Oh No-Not Again! Taking a Fresh Look at Your Fall Prevention Program

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Objectives

Understand	Understand the regulatory guidance as it relates to accidents/supervision and falls
Identify	Identify data sources to assist in developing a fall prevention program
Describe	Describe ways to proactively address fall prevention
Utilize	Utilize tools and recommendations to improve resident safety through an effective fall prevention program

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Fall Facts and Stats

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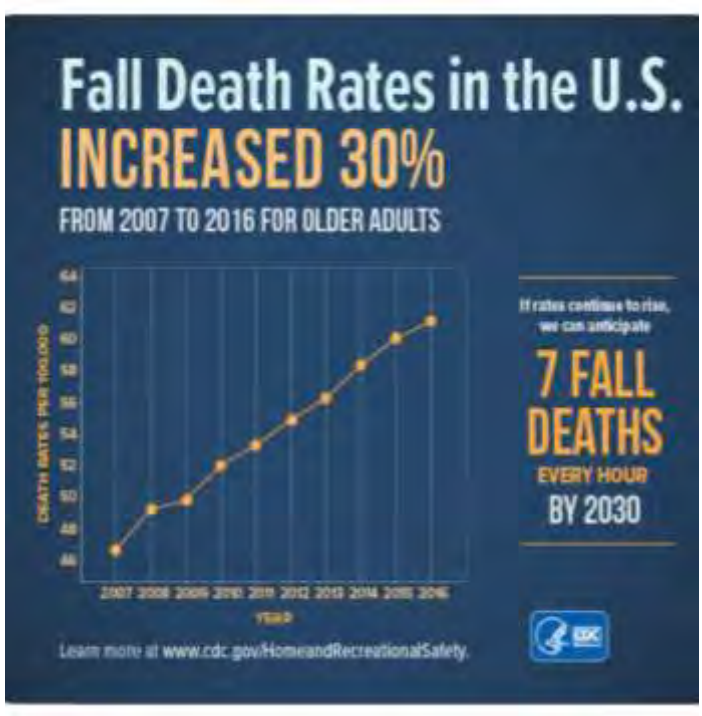

Facts About Falls

One out of 5 falls causes serious injury such as broken bones and head injuries

Each year 3 million older people are treated in the ED for fall injuries

Over 800,000 patients/year are hospitalized for a fall-related head injury or hip fracture

More than 95% of hip fractures are caused by falling, usually sideways

Falls are the most common cause of Traumatic Brain Injuries (TBI)

www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html

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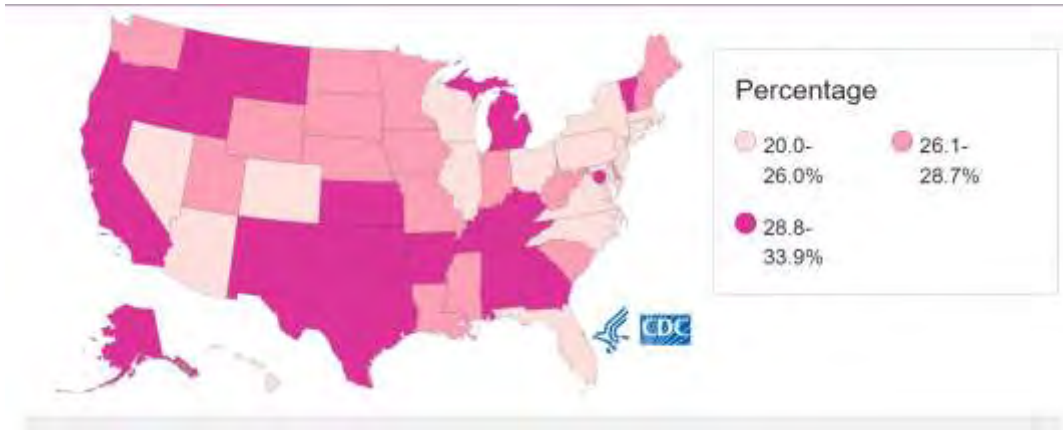
Falls Reported by State 2018



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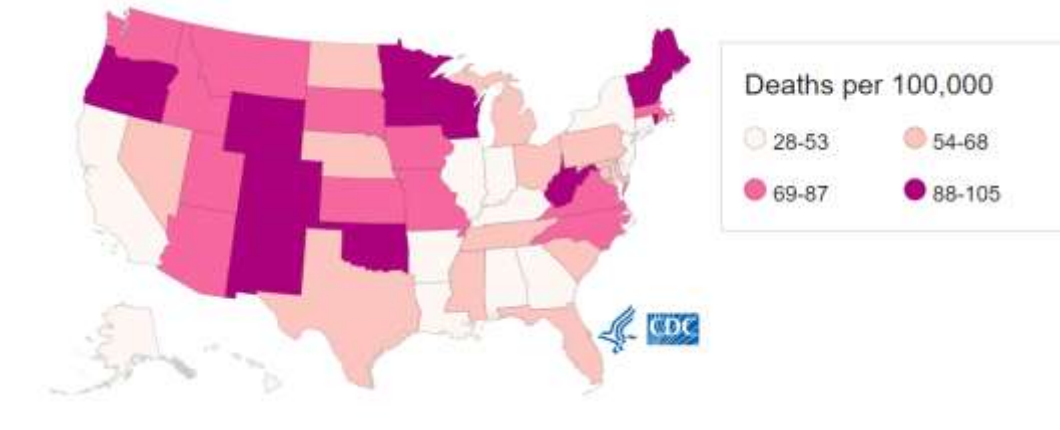
Deaths From Falls 2018



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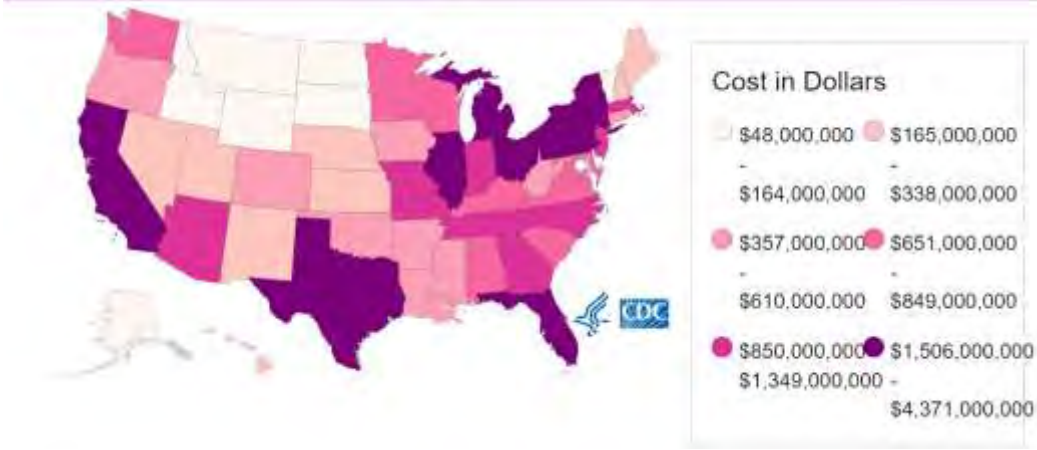
Cost of Older Adult Falls 2014



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Statistics

Muscle weakness and gait problems account for about 24% of nursing home falls and environmental hazards cause16% to 27% of falls for residents.

In older persons, age 65 or greater, falls are the leading cause of injury-related death, non-fatal injuries and hospital admissions for trauma.

Falls are associated with increased length of stay, increased healthcare utilization, poorer health outcomes and increased costs.

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QCOR FY 2022 Region 7 KC-MO

STANDARD HEALTH

COMPLAINT HEALTH

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QCOR FY 2023 Region 7 KC-MO

STANDARD HEALTH

COMPLAINT HEALTH

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QCOR FY 2022 Region 7 KC-MO
Standard Health

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Missouri Active Providers=518		Total Number of Surveys=192
F0812	Food Procurement, Store/Prepare/Serve Sanitary	112	21.4%	58.3%
F0880	Infection Prevention & Control	98	18.7%	51.0%
F0689	Free of Accident Hazards/Supervision/Devices	77	14.5%	40.1%
F0656	Develop/Implement Comprehensive Care Plan	70	13.5%	36.5%
F0658	Services Provided Meet Professional Standards	60	11.6%	31.3%
F0677	ADL Care Provided for Dependent Residents	58	11.0%	30.2%
F0761	Label/Store Drugs and Biologicals	55	10.6%	28.6%
F0584	Safe/Clean/Comfortable/Homelike Environment	53	10.0%	27.6%
F0625	Notice of Bed Hold Policy Before/Upon Trnsfr	51	9.8%	26.6%
F0623	Notice Requirements Before Transfer/Discharge	49	9.5%	25.5%

QCOR FY 2022 Region 7 KC-MO
Complaint Health

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Missouri Active Providers=518		Total Number of Surveys=2139
F0689	Free of Accident Hazards/Supervision/Devices	68	11.0%	3.2%
F0600	Free from Abuse and Neglect	53	9.3%	2.5%
F0609	Reporting of Alleged Violations	52	8.7%	2.4%
F0677	ADL Care Provided for Dependent Residents	42	7.3%	2.0%
F0610	Investigate/Prevent/Correct Alleged Violation	38	6.4%	1.8%
F0658	Services Provided Meet Professional Standards	38	6.0%	1.8%
F0684	Quality of Care	36	6.0%	1.7%
F0888	COVID-19 Vaccination of Facility Staff	34	6.2%	1.6%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	32	5.4%	1.5%
F0880	Infection Prevention & Control	29	5.4%	1.4%

