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MDS Alert

SPECIAL FOCUS: Fall Prevention And Management--4 Rules Will Help Ensure Your Fall Prevention And Management Program Measures Up

This simple plan will keep you out of F323 land.

With the tougher F323 tag now in effect, you'll want to pull out all the stops to identify and address residents' risks for falling.

Rule No. 1: Your care plan is only as effective as the interdisciplinary team's fall risk assessment. And "you don't want to rely just on the usual fall risk assessment forms," advised **Jacqueline Vance, RN**, in a presentation on falls at the most recent **American Association of Homes & Services for the Aging** conference in San Francisco. In doing expert witness work for nursing facility defense, Vance finds that when nursing facilities overly rely on their usual fall risk assessment forms, they tend to "lock themselves in a box." You have to go beyond that and "play detective," emphasized Vance, director of clinical affairs with the **American Medical Directors Association.**

For example, a fear of falling can be a self-fulfilling prophecy. If the patient had a previous fall, he may limit his mobility so that he becomes deconditioned, increasing his fall risk, Vance pointed out.

"People who develop a fear of falling start to deport themselves differently ... they don't walk exactly in their normal way," which can increase their fall risk, added **Alva "Buzz" Baker, MD**, president of AMDA, who co-presented with Vance.

Other conditions associated with falls that you might check to see are on your fall assessment form include, according to Vance:

• Arthritis
• Any ADL impairment at all
• History of previous falls within the last 90 days
• Period of immobility during the pre-admission hospitalization due to pneumonia, as one example
• Cardiac arrhythmias
• Delirium
• Urinary and fecal urgency that causes the person to rush to the bathroom
• Ill-fitting footwear or ones that don't provide adequate traction
• Need for assistive devices, including the "furniture holders" when they cross the room
• Multiple medications--and not just those that cause orthostatic hypotension, said Vance.

Keep in mind: Even mild cognitive impairment or short-term memory loss can cause a resident to forget to get up slowly or to call for assistance, even if there is a sign reminding him to do that, Baker noted in his talk.

Rule No. 2: Devise an individualized care plan to address the identified risks. Leap into the creative realm with interventions that a resident enjoys. There's been some "interesting work" suggesting that performing Tai Chi and ballet movements to music can help improve a person's balance, Baker noted.

You can also individualize a resident's environment as part of the care plan. If a facility is doing that, "you'd expect to see different-height beds" in the facility "and use of transfer poles in some cases," observes physical therapist and consultant **Katy O'Connor**, with **Zimmet Healthcare Services Group** in Morganville, NJ. "Some residents do better with a low bed, whereas an occasional resident may need the bed to be higher for him to safely get out of bed."

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Stop the beeping: Consultant **Lynda Mathis, RN**, says a bed or chair alarm is the next-to-the-last intervention she'd recommend. The noise of alarms going off tends to upset the resident and those around her, notes Mathis, lead clinical consultant for **LTC Systems** in Conway, AR. And "when a facility has too many alarms in use, staff often spend crucial time locating the specific elder at risk before a negative outcome occurs."

Rule No. 3: Keep the care plan and staff interventions current, advises **Nancy Augustine, RN, MSN**, senior consultant with **LTCQ Inc**. in Lexington, MA. Suppose you coded a resident as requiring ADL supervision on the most recent MDS, which was accurate during the lookback period of the assessment, Augustine says. But now the resident is independent. "In that case, the care plan needs to ... reflect that change in ADL status." Otherwise, the facility is going to have a survey and liability problem if the resident falls when independently using an assistive device, such as a walker, Augustine cautions.

Stay on top of sig change assessments: Consultant **Bet Ellis, RN**, notes that the team may change the care plan without doing a significant change in status assessment.

"But if the resident has had a significant improvement or decline in two or more ADLs, the team should carefully evaluate whether to do an SCSA, which involves working the RAPs and care planning," says Ellis,a consultant with **LarsonAllen** in Charlotte, NC.

Rule No. 4: Get on the case immediately after a fall. Oak Grove Rehab and Skilled Care has a team comprised of nurses, maintenance, housekeeping and dietary staff go to the fall site when the fall happens, reports **Tamar Abell, MA, CCC-SLP, LNHA**, with the facility in Carbondale, IL. "We all work together to do a root-cause analysis."

Go beyond the RAPs: The resident assessment protocols can sometimes "provide clues" about the possible causes of a fall, Vance said. But in her view, it's important not to rely solely on the MDS in analyzing falls for a specific individual.

At a minimum after a fall, ask the pharmacy consultant to review the patient's meds and to fax you a report identifying which ones lead to falls, Vance advised. Also, you can ask the resident to rise from a chair without using his arms, walk several paces and return to sitting, she suggested. If he shows some difficulty or unsteadiness, "you may want to take that further and not necessarily just with physical therapy," Vance suggested. She said facilities can get caught up in thinking they just need PT, OT or restorative nursing to address falls.

But if the cause of a fall is not clear--or a person continues to fall despite interventions--ask the physician or physician extender to examine the person for an underlying medical cause, Vance urged.

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