinsic factors include: generalized muscle weakness, gait and balance disorders, cognitive impairment, a history of falls, being on 3-4 medications (CDC guidelines), psychotropic medications, urinary or fecal urgency, fear of falling, and dizziness. A few common extrinsic factors include: inadequate lighting, wet or slippery floor, bed too high, unfamiliar environment, ill-fitting footwear, lack of footwear, lack or improper use of assistive devices, uneven floor surface, caregivers not trained in fall prevention, lack of safety railings in bathroom or hallway.

So what are the recommendations from evidenced based practices and research implications? First, we look at screening and assessment. Both nurses and CNAs should be mindful that *one solitary fall is the best predictor of future falls*. Residents, who have fallen once, even prior to admission should be targeted for comprehensive fall risk assessment and indi-

Director's Corner: Diane Henry, RN

Many people believe that falls are a normal part of aging. The truth is, they're not. Regular physical activity is the first line of defense against falls and fractures.[6] Strength and balance exercises have proven to be a key intervention in preventing falls. The Oklahoma State Department of Health (OSDH) Injury and Prevention Service has implemented Tai Chi as an integral part of the fall prevention program. Some of the benefits of Tai Chi include: improves balance and posture, strengthens muscles, builds confidence from fear of falling, improves musculoskeletal conditions and functional limitations. You can contact OSDH Injury and Prevention Service at (405) 271-3430 or http://falls.health.ok.gov for more information on classes and/or instructor classes to implement Tai Chi in your facility.

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vidualized interventions. A comprehensive review of the resident's risk factors (see above paragraph) will lead to more reliable and appropriate interventions by staff. Involve CNAs in creating fall prevention strategies. Asking, for example, "Can you give me three interventions for this resident that we can implement right away, to lessen her risk of falls?" This will increase the CNAs' investment in the process. Research shows that when all staff are involved in identifying and developing solutions to issues, they are more likely to follow the plan of care.[5]

The most effective fall interventions address multiple factors and use an interdisciplinary team. There is a critical relationship between CNAs, nurses, medical providers, and facility support staff (such as housekeeping, dietary, etc.) in identifying potential falls. One study revealed that CNAs may detect change in condition (for example, weakness, cognitive changes, and dizziness) as many as five days prior to nurses. A failure of the CNA to report this change directly to the licensed nursing staff could delay a thorough evaluation of the resident. Be diligent in informing families and CNAs of medication changes, including dosage adjustments of psychoactive medications, phenytoin, or digoxin. When medication orders or changes are written determine (ask Physicians, pharmacists, review literature, etc.) what side effects to anticipate. Discuss with CNAs, therapists, and support staff the possible side effects or drug interactions (such as drowsiness, urgency, etc.) related to falls. Excellent communication amongst staff members is an effective fall reduction strategy.

Nurses and CNAs are key players in the interdisciplinary team. There are multiple fall prevention interventions to consider. Anticipating and meeting the residents' physical needs (toileting, hunger, and thirst) is a vital nursing intervention. Making certain mobility devices are available, supporting with mobility as necessary, assisting resident to void prior to administering medications causing drowsiness, and helping the resident keep eye glasses and hearing aids in working order are just a few needs to anticipate.

Occupational and Physical therapists should receive referrals immediately any time there is even an intercepted fall. Actually, it is appropriate to make a referral for therapy services for any of the following situations: the resident has difficulty ambulating, poor safety awareness, unsteady gait, shortness of breath after walking a short distance, fear of falling, improperly using a walker or other assistive device, or any functional or cognitive decline. The goals of occupational and physical therapy are to help recuperate residents from falls as well as to preclude future falls from occurring. Physical therapists may want to assist in creating an exercise program for at risk residents in the facility. Customizing an individual exercise program can encourage the resident to be active safely.

Falls and the injuries associated with them continue to be a significant issue across all settings. Coordinating efforts between all members of the interdisciplinary team and applying evidenced based practices may lead to the problem of falls being managed more effectively.

1.Currie L. Fall and Injury Prevention. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 10. Available from: http://www.ncbi.nlm.nih.gov/books/NBK2653/
2.Center for Disease Control and Prevention. Falls and Prevention. 2014. [Accessed November 7, 2014] Available from: http://www.cdc.gov/homeandrecreationalsafety/fallsnursing.html#prevent
3.CMS Nursing Home MDS 3.0 Quality Measures: Final Analytic Report September 2012. Available from: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-InstrumentsNursingHomeQuaityInits/4.NHQIQualityMeasures.html Bonner, A. Falling into Place: A Practical Approach to Interdisciplinary Education on Falls Prevention in Long-Term Care. Annals of Long-Term Care. 2006 June; 14(6):21-29
5.Lampiasi, N. The Role of Physical and Occupational Therapies in Fall Prevention and Management in the Home Setting. Care Management Journals. 2010. 11(2): 122-127
6. OSDH Injury & Prevention Service, Injury Prevention Brief: Preventing Falls, July 2014. Available at: http://www.ok.gov/health2/documents/IP_Brief_Adult_Falls_TaiChi_ 2014.pdf

MDS Assessment Tip: Definition of a fall

A fall is: An unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident).