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State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Missouri Active Providers=515		Total Number of Surveys=540
F0884	Reporting - National Health Safety Network	293	18.1%	54.3%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	18	3.5%	3.3%
F0689	Free of Accident Hazards/Supervision/Devices	18	3.5%	3.3%
F0880	Infection Prevention & Control	18	3.3%	3.3%
F0656	Develop/Implement Comprehensive Care Plan	15	2.9%	2.8%
F0584	Safe/Clean/Comfortable/Homelike Environment	14	2.5%	2.6%
F0623	Notice Requirements Before Transfer/Discharge	13	2.5%	2.4%
F0684	Quality of Care	13	2.3%	2.4%
F0732	Posted Nurse Staffing Information	12	2.1%	2.2%
F0761	Label/Store Drugs and Biologicals	10	1.9%	1.9%

QCOR FY 2023 Region 7 KC-MO Complaint Health

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Missouri Active Providers=515		Total Number of Surveys=172
F0684	Quality of Care	3	0.6%	1.7%
F0689	Free of Accident Hazards/Supervision/Devices	2	0.4%	1.2%
F0609	Reporting of Alleged Violations	2	0.4%	1.2%
F0690	Bowel/Bladder Incontinence, Catheter, UTI	1	0.2%	0.6%
F0691	Colostomy, Urostomy, or Ileostomy Care	1	0.2%	0.6%
F0726	Competent Nursing Staff	1	0.2%	0.6%
F0656	Develop/Implement Comprehensive Care Plan	1	0.2%	0.6%
F0602	Free from Misappropriation/Exploitation	1	0.2%	0.6%
F0758	Free from Unnec Psychotropic Meds/PRN Use	1	0.2%	0.6%
F0880	Infection Prevention & Control	1	0.2%	0.6%

Regulatory Description & Definitions

STATE OPERATIONS MANUAL (SOM)
RESIDENT ASSESSMENT INSTRUMENT(RAI) MANUAL

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F689 Free of Accidents Hazards, Supervision/Devices

- §483.25(d) Accidents.
- The facility must ensure that –
- §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and
- §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

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INTENT

- INTENT: §483.25(d)
- The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:
  - Identifying hazard(s) and risk(s);
  - Evaluating and analyzing hazard(s) and risk(s);
  - Implementing interventions to reduce hazard(s) and risk(s); and
  - Monitoring for effectiveness and modifying interventions when necessary.

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FALL: SOM

Refers to **unintentionally** coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident).

An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall.

A fall without injury is still a fall.

Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred (refer to Resident Assessment Instrument User's Manual. Version 3.0, Chapter 3, page J-27).

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FALL: RAI

FALL 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**.

CMS understands that challenging a resident's balance and training him/her to recover from a loss of balance is an **intentional therapeutic intervention** and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

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AVOIDABLE ACCIDENT

- An accident occurred because the facility **failed** to:
  - Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or
  - Evaluate/analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible; and/or
  - Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident; and/or
  - Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.

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Unavoidable Accident

- An accident occurred despite sufficient and comprehensive facility systems designed and implemented to:
  - Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and
  - Evaluate/analyze the hazards and risks and eliminate them, if possible and, if not possible, reduce them as much as possible;
  - Implement interventions, including adequate supervision, consistent with the resident's needs, goals, care plan, and current professional standards of practice in order to eliminate or reduce the risk of an accident; and
  - Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current professional standards of practice.

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Supervision/Adequate Supervision

An intervention and means of **mitigating the risk** of an accident. Facilities are obligated to provide adequate supervision to prevent accidents.

Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment.

Adequate supervision may vary from resident to resident and from time to time for the same resident.

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Assistance/Assistive Devices

- Refers to any item (e.g., fixtures such as handrails, grab bars, and mechanical devices/equipment such as stand- alone or overhead transfer lifts, canes, wheelchairs, and walkers, etc.) that is used by, or in the care of a resident to promote, supplement, or enhance the resident's function and/or safety.

NOTE: The currently accepted nomenclature refers to "assistive devices." Although the term "assistance devices" is used in the regulation, the Guidance provided in this document will refer to "assistive devices."

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Use of Mechanical Devices

- Mechanical assistive devices for transfer include, but are not limited to, portable and stationary total body lifts, sit-to-stand devices, and transfer or gait belts
- The resident assessment helps to determine the resident's degree of mobility and physical impairment and the proper transfer method; for example, whether one or more caregivers or a mechanical device is needed for a safe transfer. Residents who become frightened during transfer in a mechanical lift may exhibit resistance movements that can result in avoidable accidents. Communicating with the resident and addressing the resident's fear may reduce the risk.

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Environment

- Refers to any environment or area in the facility that is frequented by or accessible to residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.

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Risk

- Refers to any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident.

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Taking a Proactive Approach to Prevention

FACILITY COMMITMENT

RISK AND HAZARD IDENTIFICATION

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Committing to a Fall Prevention Program

A Fall Prevention program requires a top down/bottom-up approach from all stakeholders within and others associated with the organization.

Development of polices and procedures addressing the vision of the program, measurable goals and objectives, identification of resident risk, stakeholder roles and involvement, and communication methods for reporting progress toward goals.

Identifying a champion to lead the program, e.g. DON/ADON, Restorative Coordinator,

Staff Development Coordinator, QA Nurse or Therapist.

- Implementing a culture of safety with all eyes and hands on deck to limit resident falls and falls with injury.

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A Culture of Safety

- Acknowledge the high-risk nature of its population and setting
- Develop effective communication, including a reporting system that does not place blame on the staff member for reporting resident risks and environmental hazards;
- Engage ALL staff, residents and families in training on safety, and promote ongoing discussions about safety with input from staff at all levels of the organization, as well as residents and families; (QAPI)
- Encourage the use of data to identify potential hazards, risks, and solutions related to specific safety issues that arise; (How do you analyze data?-What data do you collect?)
- Direct resources to address safety concerns; and
- Demonstrate a commitment to safety at all levels of the organization.

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Evaluation and Analysis

- The process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents.
  - Interdisciplinary involvement is a critical component of this process.
- Analysis may include, for example,
  - considering the severity of hazards,
  - the immediacy of risk,
  - and trends such as time of day, location, etc.

- Both the facility-centered and resident-directed approaches include evaluating hazards and accident risk data which includes prior accidents/incidents, analysis to identify the root causes of each hazard and accident risk and identifying or developing interventions based on the severity of the hazards and immediacy of risk. Evaluations also look at trends such as time of day, location, etc.

EVALUATION

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Data Collection Tools for Risk and Hazard Identification

Facility Assessment Tool: high risk, high volume, problem prone	MDS: Sections B, C, D, E, G, GG, H, I, J, N, O and CAA triggers	Preadmission screening	Referral paperwork
Risk assessments: Fall, Braden, side rail, bowel & bladder	Medical history and physical exam	Resident observation and rounds	Environmental rounds
	Quality Measure reports, Facility and Resident Level summaries	QAA/QAPI activities	

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Resident Risk Identification

- Consider unique characteristics and abilities for each resident:
  - Diagnosis: Fractures, Parkinson's disease, CVA, vertigo, hypotension, arthritis, osteoporosis
  - Physical abilities: Abnormal gait, balance issues, loss of limb(s), contractures
  - Cognition: Confusion, dementia, delirium, psychiatric/mood disorders
  - Strengths: Active engagement in care, desire to return home
  - Weaknesses: History of previous falls, impulsiveness, inability to follow simple directions, poor vision

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Contributing Factors

- Unsafe or absent footwear
- Underlying chronic medical conditions, such as arthritis, heart failure, anemia and neurological disorders
- Acute change in condition such as fever, infection, delirium
- Functional impairments (difficulty rising from a chair, getting on or off toilet, etc.)
- Medication side effects
- Orthostatic hypotension
- Balance disorders
- Gait disorders
- Pain
- Visual deficits
- Lower extremity weakness
- Poor grip strength
- Cognitive impairment
- Incontinence

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Environmental Hazards & Risks

- Plant hazards:
  - Propped fire doors, disabled locks or latches
  - Non-functioning alarms: doors, personal
  - Buckled or torn carpet or flooring
  - Cords on floor: O2, electric beds, televisions, lamps, air mattresses, air pumps
  - Irregular walking surfaces/colored or patterned carpet, shiny floors
  - Ill fitting equipment: chairs, beds, walkers
  - Poor lighting: too dim, too bright, glares

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FALL RISK EVALUATION

RESIDENT FALL RISK EVALUATION

Perform a Fall Risk Evaluation upon admission/readmission, with a significant change in condition, quarterly and after each fall

Identify "at risk" residents, prioritizing based on:

Limited mobility and/or activity

Cognitive status (assess for delirium)

Medication review

Engage the resident, family and care givers as partners in the fall prevention program

