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OASIS Alert

Item Focus: M1910: Know Your Tools for Identifying Falls Risk

Avoid making this common fall risk assessment error.

Before you can choose an accurate response for M1910 — Has this patient had a multi-factor Fall Risk Assessment? — you'll need to make certain you have a solid understanding of the requirements for this item. Master the ins and outs of this publicly reported process measure question to avoid future scrutiny, even if your agency's scores look good.

Establish the Basics

OASIS item M1910 asks you to indicate whether you conducted a multi-factor fall risk assessment with your patient.

Your response options for M1910 are:

0 — No multi-factor falls risk assessment conducted;
1 — Yes, and it does not indicate a risk for falls; or
2 — Yes, and it indicates a risk for falls.

Timepoints: You'll complete M1910 at start of care and resumption of care.

Know What Constitutes Multi-Factor

The **Centers for Medicare & Medicaid Services** requires you to use a multi-factor falls risk assessment tool in order to select a "Yes" response for this item. That means one component of the assessment must be a standardized, validated fall risk assessment tool. It's up to your agency to determine whether any particular tool meets this requirement.

According to the CMS OASIS Q&As, the tool must:

- Have undergone scientific tests and validation for a population with characteristics similar to that of the patient you are assessing;
- Have been shown to be effective in identifying people at risk for falls;
- Include a standardized response scale; and
- Be appropriately administered based on established instructions.

Your falls risk assessment must also be multi-factorial — it should assess multiple factors that contribute to the risk of falling. To meet this requirement, you can either

- Use a single multi-factor, standardized, validated fall risk assessment tool; or
- Use a standardized, validated performance assessment combined with at least one other risk factor, such as fall history, polypharmacy, impaired vision, or incontinence.

Choose Your Tool

Making a decision about which tool or tools your agency will use in evaluating fall risk is challenging, says **Rhonda Will, RN, BS, COS-C, BCHH-C,** with Northampton, Mass.-based **Fazzi Associates**. And once you've selected a tool, it's important to make certain that staff knows how to use and score it properly based on the instructions provided by the tool's author.

For best results, everyone in the agency should conduct the assessment within the same parameters. Making sure everyone has the same understanding of how to use the tool is important in securing accurate data. For example, if your

agency uses the TUG, how is everyone marking 10 feet? And how are they timing the patient?

Bottom line: Ensure that everyone who will be administering the falls risk assessment understands the instructions and the scoring system.

Select the Best Response for Your Patient

You'll choose response "0 □ No multi-factor falls risk assessment conducted" in these three situations:

- The patient couldn't perform the tasks required by your assessment tool;
- The assessing clinician didn't conduct a multi-factor falls risk assessment; or
- The assessing clinician didn't conduct the multi-factor falls risk assessment within the required timeframe.

Choose response "1 □ Yes, and it does not indicate a risk for falls" if your patient scores as no-risk, low-risk, or minimal risk on your assessment tool's standardized response scale, CMS says.

Select response "2 □ Yes, and it indicates a risk for falls" if your patient rates as anything above low/minimal risk on your assessment tool's standardized response scale.

Pointer: And if the assessment tool doesn't provide various risk levels, but instead employs a single threshold that separates those "at risk" from those "not at risk", you'll select response "2" for patients scoring "at risk."

Take Note of this Important Scoring Distinction

One common misunderstanding about M1910 comes from agencies using a single-factor, validated assessment tool combined with another risk factor or non-validated tool to meet the CMS requirement of a multi-factor assessment, Will says. In these situations, the answer to M1910 should come from the results of the validated tool, not from the additional factor or non-validated tool, she explains.

In such cases, the answer to "M1910 should be Response 1 or Response 2, depending on whether or not risk was identified by the validated assessment tool," CMS says in the January 2013 OASIS Q&As.

If your agency uses more than one validated, standardized, multi-factor tool and the findings differ, CMS recommends erring on the side of safety. Report this patient as "at risk" for falls.

If your agency uses two validated tools □ a single-factor assessment tool and a multi-factor assessment tool □ base your M1910 response on the results of the multi-factor tool, CMS advises.

And when your validated, standardized, multi-factor assessment tool detects no fall risk, but some other factor such as patient history indicates the patient is at risk, answer M1910 with response 1 "no risk," CMS advises. But be sure to document any concerns in the clinical record and use your judgment about any appropriate falls interventions.