An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person –this is still considered a fall.

REMINDER

The period of review for J1700 is 180 days (6 months) prior to admission, looking back from the resident's entry date (A1600).

Fall Assessment Tool – a best practice approach

Fall Risk Checklist

Patient: Date: Time: AM/PM

Fall Risk Factor Identified	Factor Present?	Notes
Falls History		
Any falls in past year?	☐ Yes ☐ No	
Worries about falling or feels unsteady when standing or walking?	☐ Yes ☐ No	
Medical Conditions		
Problems with heart rate and/or rhythm	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Incontinence	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Foot problems	☐ Yes ☐ No	
Other medical conditions (Specify)	☐ Yes ☐ No	
Medications		
Any psychoactive medications, medications with anticholinergic side effects, and/or sedating OTCs? (e.g., Benadryl, Tylenol PM)	☐ Yes ☐ No	
Gait, Strength & Balance		
Timed Up and Go (TUG) Test ≥12 seconds	☐ Yes ☐ No	
30-Second Chair Stand Test Below average score (See table on back)	☐ Yes ☐ No	
4-Stage Balance Test Full tandem stance <10 seconds	☐ Yes ☐ No	
Vision		
Acuity <20/40 OR no eye exam in >1 year	☐ Yes ☐ No	
Postural Hypotension		
A decrease in systolic BP ≥20 mm Hg or a diastolic bp of ≥10 mm Hg or lightheadedness or dizziness from lying to standing?	☐ Yes ☐ No	
Other Risk Factors (Specify)		
	☐ Yes ☐ No	
	☐ Yes ☐ No	

A best practice approach includes use of the Fall Risk Checklist which is part of the STEADI Tool Kit on the CDC website. The Fall Risk Checklist is quick to administer and provides a determination of risk for falling based on falls history, medical conditions, medications, vision, gait, strength and balance and postural hypotension. This tool screens for primary prevention of falls and is integral in a post-fall assessment for the secondary prevention of falls.

Fall risk merits thorough assessment as well as timely interventions and treatment. This model may be used to monitor fall risk over time, minimally yearly, and with patient status changes.

Available at :
CDC website
http://www.cdc.gov/homeandrecreationalsafety/Falls/steadi/index.html

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MARK YOUR CALENDAR!

Upcoming MDS Training (Tentative)

February 18, 2015
Special Clinical Focus, OKC or Shawnee

February 19, 2015
Special Clinical Focus, Tulsa

Check our calendar to confirm dates, locations, and future trainings.
http://mds.health.ok.gov

MDS Automation Tips

Bob Bischoff—Program Manager, MDS/OASIS Automation

What triggers Falls on your Quality Measure Report?

Prevalence of Falls

Numerator: Long-stay residents with one or more look-back assessments that indicate the occurrence of a fall (J1800 = [1]).
Denominator: All long-stay nursing home residents with one or more look-back scan assessments except those with exclusions.
Exclusions: Resident is excluded if the following is true for all of the look-back scan assessments: The occurrence of falls was not assessed (J1800 = [-]).

Falls with Major Injury

Numerator: Long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1, 2]).
Denominator: All long-stay nursing home residents with a one or more look-back scan assessments except those with exclusions.
Exclusions:
Resident is excluded if one of the following is true for all of the look-back scan assessments:
1. The occurrence of falls was not assessed (J1800 = [-]), OR
2. The assessment indicates that a fall occurred (J1800 = [1]) AND the number of falls with major injury was not assessed (J1900C = [-]).
Note: These triggers could remain on your QM reports for up to one year.

New MDS Coordinators

If you are somewhat new to the MDS world, I suggest that you go to our MDS current and archived newsletters and training web page at http://mds.health.ok.gov and click on educational. You can view our upcoming training calendar and all newsletters. Please note that newsletter items are time sensitive and may not have the latest interpretation depending on the release dates of the newsletter and updates to the RAI manual.

Security & Safeguards

When a person who had access to MDS information leaves your facility, you must remove all passwords belonging to that person. Contact the QIES Help Desk for further guidance at: 405-271-5278

MDS Vendor Call Q&A

Call dated 10-21-2014

Vendor Question.

The new edit for generating a RUG in order to bill the third party insurance company is not allowing facilities to lock the assessment and complete the assessment in order to generate the required RUG for billing purposes.

CMS Response.

Vendors should work with their providers to meet their needs. How these needs are met are between the provider and the vendor. Note that this is not a feature with the free CMS provided software, jRAVEN.

CORRECTION
MDS Quality Measure Manual Update

Our last MDS newsletter reported there would be a new release during September 2014 of the Quality Measure Manual. Based on the latest information from CMS this manual will not be released until October 2015. We apologize for any inconvenience this may have caused.

Look for the current QM manual by going to www.qtso.com and click on MDS 3.0 on the left side of the screen, then click MDS 3.0 QM User Manual v8.0, to view the manual.

Automation Tip:

Security & Safeguards.

When selling, donating, or disposing of your MDS computer, ensure that the hard drive and any software have been totally cleared of all resident identifiable information.

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