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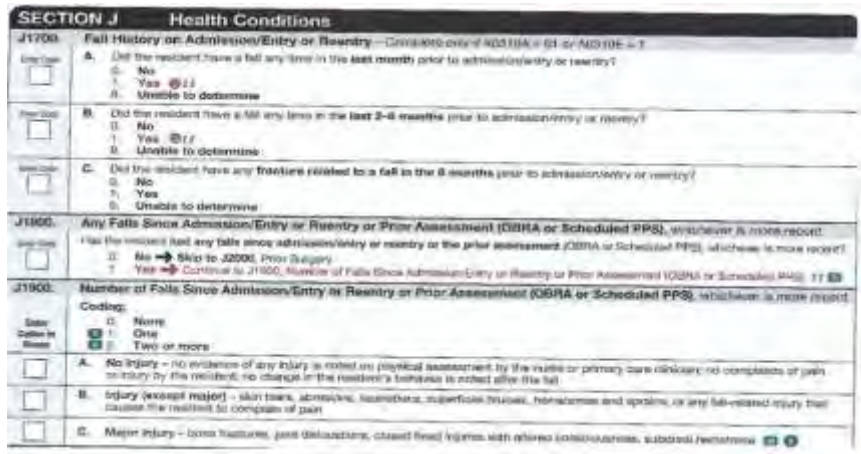
MDS Section J Health Conditions



SECTION J Health Conditions

J1700. Fall History on Admission/Entry or Reentry – Complete only if A0310A = 01 or A0310E = 1

A. Did the resident have a fall any time in the **last month** prior to admission/entry or reentry?
0. No
1. Yes
8. Unable to determine

B. Did the resident have a fall any time in the **last 2–6 months** prior to admission/entry or reentry?
0. No
1. Yes
8. Unable to determine

C. Did the resident have any **fracture related to a fall in the 6 months** prior to admission/entry or reentry?
0. No
1. Yes
8. Unable to determine

J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Has the resident had **any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?
0. No → Skip to J2000, Prior Surgery
1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Coding:
0. None
1. One
2. Two or more

A. **No injury** – no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

B. **Injury (except major)** – skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains, or any fall-related injury that causes the resident to complain of pain

C. **Major injury** – bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

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Implementing Universal Fall Precautions

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Implementing Universal Fall Precautions

Familiarize	Have	Keep	Have	Place	Keep	Keep
Familiarize the resident to the environment	Have the resident demonstrate call light use and keep the call light within reach	Keep the resident's personal possessions within safe reach	Have sturdy handrails in the resident's bathroom, room, and hallway	Place the bed in low position when the resident is resting in bed; raise the bed to a comfortable height when the resident is transferring out of bed	Keep the bed brakes locked	Keep wheelchair wheel locks in "locked" position when stationary, if appropriate

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Implementing Universal Fall Precautions

Keep	Use	Keep	Keep	Keep	Implement	Follow
Keep nonslip, comfortable, well-fitting footwear on the resident	Use night lights or supplemental lighting	Keep floor surfaces clean and dry. Clean up all spills promptly	Keep resident care areas uncluttered	Keep resident items within reach (nest)	Implement staff training on fall prevention, including use of lifts	Follow safe handling practices: • Complete scheduled rounding to ensure universal fall precautions are implemented, (bed in low position, mat on floor, wearing of non-skid socks) and resident needs are met

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Standardize and implement interventions based on patient risk for falling. Align individualized interventions to respective risk:

- Previous fall history
  - Determine circumstances of a previous fall
  - Implement tailored interventions to prevent a similar fall
- Gait instability/lower-limb weakness
  - Nonskid footwear
  - Assistive devices
  - Physical therapy
  - Assistance getting out of bed and with ambulation
  - Avoid bedrest
- Urinary incontinence, frequency, and/or the need for toileting
  - Hourly rounding
  - Toileting schedule
  - Incontinence briefs
- Agitation, confusion, impaired judgment
  - Frequent rounding/surveillance plan
  - Continuous virtual monitoring
  - Bed/chair alarm
  - Floor mats to reduce trauma from bed-related falls
  - Assess for alcohol/ drug withdrawal and place patient on appropriate protocol
  - Rule out delirium
- Medications, especially sedative hypnotics
  - Consult pharmacist about medications
  - Assess for/treat orthostatic hypotension (adequate fluid intake, slow position changes, compression stockings)
- Advanced age
- Poor vision and/or difficulty hearing

IMPLEMENTATION STRATEGIES

Incorporate alerts, tasks, records, prompts in the EHR

Initiate walking rounds that include fall risk concerns

Optimize resident mobility:

Address potential impact of immobility: loss of muscle mass and strength, loss of independence, potential for chronic pain, potential loss of confidence after a fall

Address "fear" of falling

Recognize limitations of select interventions: bed alarms, sitters, signage

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POST-FALL ACTIONS

- Ascertain if there were injuries, and provide treatment as necessary
- Determine what may have caused or contributed to the fall (root cause analysis), including ascertaining what the resident was trying to do before he/she fell
- Conduct a post-fall huddle as soon possible after the fall
- Involve all staff levels, and the resident, if possible
- Discuss the fall, how it happened and why, addressing any psychological factors (medications or medical conditions)

Ensure the huddle includes:

- Whether appropriate interventions were in place
- Special considerations as to why the fall may have occurred:
  - Call light on? How long?
  - Staffing at the time of the fall
  - Environmental care factors in play, (e.g., toilet height, slip/trip hazards, lighting)
  - How similar outcomes may be avoided
  - How the care plan has changed: revise with interventions and/or referrals

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Post Fall Huddle Guidelines

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Resident Interventions

- Therapy: PT/OT/ST/Restorative
- Social services, psychologist/psychiatrist
- TOILET, TOILET, TOILET!
- Hydration
- Feet:
  - Footwear, non-slip socks
  - Check no slip surfaces
  - Shuffling gate
  - Cognitive impairment? Moccasins or non-slip socks
- Pain
- Glasses: are they clean? Contacts?
- Belongings in reach (nest)
- Orthostatic issues
- Anticipate needs
- Avoid sensory overload
- Environment changes
- Rest periods
- Activities
- Exercise
- Exercise pedals
- Distractions while waiting
- Wii
- Dance music therapy
- Daily ambulation program (group/individual)
- Hip protectors, knee/elbow pads
- Cues/reminder signs
- Large number clocks/calendars
- Reminiscence/life review
- Tapes of loved ones and friends (family videos or albums)
- Spiritual support
- Intergenerational cultural, pet programs
- Remove objects that may trigger (i.e. coat hat, suitcase)
- Limit caffeine
- HONOR THEIR ROUTINE
- Involve in choices and plan
- Safety contract

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Family Interventions

- Education: if the resident fell at home… behavior likely to continue when in our care
- Involve in planning care
  - Predicted course of illness
  - Anticipated behavior/cognitive changes
- Patient history: habits and customs
- Coping mechanisms/triggers (dates, smells, color, person)
- Encourage use of family/sitters to stay with high-risk resident (essential caregivers)
- Recording of reassuring messages (this may agitate some residents and cause them to look for the family member)
- Family scrap book or photo box, memorable event/objects of affection

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Environmental Interventions

- Personalize rooms, familiar objects
- Room relocation
- Call light system
- Bedside commode
- Bed height
- Trapeze, bed handle, transfer pole
- Body pillows
- Bolsters
- Bedside table
- Clutter free
- Frequent rest areas
- Position bed to accommodate weakness
- Reduce noise
- Floor mats
- Padding
- Carpeted surfaces or non-slip wax, low buff to reduce glare
- Non-skid on floor in front of sink, toilet, bed
- Exit doors (keep exit door closed, stop signs)
- Higher seated lounge chairs and toilets
- Appropriate size equipment
- Visual cues/signage
- Memory trigger
- Minimized hall equipment
- Adequate lighting
- Light and color, high contrast/avoid busy patterns
- Property fencing
- Establish a wandering path/ courtyard

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Staff Interventions

- Everyone is responsible!!!!!
- Fall prevention team includes direct care staff
- House rules:
  - Clean up spills immediately
  - Pick up/move items
  - Identify rough flooring/carpet
  - Report light not working
  - Clean dirty eyeglasses
  - Address pants too long
- Determine reason for and relieve discomfort
- Frequent rounding with eyes open
- Address call light promptly
- Permission before touching, moving, hugging
- Move slowly around ambulatory residents/avoid abrupt changes or rushing
- Calm approach
- Avoid confrontation
- Consistent caregivers
- Actively listening/validate feelings
- Structured activities
- Assess sleep pattern
- Assistive devices in use, properly used
- Medication review/changes

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Supervision

- Supervision is an intervention and a means of **mitigating accident r**isk. Facilities are obligated to provide adequate supervision to prevent accidents.
- Adequacy of supervision is defined by type and frequency, based on the individual resident's assessed needs, and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.
- Devices such as position change alarms may help to monitor a resident's movement temporarily, but do not eliminate the need for adequate supervision.
- The resident environment may contain temporary hazards (e.g., construction, painting, housekeeping activities, etc.) that warrant additional supervision or alternative measures such as barriers to prevent access to affected areas of the resident environment.
- Adequate supervision to prevent accidents is enhanced when the facility:
  - Accurately assesses a resident and/or the resident environment to determine whether supervision to avoid an accident is necessary; and/or
  - Determines that supervision of the resident was necessary and provides supervision based on the individual resident's assessed needs and the risks identified in the environment.

