MDS Alert

Falls: How Your Section D Assessment May Impact Falls

Employ 'post-fall huddle' technique to determine the root cause of falls.

Falls, especially those with major injuries, top the list of key issues in the MDS-Focused Surveys. But could your resident mood interview for the MDS play an integral role in detecting fall risk or even preventing falls altogether? Some experts think so.

What's more: "Fall prevention has clear clinical importance and organizational relevance in that adverse falls (i.e., falls that trigger emergent care) is one of Medicare's quality indicators and is associated with increased costs," according to the **Oklahoma State Department of Health** (ODH) Quality Improvement & Evaluation Service. "Including timely identification of patients at high risk for falls, as well as modifiable risk factors in the fall risk assessments is important."

Can Depression Increase Risk for Falls?

Depression has been linked to increased risk for falls in the elderly, although the reason depression increases fall risk is yet unknown. And depression is often under-recognized and undertreated in older adults, ODH noted. Many studies have indicated a link between depression and falls, but the studies don't agree on whether depression contributes to an increased risk for falls, or if patients who fall are at a greater risk for depression.

Example: A 2013 clinical review published in the American Journal of Geriatric Psychiatry (www.ncbi.nlm.nih.gov/pubmed/23570891) confirmed that depression and falls have "a significant biodirectional relationship" in older adults. Researchers discovered that excessive fear of falling, which is frequently associated with depression, also increases the risk of falls.

This is because both depression and fear of falling are linked with gait and balance impairment, according to the study. But managing depression in fall-prone older adults is challenging, because antidepressant medications can actually increase fall risk and fragility fractures.

Nevertheless, the link is clear, and "continuing depression screening in conjunction with fall risk screening tools may help identify more individuals at risk for falls," ODH suggested.

The primary area of the MDS where you can screen for depression is in Section D Mood, specifically in Item D0200 Resident Mood Interview (PHQ-9©). You must attempt the resident mood interview with all residents who are able to make themselves understood at least some of the time.

Heed Expert Tips for Conducting the Resident Interview

Conducting the resident mood interview isn't always easy, especially if the resident has difficulty communicating or simply doesn't want to talk about his feelings. Make sure the resident can see and hear you clearly, and be sure that you conduct the interview in a quiet, private setting, advised **Shirley Boltz, RN**, RAI/Education Coordinator for the **Kansas Department for Aging and Disability Services** (KDADS), in a Jan. 14 educational session.

Remember: Item D0200 has a 14-day lookback period that may include the preadmission period for newer residents, Boltz noted. You should conduct the interview preferably the day before or the day of the Assessment Reference Date

(ARD) for accurate, timely coding of answers.

Here are some essential tips and techniques to complete the resident interview for D0200:

- **Start by explaining the reason.** Begin by explaining the reason for the interview, Boltz advised. For instance: "I am going to ask you some questions about your mood and feelings over the past two weeks. I will also ask you about some common problems that are known to go along with feeling down. These questions may seem personal, but everyone is asked to answer them, and your answers will help us to provide you with better care."
- **Ask and show cue cards.** You should both ask the resident the interview questions verbally and show him the cue cards at the same time, Boltz said. Explain to the resident: "I am going to ask you how often you have been bothered by a particular problem over the last two weeks. I will give you the choices you see on this card."
- **Read the questions as written.** Don't provide definitions or explanations of the questions; simply read the interview questions as they're written, Boltz advised. Also, ask each question in order (for both "Presence" in Column 1 and "Frequency" in Column 2) before going to the next question.
- **Repeat the question.** If you think that the resident misunderstood, misinterpreted, or didn't hear the question, make sure you repeat it.
- **Don't let the resident go astray.** Some residents are chattier than others and may be eager to talk with you, but may have trouble staying on the topic at hand, ODH noted. When the resident strays from the interview question, you should gently guide the conversation back to the topic.
- **Use this strategy to elicit a response.** If the resident is struggling with selecting a frequency response, offer a single frequency response and follow with a sequence of more specific questions, ODH advised. This technique is called "unfolding."
- **Select only one frequency response.** Remember that the resident must choose a single response to each item, according to Boltz. If the resident has difficulty choosing between two frequencies or chooses different frequencies based on more than one phrase contained in the item, select the highest frequency that the resident noted.
- **Explore noncommittal responses further.** You should explore any noncommittal responses like "not really," ODH recommended. If the resident seems reluctant to report symptoms, gently probe by asking neutral or nondirective questions, such as:

    - "What do you mean?"
    - "Tell me what you have in mind."
    - "Tell me more about that."
    - "Please be more specific."
    - "Give me an example."

Summarize long answers. If a resident gives you a long, detailed answer to an interview item, use the "echoing" technique summarize the resident's longer answer, and then ask him which response option best applies.

Break down longer questions. If the resident struggles with longer interview items, separate the item into shorter parts and provide a chance for the resident to respond after each part, ODH suggested. This technique of "disentangling" is especially helpful for residents who have moderate cognitive impairment but can still respond to simple, direct questions.

Allow the resident to respond any way. Keep in mind that the resident may respond to questions verbally, by pointing to answers on the cue cards, or by writing out answers, or any combination of these methods.

Consider a 'Post-Fall Huddle'

In the event of a fall, many acute care settings have a practice of conducting a "post-fall huddle." This is "a brief meeting occurring immediately after a fall that includes staff caring for the resident and the resident himself/herself (if applicable)," noted **Katy Nguyen, MSN, RN**, QIPMO Educator with the **University of Missouri Health System** Sinclair School of Nursing in a recent tutorial.

"The purpose of this practice is to guide critical thinking about the event of the fall to discover the root cause of the

incident," Nguyen explained. "During this process, the team comes together immediately after the fall to observe, assess, and create or revise a fall-prevention plan." (For a sample post-fall huddle worksheet, see "Use This Handy Worksheet For Your 'Post-Fall Huddle'" on page 18.)

If you want to form a post-fall huddle team as part of your fall prevention program, Nguyen offered the following elements to consider in forming a team and effectively conducting a post-fall huddle:

- **Pick a leader.** Every huddle team should have a leader, preferable a registered nurse, who can lead the team to conduct a root cause investigative analysis and perform further assessment to determine the cause of the fall.
- **Train the team.** The team needs training on how and where to hold the huddle, who will be the designated facilitator during the huddle procedure, and what form or documentation the team will use. The team also needs training on observation, screening, and assessment skills, including how to avoid negative behaviors like blaming, finger-pointing and overt criticism when analyzing the problem.
- **Aim for a rapid response.** The post-fall huddle should take place no more than 15 minutes after the fall. The timing is important because you want the events of the fall to be fresh in the minds of the resident, nursing staff, and anyone who may have witnessed the fall and can help determine the cause. (Of course, any need for emergency care would precede the post-fall huddle.)
- **Determine the cause.** If possible, ask the resident about what caused the fall. Then, the huddle team should decide on the type of fall, whether the fall was avoidable, and if other intrinsic or extrinsic factors contributed to the fall, such as environmental objects or medication changes.
- **Document and develop interventions.** The huddle team should document the incident and begin to develop interventions for future fall prevention. If necessary, the team leader may consult with other healthcare professionals and the resident's family members to revise the care plan.

Follow up. The interdisciplinary team should provide crucial follow-up care to ensure staff are carrying out the care plan and implementing the interventions.