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Implementation of Interventions

Implementation refers to using specific interventions to try to reduce a resident's risks from hazards in the environment

The process includes:

- Communicating the interventions to all relevant staff
- Assigning responsibility
- Providing education, as needed
- Documenting interventions (e.g. care plans for the individual resident or plans of action developed by the Quality Assurance Committee)
- Ensuring interventions are put into action and monitored

Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with professional standards, including evidence-based practice.

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Implementation of Interventions

Development of interim safety measures may be necessary if interventions may not immediately be fully implemented

Facility-based interventions may include, but are not limited to:

- Educating staff
- Repairing a device/equipment
- Developing or revising policies and procedures

Resident-directed approaches may include implementing specific interventions as part of the plan of care, supervising staff and residents, etc.

Documentation in facility records and the resident's care plan should include the newly implemented interventions

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Monitoring and Modification

Monitoring is the process of evaluating the effectiveness of care plan interventions

Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks

Monitoring and modification processes include:

- Ensuring that interventions are implemented correctly and consistently
- Evaluating the effectiveness of interventions
- Modifying or replacing interventions as needed
- Evaluating the effectiveness of new interventions

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Utilizing the Data

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Monitoring Best Practices

Assess and monitor	Assess and monitor fall rates, repeat fall rates and severity of fall-related injuries and practices
Measure	Measure percent of falls and injury risk factors treated (mitigated or eliminated) as a result of individualized care planning
Make	Make system modifications for repetitive themes (e.g. limiting use of sleep medications after certain hours)
Assess	Assess resident satisfaction with the fall prevent plan of care upon discharge and with a follow up call
Provide	Provide unit-level feedback to implement strategies for motivation and continuous monitoring and improvement by posting "days since last fall"
Present	Present facility performance to QAA committee

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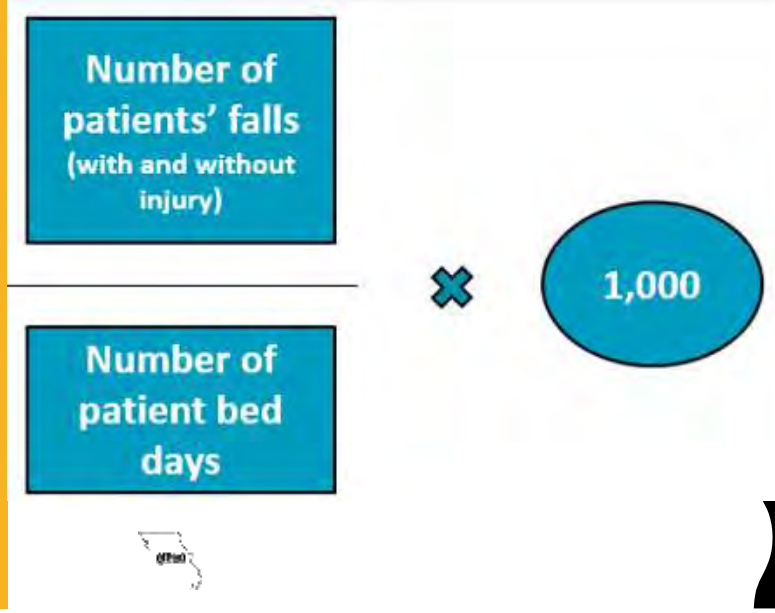

How to Calculate Your Facility Fall Rate

Count the number of falls in the month.

Figure out how many beds were occupied each day.

Add up the total occupied beds each day for the month (patient bed days).

Divide the number of falls by the number of patient bed days for the month.

Multiply the results by 1,000 to get the fall rate per 1,000 patient bed days.

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Fall Rate Calculation Example

Directions	Example
Count number of falls in April.	3 falls in April
Count occupied beds each day in April.	26 on April 1, 28 on April 2, …
Add up the total occupied beds each day for April (patient bed days).	879 occupied beds
Divide the number of falls by the number of patient bed days in April.	3/879 = 0.0034
Multiply by 1,000.	0.0034 x 1,000 = 3.4 falls per 1,000 patient bed days

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Safety Huddle

- Hardwire safety processes, such as safety huddles, post-fall huddles and staff rounding
- Regularly reassess staff knowledge and enlist leaders with focused safety huddles to include "at risk" residents
  - Safety huddle: A safe culture is built on high awareness of real and potential safety issues at all times and at all levels of organizational operations
  - Provides a quick and easy format for personnel to share safety concerns, develop plans and celebrate successes
  - An informal forum to share information about potential safety problems and increase safety awareness among personnel at all levels of the organization
- Promote a blame-free environment

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Resident & Family Engagement

- Reinforce resident and family education:
  - Teach fall prevention and reduction strategies
  - Solicit the voice of the resident and family to partner mitigating risk in the facility and their home
  - Enlist the resident in a toileting plan, if appropriate
  - Address health literacy and develop targeted educational materials
  - Consider the use of fall prevention videos for risk awareness education
  - Invite a resident family advisor to be a member of a fall/mobility multidisciplinary improvement team
  - Use a resident agreement to promote compliance and ensure the resident feels a part of the team

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Quality Measure: Falls with Major Injury

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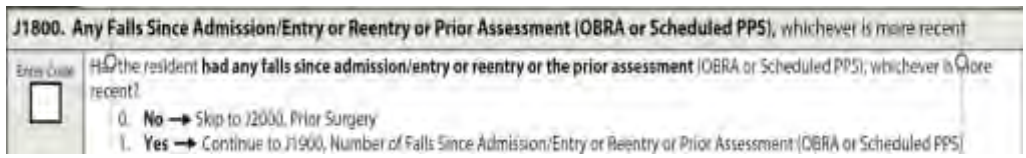
What Triggers?

- J1800: Has the resident **had any fall since admission, entry, or reentry, or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?



J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Enter Code

Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?

0. **No** → Skip to J2000, Prior Surgery
1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

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Percentage of Residents Experiencing One or More Falls with Major Injury

This measure reports the percentage of long-stay residents who have experienced one or more falls with major injury reported in the target period or look-back period (one full calendar year).

Based on your report date it captures a look back scan.

- What is a look back scan?
  - Last assessment then **275** days prior to that (can be over a year dependent on MDS schedule)
  - Looks at all assessments in that range

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Steps to Take

- Ensure the MDS was coded accurately
- Was it really a fall? Review the RAI manual definition for a fall
- Miscoded? MDS Coordinator to consider completing a significant correction

- Evaluate:
- Why and how did the fall occur?
- What is the prevention strategy for fall risk reduction, versus an intervention after a fall has occurred?
- Are you proactive or reactive?
- Are you are waiting for the quality measure report to see improvements? Completing internal data/tracking?

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CMS

CASPER Report

MDS 3.0 Facility Level Quality Measure Report

This report may contain privacy protected data and should not be released to the public. Any attempt to this report is strictly prohibited.

MDS 3.0 Facility Level QM Report

Facility Observed %

Facility Adjusted %

Comparison group state average

Comparison group national average

Comparison group national percentile

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MDS 3.0 Resident Level QM Report

Select the timeframe. The report defaults to the most recent completed six-month period prior to the month the data was last calculated

Lists the residents (active and discharged) by name

Identifies the QMs each resident triggers

Helps identify residents who trigger multiple QMs. These residents may merit special consideration or more intensive review

QM data for this report is calculated weekly for the assessments submitted since the previous week's data calculation

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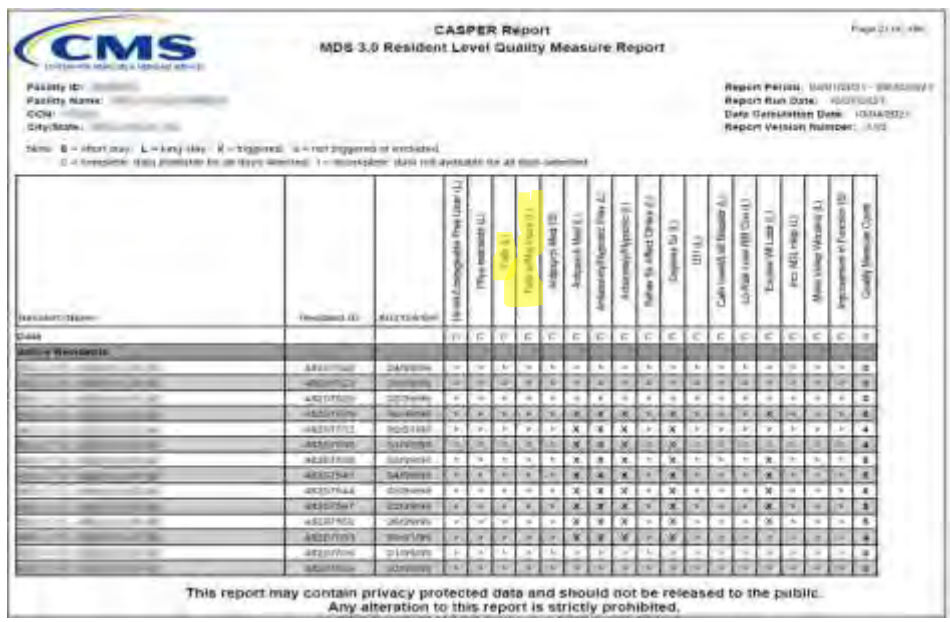
CASPER Report
MDS 3.0 Resident Level Quality Measure Report

This report may contain privacy protected data and should not be released to the public.
Any alteration to this report is strictly prohibited.

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Interpreting the Data

Look at the Threshold page (Facility Level)

- Focus on:
  - Those over 75% (triggered items)
  - The 3 Look back scan measures:
    - Short Stay Antipsychotic
    - Falls
    - Falls with Major Injury

Identify opportunities for improvement

Input from QAPI team? Staff? Residents?

Are there any "misnomers" …

- People that triggered that you are not sure why or how they triggered?
- People that triggered that don't belong?

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Falls Management Program Case Study

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Mrs. P is Admitted to Your Home

- Mrs. P is a 93 year old white female admitted to your facility. She has had Alzheimer's disease for approximately 7 years and has been cared for by her husband and daughter at home. Her other past medical problems include: diabetes mellitus, hypertension, osteoarthritis, depression and a history of falls. Over the past several months, her family has found it increasingly difficult to care for her at home due to worsening agitation and insomnia.
- Mrs. P has been at your facility for 3 days and has slept only 3 hours per night. She is extremely restless and anxious and often cries out for her husband. She constantly wants to get up from her chair or bed. Mrs. P was found on the floor by staff at 8 pm and apparently had fallen onto her buttocks; no injuries were found. Mrs. P was assisted to bed for the night. She is noted to have 1/2/side rails on the right and left.
- Later that evening Mrs. P was found on the floor. Her undergarments were soiled and she continued to cry out for her husband. She was assessed to have no injuries resulting from the fall. The nurse obtained an order for a sedative from the physician and Haldol 0.5 mg was given at 1 am. She was put back to bed and finally went to sleep for the night.

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What Are Mrs. P's Known Fall Risk Factors

- Environment/equipment(Extrinsic factors)
  - New admission—unfamiliar surroundings
  - Side rails—increased risk of serious injury
- Medical Conditions (intrinsic factors)
  - History of falls at home
  - Dementia
- Unsafe behaviors
  - Trying to stand, transfer or walk alone unsafely
  - Tries to climb over side rails or get out of bed alone unsafely
- Chronic conditions:
  - Visual impairment due to aging and diabetes
  - Hypo/hyperglycemia
  - Loss of sensation in feet due to diabetic neuropathy
  - Pain, contractures or decreased ROM resulting from osteoarthritis
  - Urinary urgency and/or frequency
  - Additional gait and mobility problem
- Medications
  - Postural hypotension as a result of CV medications
  - Side effects of antidepressants
  - Side effects of sedatives/hypnotics
- Acute illness—possible systemic illness
- Environment/equipment—Unlocked bed wheels or unstable furniture

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What Interventions to Reduce Mrs. P's Fall Risk are Important to Consider?

- Environmental/equipment:
  - Reduce clutter, keep pathways clear
  - Provide adequate lighting at night
  - Add labels/pictures to help her locate her room and bathroom
  - Provide frequent reassurance and orientation to facility
- Gait and mobility:
  - Screen resident's ability to transfer and ambulate safely to determine level of staff assistance needed and if further evaluation necessary
  - Based on screen, order an evaluation for PT/OT

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What Interventions to Reduce Mrs. P's Fall Risk are Important to Consider?

- Medications
  - Request PCP to review all medications for possible interactions and side effects
  - Request consultant pharmacist to review all medications
  - Implement sleep hygiene measures—provide comfort measures at bedtime, offer food or snack, individualized toileting program at night, supervise when up at night
- Pain management
  - Evaluate resident's pain level using appropriate pain scale for residents with dementia
  - Give a trial analgesic, if appropriate
- Anxiety, agitation and unsafe behavior
  - Implement general behavior management strategies
  - Move closer to the nurses station
  - Use adequate night light
  - Leave door open at night for regular checking as staff walk by
  - Provide frequent reminders for call light, if appropriate
  - Use low bed and mat
  - Provide comfort measure, reassure frequently
  - Learn culture, likes/dislikes and religious preferences
  - *Know 3 things that give her comfort
  - Develop a toileting schedule, evaluate bathroom safety, possible use of bedside commode

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Mrs. P's Post-Fall Assessment

Step 1 Evaluate and monitor resident x 72 hours:

- Complete physical assessment for possible/actual injuries:
  - Musculoskeletal
  - Head/neck
  - Mental status changes
  - Changes in LOC
- Obtain vital signs with postural vital signs since resident taking antihypertensive medications, H/O frequent falls
- Documentation of neurological assessment since found on floor
- Blood glucose since resident has a diagnosis of diabetes

- Mrs. P was found on the floor in her room at 8:00pm this evening. Resident states "I was needing to use the restroom." It has been reported that Mrs. P has been agitated and restless off and on since admission and has been showing signs of unsafe behavior-attempting to transfer without staff assistance, getting out of bed at night with disturbed sleeping patterns.
- Vital signs-100/60, 66, 20, 98.6, Blood glucose=70, Orange juice and two packets of sugar given, blood glucose=100, ½ hour later. Pulse Ox=98%.
- Postural BP: standing at 1 minute 90/60, 80. No evidence of orthostatic hypotension at this time. Resident in her room alone at time of fall, attempting to get up out of chair unassisted-wants to use bathroom. Gait slightly unsteady and needs the assistance of one person for transfers. Resident ambulates in regular socks.
- Dr. Roberts notified at 8:30pm. Mrs. Mary Taylor, resident's daughter, was notified by telephone at 9:00pm. Resident's status and immediate measures taken were explained to daughter. Daughter was reminded of her mother's care plan conference on Friday.
- Interventions to be determined based on further assessment and interdisciplinary evaluation.

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Mrs. P's Post-Fall Assessment

Step 2 Investigate the Fall:

Mrs. P had 2 falls within 24 hours after admission to the facility:

- Environmental clues:
  - Where was Mrs. P lying?
  - What was she wearing on her feet?
  - What clothes was she wearing?
  - Was there anything next to her?
  - What direction was she headed?
  - Where was the call light?
  - Was there enough light for her to see?
- Equipment clues:
  - Where was her chair?
  - Were any assistive devices present? Cane? Walker?
  - Was the bed locked in a stable position?
  - Were the side rails up or down?
- Resident Condition:
  - Was she wet or soiled?
  - Was she confused or agitated?
  - What did Mrs. P say happened?
  - When was her last food intake?
  - When was the last time she was toileted?

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Mrs. P's Post-Fall Assessment

Step 3 Record circumstances:

- Complete Fall Risk Evaluation after each fall
- Write a concise nursing note x 72 hours
- Complete neurologic checks x 72 hours, if indicated
- Document staff response to fall

Step 4 PCP and Family notification:

- Follow the facility protocol for contacting the physician:
- During office hours/after hours
- Resident with/without injury
- Notify family of fall, assessment, new orders, interventions

Step 5 Implement immediate intervention(s): what intervention can you put in place for next 24 hours:

- Increase staff surveillance of resident, monitor frequently-every 15-30 minutes
- Toilet resident as needed
- Use a low bed with mat when in bed
- Use non-skin socks when in bed and canvas shoes when up
- Offer a snack and reassure resident.
- Locate at nurses station at night if agitated and trying to get out of bed.

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Mrs. P's Post-Fall Assessment

Step 6 Develop a Plan of Care: Potential interventions:

- Close observation with increased supervision
- Frequent orientation to room, bathroom and facility
- Medication review
- Use of safe footwear
- Staff assistance to toilet or use of bedside commode
- Evaluation of side rail safety versus use of enabler
- Behavior management strategies to address confusion, agitation,, restlessness and unsafe behaviors, i.e. calm approach, simplify the environment, use distraction when appropriate, and provide comfort measures
- Talk with family to learn about Mrs. P's home environment, culture, spirituality and work experience
- Identify activities of interest

Step 7 Monitor Implementation:

- Nurse to communicate to CNA's interventions placed status post-fall
- Nurse to monitor interventions in place and effectiveness of interventions
- Approaches to be modified to reflect changes in resident condition

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CARE PLANNING

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THE 5 P'S OF FALL PREVENTION

Pain—is your resident experiencing pain?

Personal needs—does your resident need assistance with personal care?

Position—is your resident in a comfortable position?

Placement—are all your resident's essential items within reach?

Prevent falls—always provide person-centered care

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Care Plan Example

- Traditional

  Problem: Resident has a hx of falling d/t/weakness and unsteady gate

  Goal: Resident will remain free from falls for the next 90 days

- Person-Centered

Jim has a history of falling late in the afternoon. He walks all throughout the day with his walker. Jim has early stages of dementia and gets restless. Walking helps him relieve anxiety; however, by the end of the day he is tired.

Staff will be available to walk with Jim and engage him, particularly as he tires, using poetry gait rhythm method that encourages rest stops. Jim's goal will be to reduce the number of episodes and risk of injury from falling while improving his quality of life through meaningful engagement.

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Care Plan Example

- Bill has experienced impaired physical mobility due to ongoing weakness to his right lower extremity caused by a CVA in 2019. He currently utilizes a walker but has a goal of advancing to a quad cane. He was recently hospitalized for pneumonia which has led to an overall weakened state putting him at risk for falls. Bill is admitted to Mary Hall for short term rehab.

- Bill's goal during his short stay is to improve his stamina to his prior level of function or better while reducing the potential risk of falling. Staff will encourage Bill to request assistance as needed with transfers and ambulation while working with therapy. He will continue to ambulate utilizing his walker. His current medication regimen includes Losartan/HCTZ daily. Bill will notify staff if he experiences dizziness or lightheadedness. Staff will monitor Bill's vital signs and report any abnormalities to his PCP.

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Care Plan

- Mr. Daniels has dementia, is unsteady on his feet and has fallen three times in the past month. He has a limited ability to communicate his needs to staff. He currently receives Aricept 10mg daily.
- The goal for Mr. Daniel is to reduce the likelihood of falls while maintaining his dignity and independence through the next review.
- Staff have tried several interventions, but he continues to fall. Staff are unable to determine why he is falling.

Possible interventions:

- Monitor for potential medication side effect, i.e. lightheadedness, nausea, vomiting, diarrhea. Los of appetite, insomnia or tiredness
- Look for patterns in the time of day, location of the falls and possible activity resident was attempting (toileting need, self transfer, looking for his room)
- Communicate with the family, inquiring about past routines, occupation and hobbies
  - After talking with the family, staff learned that Mr. Daniels had a grandparent who fell out of a recliner. A week ago, staff moved a recliner into Mr. Daniel's room and that is when he began falling. Any time someone tried to sit in the recliner, Mr. Daniels became anxious. Without family input, staff would not be aware of the recliner incident.

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Tools for a Successful Fall Prevention Program

FACILITY ASSESSMENT

INTERACT FALL CARE PATH & STOP AND WATCH TOOL

CMS CRITICAL ELEMENT PATHWAYS

HSAG QM TIP SHEETS

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Facility Assessment: Care & Competencies

Staff competencies and annual training requirements per regulatory authority and/or facility policy:

- Abuse, Neglect, Exploitation, and Misappropriation
- Advance Directives
- Behavioral Health
- Communication
- Compliance and Ethics
- CPR
- Dementia Care Management
- Equipment and assistive device training
- Infection Control
- Other areas identified as areas of weakness during annual performance review competency evaluation
- Promoting resident's independence
- Quality Assurance and Performance Improvement
- Resident Rights including confidentiality of resident information, right to dignity, privacy, and property
- Safety and emergency procedures, including the Heimlich Maneuver
- Job responsibilities and lines of authority
- Emergency Preparedness
- Facility policies and procedures

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Interact Tools

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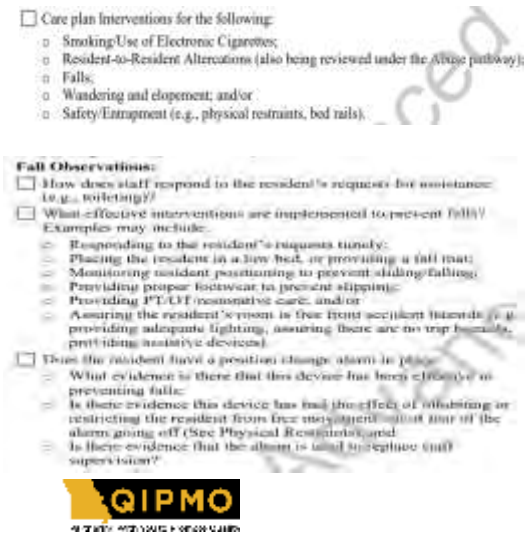
CMS 20127 Accidents CEP



- Care plan interventions for the following:
  - Smoking/Use of Electronic Cigarettes;
  - Resident-to-Resident Altercations (also being reviewed under the Abuse pathway);
  - Falls;
  - Wandering and elopement; and/or
  - Safety/Entrapment (e.g., physical restraints, bed rails).

Fall Observations:

- How does staff respond to the resident's requests for assistance (e.g., toileting)?
- What effective interventions are implemented to prevent falls? Examples may include:
  - Responding to the resident's requests timely;
  - Placing the resident in a low bed, or providing a fall mat;
  - Monitoring resident positioning to prevent sliding/falling;
  - Providing proper footwear to prevent slipping;
  - Providing PT/OT restorative care; and/or
  - Assuring the resident's room is free from accident hazards (e.g., providing adequate lighting, assuring there are no trip hazards, participating assistive devices).
- Does the resident have a position change alarm in place?
  - What evidence is there that this device has been effective in preventing falls?
  - Is there evidence this device has had the effect of inhibiting or restricting the resident from free movement other than the alarm going off (See Physical Restraints); and
  - Is there evidence that the alarm is used to replace staff supervision?

- Assistive Devices/Equipment Hazards
  - Are assistive devices (e.g., canes, standard and rolling walkers, manual or on-powered wheelchairs and powered wheelchairs) in good repair, safe based on the resident condition, personally fit for the resident, maintained in good repair, and safe staff practices?
  - Are assistive devices for transfer (e.g., mechanical lifts, sit to stand devices, transfer or gait belts) are based on the resident condition and maintained in good repair?

Record Review:

- Review nursing notes, therapy notes, and IDT notes. Has the resident's accident risk been assessed (e.g., fall risk, elopement risk, or safe smoking assessment)?
- Were the underlying risk factors identified?
- Has the resident had any accidents since admission?
- Were preventative measures documented prior to an accident:
  - Was the accident a result of an order not being followed? A care intervention not being addressed? A care-planned intervention not implemented?

Based on a review of the most recent MDS Assessment (J1900), if the resident had a fall(s), is the MDS coded accurately for falls in each category (no injury, injury except major, major injury)?

If concerns are identified, review facility policies and procedures with regard to accidents.

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Additional CEPs to Consider

- **20080** Specialized Rehabilitative or Restorative Services CEP: Use this pathway for a resident to ensure the facility obtains and provides necessary rehabilitative or restorative services. It includes the use of assistive devices. Surveyor to review to ensure resident receives necessary rehab or restorative services
- **20066** Activities of Daily Living (ADL) CEP: Use this pathway for a resident who requires assistance with or is unable to perform ADLs. Care plan (e.g., ADL assistance, specific care interventions staff will provide, premedication prior to ADLs, environmental approaches and devices used to maximize independence, therapy interventions, or restorative approach).
- **20120** Positioning, Mobility and Range of Motion (ROM) CEP: Use this pathway for a resident with concerns related to ROM, mobility, and/or positioning.
- **20125** Bowel and Bladder Incontinence CEP: Use this pathway for a resident identified with concerns related to bladder or bowel incontinence. Whether environmental accommodations have been made to promote continence, such as providing adaptive equipment or devices, based on resident identified needs, such as elevated toilet seats, grab bars, urinals, bedpans, or commodes; and assuring adequate lighting and assistance as needed to use devices such as urinals, bedpans and commodes.

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SUGGESTED RESIDENT INTERVENTIONS TO MANAGE FALLS

FALL FROM BED

Resident Able to Transfer

- ❑ Make sure bed is locked and in lowest position
- ❑ Provide a night light
- ❑ Clear path to the bathroom—no obstacles
- ❑ Call light within reach and secured
- ❑ Toilet schedule
- ❑ Footwear to prevent slipping (ex. Socks with grippers)
- ❑ Placement of assistive devices (within reach but not an obstacle)
- ❑ Assessment for ½ rails for mobility
- ❑ Assess for need for pain medications
- ❑ Offer fluids and snacks between meals at HS

Resident Unable to Transfer Self:

- ❑ Bedside table with needed items within reach
- ❑ Contour mattress
- ❑ Body pillows for positioning
- ❑ Assessment for ½ rails
- ❑ Bed alarm to alert staff to position changes
- ❑ Toileting schedule
- ❑ Assess for need for pain medications
- ❑ Mat beside bed
- ❑ Offer fluids and snacks between meals, HS
- ❑ Chair alarms to alert staff to position changes

FALL OUT OF WHEEL CHAIR

Assess reason for fall in order to choose appropriate intervention—ex. Reaching, attempting transfer or standing, leaning too far forward, sliding out of chair, etc.

- ❑ Assess for pain
- ❑ Keep wheelchair unlocked if the resident has a need to move
- ❑ Rocking chair
- ❑ Activity programming—exercises, TV programs
- ❑ Offer snacks, fluids between meals
- ❑ Toileting schedule
- ❑ Chair alarms to alert staff to change of position
- ❑ Seat chair alarm if resident disables other alarms
- ❑ Chair alarms with appropriate length cord to cue resident as to how far they can safely reach
- ❑ Restorative programming
- ❑ Assess that wheel chair is of appropriate size, assess need for footrests; assess for need to have a wheelchair locked/unlocked for safety
- ❑ Drop seat in wheelchair if necessary
- ❑ Assess for anxiety/behaviors—involve Social Services for interventions

FALLS WITH COGNITIVELY IMPAIRED RESIDENTS

- ❑ Toileting programs, schedule
- ❑ Ask families to make an activity basket, memory book, photo albums
- ❑ Restorative programs—exercises, ambulation
- ❑ Appropriate footwear
- ❑ Alarms (chair, bed) – to alert staff to changes of position

SUGGESTED RESIDENT INTERVENTIONS TO MANAGE FALLS (continued)

FALLS FOR AMBULATORY RESIDENTS

- ❑ Monitor, remind resident appropriate use of assistive devices
- ❑ Appropriate footwear
- ❑ All shoes worn should be slip resistant with tread on the bottom
- ❑ Shoes should be firm and have low, even heels
- ❑ Avoid thick soled shoes and those with a negative heel (e.g. running shoes or earth shoes)
- ❑ Shoes should not be too large or too small and socks should always be worn
- ❑ Refer to podiatrist for podiatry problems
- ❑ Use gripper socks when shoes cannot be worn
- ❑ Give proper foot care and frequent assessment
- ❑ Observe residents walking in their shoes and assess for difficulties
- ❑ Remind, monitor residents ability to maneuver change in flooring *ex. Carpet to tile)

RESIDENTS WITH MULTIPLE FALLS

- ❑ Trending of falls for the individual—time of day, reason for fall, location of fall, etc.
- ❑ Consider room change to move resident closer to the nurses station
- ❑ Keep resident in view during high risk times if possible
- ❑ Refer to therapy
- ❑ Discuss at stand up, grand rounds, with interdisciplinary team
- ❑ Restorative programs—ambulation
- ❑ Have staff member from each shift come up with individual interventions for residents with frequent falls
- ❑ Have family / friends visit at high risk times as “partners in caring”
- ❑ Discuss reason for falls with direct care givers
- ❑ Communicate planned interventions to all associates
- ❑ Routine monitoring for implementation of interventions
- ❑ Involve Recreation for activity interventions:
  - Tai Chi/Exercise/Movement groups fro frequent fallers.
  - Falls Focus Exercise Group with emphasis on challenging the “movement” causing the fall ie “ reaching”
  - Favorite TV programs, radio shows for high-risk times
  - Hydration group—activity during risk times.
  - Resident specific Activity “Bag of Tricks” for staff to use
  - Activities scheduled for residents at their high risk times
- ❑ Assess medical condition/medication as possible causal factors:
  - Examples:
  - Pain Management with consideration of pain assessment for cognitively impaired
  - Blood sugar fluctuations
  - Blood pressure fluctuations, orthostatic
  - UTI or other infection process
  - Timing of medications in relation to falls
- ❑ Assess for need for restraint—least restrictive
- ❑ Evaluate need for high/low bed

Quality Measure Tip Sheet:
Falls With Major Injury—Long Stay

Quality Measure Overview

- This measure is a look-back scans measure. If the resident had one or more falls with a major injury on one or more of the look-back scan assessments, it will trigger the measure.
- Measure triggers if the event/condition occurred any time during a one-year period.
- Fall history is obtained with a look-back of up to six months prior to admission.

Exclusions:

- The occurrence of fall was not assessed.
- The assessment indicates that a fall occurred and that the number of falls with major injury was not assessed.

MDS Coding Requirements

In the Minimum Data Set (MDS):

- Include fall history on admission/entry or re-entry.
- Include number of falls since admission/entry, re-entry, or prior assessment (Omnibus Reconciliation Act [OBRA] or scheduled Medicare Prospective Payment System assessment)—whichever is more recent.
- Indicate major injuries for:
  - Bone fractures.
  - Joint dislocations.
  - Closed head injuries with altered consciousness.
  - Subdural hematoma.

Ask These Questions...

- Was the MDS coded as per the Resident Assessment Instrument requirements?
- Was a fall risk assessment completed on admission, quarterly, and with changes to identify appropriate risk?
- Was a process in place to initiate a fall event to initiate preventive measures?
- Were preventive measures communicated to direct-care staff members?
- Are interventions monitored for placement and function?
- Are gait belts accessible for transfers?
- Do the nurses demonstrate competence for assessing fall risk?
- Are the direct-care staff members proficient in transfers and mobility functions?
- Are fall precautions taken if the resident is on anticoagulants, antidepressants, antipsychotics, antihypertensives, antiparkinson agents, benzodiazepines, diuretics, neuroleptics, anti-inflammatory agents, psychotropics, vasodilators, laxatives, glycemic medications, tranquilizers, or hypotonics/sedatives?
- Are vision issues addressed?
- Is appropriate footwear used?
- Is the resident appropriately positioned?
- Are pain and comfort issues addressed?
- Are rest periods provided?
- Are activity programs individualized for the resident to meet his or her needs/preferences?
- Is continence managed?

FALLS WITH MAJOR INJURY

Was a Fall Risk assessment completed to identify risk?

Was a process in place to initiate prevention measures?

Were prevention measures communicated to staff?

Are gait belts accessible for transfers?

Are direct care staff proficient in transfers and mobility functions?

Are vision issues addressed?

Is appropriate footwear used?

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Quality Measure Tip Sheet:
Activities of Daily Living—Long Stay

★★★★★ The measure is used in the 5-star quality rating system.

Quality Measure Overview

- This measure reports the percentage of residents whose need for help with late-loss activities of daily living (ADLs) has increased when compared to the prior assessment.
- Long-stay residents with selected target and prior assessment assessments that indicate the need for help with late-loss ADLs has increased when the selected assessments are compared.
  - An increase is defined as an increase in two or more coding points in one late-loss ADL item or one point increase in coding points in two or more late-loss ADL items. Note that for each of these two ADL items, if the value is equal to 7 (7.0) on either the target or prior assessment, then recode the item to equal 8 (8) to allow appropriate comparison.
- This measure involves four late-loss ADLs:
  - Bed mobility
  - Eating
  - Transferring
  - Toileting

Inclusions:

- All four late-loss ADL items indicate total dependence on the prior assessment (4, 7, 8 coded).
- Three of the late-loss ADLs indicate total dependence on the prior assessment, and the fourth late-loss ADL indicates extensive assistance.
- Resident is comatose.
- Prognosis of life expectancy is less than six months.
- Hospice care is employed.
- Resident is not in the numerator and bed mobility or transferring, walking, or traveling level is 1.

MDS Coding Requirements

Refer to Section G

In the Minimum Data Set (MDS):

- Include look-back period of seven days.
- Code assist or resident's level of assistance when using adaptive devices such as a walker, a device to assist with donning socks, a dressing stick, a reacher, or assistive eating utensils.
- Capture the total picture of the resident's ADL performance 24 hours a day for the entire seven-day period.
- Indicate if the activity occurred three or more times within the seven-day period, using the ADL Self-Performance Algorithm (see the Resident Assessment Instrument [RAI], page G-8).

Consider These Questions ...

- Was the MDS coded per RAI requirements?
- Is the staff member's coding documentation accurate?
- Is the MDS designee conducting [illegible] observation of care and staff member interviews to determine accuracy of documentation?
- Has baseline function been determined?
- Has the root cause for the decline been determined and treated?
- Has the resident been referred to therapy for treatment?
- Are underlying health conditions that may be affecting ADL performance being treated?
- Is pain/depression managed?
- Is the resident receiving appropriate assistance from

ADLS

Has a baseline function been determined?

Has the root cause for the decline been determined and treated?

Has the resident been referred to therapy for treatment?

Have restorative programs been initiated to rehabilitate or maintain the resident's ADL performance?

Does evidence exist of the delivery of services for residents on a restorative program?

Is the resident receiving appropriate assistance from staff members?

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Quality Measure Tip Sheet: Falls With Major Injury—Long Stay

★★★★★ *This measure is used in the 5-star quality rating system*

Quality Measure Overview

- This measure is a **look-back scans** measure. If the resident had one or more falls with a major injury on one or more of the look-back scan assessments, it will trigger the measure.
- Measure triggers if the event/condition occurred any time during a **one-year period or look back period**.
- Fall history is obtained with a look-back **up to six months (180 days) prior to admission looking back from re-entry date**.

Exclusions:

- The occurrence of fall was not assessed.
- The assessment indicates that a fall occurred and that the number of falls with major injury was not assessed.

MDS Coding Requirements

In the Minimum Data Set (MDS), refer to section J:

- Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or scheduled Prospective Payment System [PPS]) and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury.
- Coding instructions for J1900C, major injury
  - Code 0, none: if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or scheduled PPS)
  - Code 1, one: if the resident has one major injurious fall since admission/entry or reentry or prior assessment (OBRA or scheduled PPS)
  - Code 3, two or more: if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment (OBRA or scheduled PPS)
- Indicate major injuries for:
  - Bone fractures.
  - Joint dislocations.
  - Closed head injuries with altered consciousness.
  - Subdural hematoma.

Consider These Questions...

- Was the MDS coded as per the *Resident Assessment Instrument* requirements?
- Was a fall risk assessment completed on admission, quarterly, and with changes to identify appropriate risk?
- Was a process in place (based on fall score) to initiate preventive devices?
- Were preventive devices communicated to direct-care staff members?
- Are interventions monitored for placement and function?
- Are gait belts accessible for transfers?
- Do the nurses demonstrate competence for assessing fall risk?
- Are the direct-care staff members proficient in transfers and mobility functions?
- Are fall precautions taken if the resident is on anticoagulants, antidepressants, antiepileptics, antihypertensives, antiparkinson agents, benzodiazepines, diuretics, nonsteroidal anti-inflammatory agents, psychotropics, vasodilators, laxatives, glycemic medications, tranquilizers, or hypnotics/sedatives?
- Are vision issues addressed?
- Is appropriate footwear used?
- Is the resident appropriately positioned?
- Are pain and comfort issues addressed?
- Are rest periods provided?
- Are activity programs individualized for the resident to meet his or her needs/preferences?
- Is continence managed?

For guidance on quality measures, reach out to Health Services Advisory Group (HSAG).

In Arizona, contact:
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Updated based on MDS 3.0 Quality Measures User's Manual v12.0, January 2019.
Tip Sheet Revised Date April 2019

Quality Measure Tip Sheet: Activities of Daily Living—Long Stay

★★★★★ *This measure is used in the 5-star quality rating system*

Quality Measure Overview

- This measure reports the percentage of residents whose need for help with late-loss activities of daily living (ADLs) has increased when compared to the prior assessment.
- Long-stay residents with selected target and prior assessment assessments that indicate the need for help with late-loss ADLs has increased when the selected assessments are compared.
  - An increase is defined as an increase in two or more coding points in one late-loss ADL item or one point increase in coding points in two or more late-loss ADL items. Note that for each of these fours ADL items, if the value is equal to [7,8] on either the target or prior assessment, then recode the item to equal [4] to allow appropriate comparison.
- **This measure Involves four late-loss ADLs:**
  - Bed mobility
  - Eating
  - Transferring
  - Toileting

Exclusions:

- All four late-loss ADL items indicate total dependence on the prior assessment (4, 7, 8 coded).
- Three of the late-loss ADLs indicate total dependence on the prior assessment, and the fourth late-loss ADL indicates extensive assistance.
- Resident is comatose.
- Prognosis of life expectancy is less than six months.
- Hospice care is employed.
- Resident is not in the numerator and bed mobility or transferring, eating, or toileting equal [-].

MDS Coding Requirements

Refer to Section G

In the Minimum Data Set (MDS):

- Include look-back period of seven days.
- Code based on resident's level of assistance when using adaptive devices such as a walker, a device to assist with donning socks, a dressing stick, a reacher, or adaptive eating utensils.
- Capture the total picture of the resident's ADL performance 24 hours a day for the entire seven-day period.
- Indicate if the activity occurred three or more times within the seven-day period, using the ADL Self-Performance Algorithm (see the *Resident Assessment Instrument* [RAI], page G-8).

Consider These Questions ...

- Was the MDS coded per RAI requirements?
- Is the staff member's coding documentation accurate?
- Is the MDS designee completing self-observation of care and staff member interviews to determine accuracy of documentation?
- Has baseline function been determined?
- Has the root cause for the decline been determined and treated?
- Has the resident been referred to therapy for treatment?
- Are underlying health conditions that may be affecting ADL performance being treated?
- Have restorative programs been initiated to rehabilitate or maintain the resident's ADL performance?
- Does the evidence exist of the delivery of services for residents on a restorative program?

- Is pain/depression managed?
- Is the resident receiving appropriate assistance from staff members?
- Are activity pursuits appropriate?
- Is adaptive equipment available, as needed, to assist the resident?

For guidance on quality measures, reach out to Health Services Advisory Group (HSAG).

In Arizona, contact:
aznursinghome@hsag.com

In California, contact:
canursinghomes@hsag.com

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Updated based on MDS 3.0 Quality Measures User's Manual v12.0, January 2019. Tip Sheet Revised Date May 2019

Fall Interventions

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Survey Citations F689

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EXAMPLE #1

- Per SOD: Facility failed to ensure adequate fall interventions were put in place to prevent accidents for bed bound resident who had falls from the bed. "D" level citation
- Progress notes:
  - "Found on the floor on left side"
  - "Found on floor on right side, appeared to have rolled out of bed." pillow for positioning
  - "Found on floor in prone position, resident stated "slid off bed
- Staff interviews: "Recent falls but not a fall risk"
- Facility P/P included:
  - fall definitions
  - standardized risk assessment
  - low/moderate/high risk protocols with interventions
  - resident risk factors and hazards evaluated for care plan development

Care Plan

- Focus: At risk for falls due to gait/balance problem
- Goal: Free of falls through the next review date
- Interventions:
  - Staff will anticipate and meet the resident's needs
  - Make sure the resident's call light is within reach and encourage the resident to use it for assistance as needed
  - Give prompt response to all requests for assistance
  - Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs
  - Follow facility fall protocol, review information on past falls and attempt to determine cause of falls, record possible root causes and alter remove any potential causes if possible

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EXAMPLE #2

- Per SOD: The facility failed to follow their policy when staff failed to ensure fall interventions were in place for 1 resident. "E" level citation
- Progress notes: Multiple entries of resident lying in bed and no fall mat on the floor
- Staff interviews: "Did not know resident needed a floor mat"
- Facility P/P for Fall Management Guidelines included:
  - Schedule for completing Fall risk assessment
  - Fall Event requirements
  - IDT review with modification of the resident's care plan, review of the incident report with follow up for completion

Care Plan

- Focus: At risk for falls as evidenced by cognition. Unaware of safety needs, deconditioning, disease processes.
- Goal: Fall related injuries will be minimized through review date
- Interventions included:
  - Anticipate and meet needs
  - Provide education and reminders to call for assistance as needed
  - Educate and provide supervision/reminders to wear appropriate, non-slip footwear
  - Fall intervention (date): found on the floor next to his/her bed, staff instructed to have fall mat on his/her floor and with him/her bed to low position.
  - Place call light within reach while in room.

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EXAMPLE #3

- Per SOD: Facility staff failed to ensure the safety of all residents when staff failed to ensure they followed proper standards of practice, facility policy, and the resident's care plan when one aide attempted to transfer one resident with no assistance. This resulted in the resident falling, sustaining a fracture. "G" level citation
- Progress notes: Show the CNA placed the lift pad under resident after dressing, hooked the straps to the lift. After raising the resident of the bed, the lift made a noise and the resident roll down and out, hitting the floor with the lower half of his/her body, sustaining a fracture.
- Staff interviews:
  - CNA had been trained to use 2 people with the lift.
  - NA stated she had not been trained upon hire but had watched videos and learned in CNA training that 2 staff were required to operate the lift.
  - Multiple other staff interviews acknowledged 2 persons required for lift use.

- Facility P/P included:
  - Requirements for 2 staff to utilized the left
  - Directions for sling placement under the resident

Care Plan:

- Resident required a Hoyer lift for transfers
- Resident required the assist of two staff with Hoyer lift transfers.

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RESOURCES

- www.cms.gov State Operations Manual Appendix PP, Critical Element Pathways 20127, 20080, 20120, 20066 & 20125, RAI User Manual Version 3.0
- https://www.cdc.gov/falls CDC toolkit and resources
- www.hsag.com HSAG Field Guide: Falls QM Tip Sheets
- www.briggshealthcare.com Fall Risk Evaluation CFS6-17P 9/2020
- www.nursinghomehelp.org Facility Assessment, Post-fall Huddle Guidelines
- https://pathway-interact.com Fall Care Path, Stop and Watch
- https://qcor.cms.gov
- https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/injuries/fallspx.html
- Falls: From Preadmission to Discharge: Melody Schrock RN, BSN, RAC-CT QIPMO Clinical Educator

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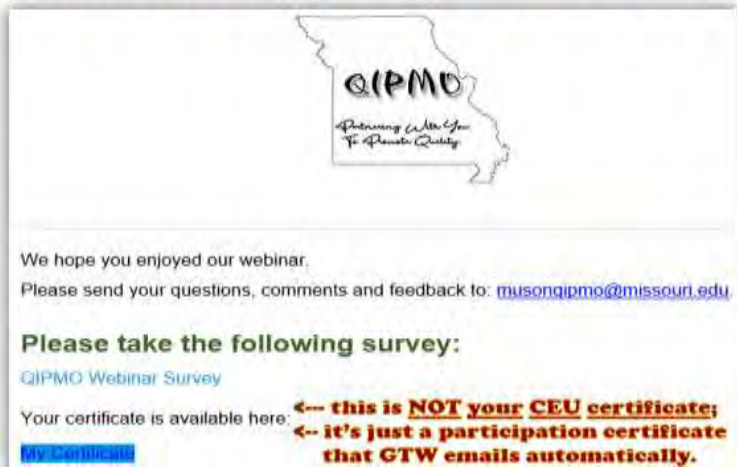
SAMPLE EMAIL FROM GOTOWEBINAR



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IN ORDER FOR MO LNHAS TO GET CREDIT:

- It is REQUIRED that you complete a brief survey/evaluation via:
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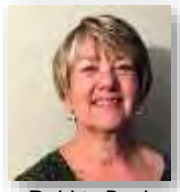

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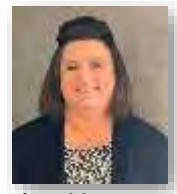

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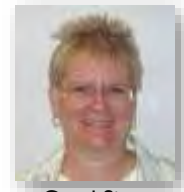

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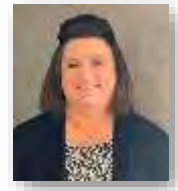

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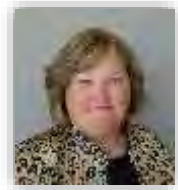

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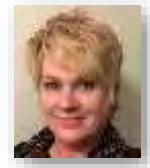

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