

AHRQ's Safety Program for Nursing Homes: On-Time Falls Prevention Training

Slide 1: Introduction to Falls Prevention Reports



SAY:

In this session we will introduce you to the On-Time Falls prevention electronic reports.



Slide 2: Falls Prevention Electronic Reports



SAY:

This section will cover each component of On-Time Falls Prevention, which includes four electronic reports. The electronic reports are:

- [Falls High-Risk Report](#).
- [Summary of Falls Risk Factors \(by Unit or Facility\)](#).
- [Contextual Factors Report \(by Unit or Facility\)](#).
- [Postfall Assessment Summary Report \(by Resident\)](#).



Slide 3: Teaching the Falls Prevention Electronic Reports



SAY:

This training will provide you with the information you need to teach the reports to the nursing home Change Team. The training will follow a similar approach to how you should present the reports to the nursing home team. We will work through four steps for each of the Falls Prevention Reports.

- **Step 1:** Review the purpose of the report.
- **Step 2:** Describe the content of the report.
- **Step 3:** Discuss the calculation details.

The facilitator needs to understand the sources of the data in each report, criteria for inclusion of residents in each report, and calculations that create the elements in the report. With this knowledge, the facilitator can answer questions that may arise about the content and accuracy of the reports.

Nursing home staff need to master enough details about the reports to be able to see the value of them, judge the accuracy of the reports, and use them to help make care plan decisions.

- **Step 4:** Use quizzes and exercises provided for each report to test participants' understanding.



Slide 4: Postfall Assessment Data Elements



SAY:

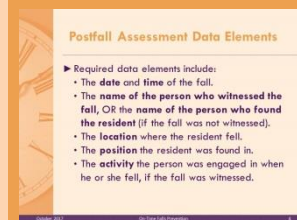
Because the creation of the On-Time Falls Prevention reports depends on the presence of standardized data elements being available in the electronic medical record (or EMR), a list of these required data elements is available in the specifications. The vendor has the option to display the question format or the field name or both.

No sample form accompanies the list of Postfall Assessment data elements as experience has shown that most EMR vendors have the required documentation elements already incorporated into their system and end users already have a preferred format to display the information.

Now let's begin by going over the required data elements.

To fully populate the On-Time Falls reports, the information that must be included in a Postfall Assessment includes:

- Fall date.
- Fall time.
- Whether the fall was witnessed.
 - If the fall was not witnessed, who found the resident and information regarding the last activity the resident was observed engaged in prior to the fall.
 - If the fall was witnessed, the activity the resident was engaged in at the time of the fall.
- Fall location.
- Position the resident was found in.



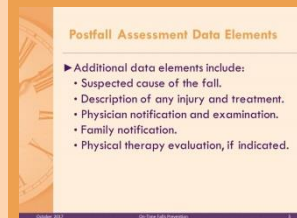
Slide 5: Postfall Assessment Data Elements



SAY:

To continue our list from the previous slide of required PostFall assessment data elements.

- Suspected potential causes of the fall,
- Other comments to describe the fall,
- Whether injury resulted from the fall and, if so, the type, site, and severity of the injury,
- Whether treatment was required for the fall,
- Physician notification and examination,
- Family notification, and
- Physical therapy evaluation postfall.



Slides 6: Postfall Assessment Data Elements



SAY:

Facility staff typically complete a fall assessment immediately after a resident fall; however, facility staff will work with their EMR vendor to determine exactly how and when these data elements are collected. Later in the program, we will discuss these a bit more when we discuss the Postfall Assessment Summary Report.



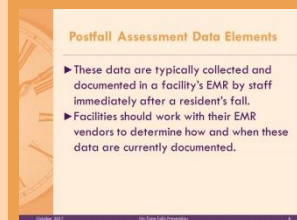
ASK:

Are there any questions regarding the required Postfall Assessment data elements?



DO:

Address any questions and clarify any issues before moving on to the next section.



Slide 7: Falls High-Risk Report



SAY:

Now let's begin by going over the Falls High-Risk Report. The Falls High-Risk Report provides a weekly snapshot of residents in a nursing home at highest risk for a fall. Only residents who meet criteria for high fall risk will display on the report.

Although all nursing home residents may be at risk of a fall, the Falls High-Risk Report will enable teams to be proactive and consistent in identifying residents at highest risk on a weekly basis and focus care planning efforts on residents with the most changes in the last week.

The report is designed to help clinicians see changes in resident status earlier and intervene earlier when risks increase. It focuses on the highest risk to prioritize residents most likely to fall.



Slide 8: Falls High-Risk Report



SAY:

To accomplish this goal, the Falls High-Risk Report displays the list of residents meeting criteria for highest risk for injurious fall; sorted by the number of changes in the last week, and for each resident included on the report, his or her risk criteria.

The report can help answer the following questions:

- How many residents triggered for highest risk for injurious fall?
- What are the most common risk factors?
- Which acute change was seen most often? Least often?
- How many residents at highest risk for injurious fall are cognitively impaired? Have no cognitive impairment?
- How many residents at highest risk had a change in status during the report week?



Slide 9: Falls High-Risk Report



SAY:

The Falls High-Risk Report displays the list of residents meeting criteria for highest risk for injurious fall; and for each resident listed, notes his or her risk criteria.

High-risk criteria were identified based on:

- A review of the literature,
- Fall elements and scoring from existing instruments, and
- Input from an advisory panel of leading experts and nursing home users.



Slide 10: Falls High-Risk Report



SAY:

High fall risk is determined by a combination of the following three components:

- **Existing conditions that are considered high risk;** referred to in *On-Time Falls Prevention* as high-risk existing conditions or HRECs. Resident existing conditions that determine risk are sourced in MDS [Minimum Data Set] assessments or postfall assessments.
- **Change of condition risk elements** that are considered high risk and are recorded within 7 days of the report date; referred to in *On-Time Falls Prevention* as high-risk change of condition or HRCC elements. HRCC elements are captured from multiple data sources within the facility's EMR, such as nurse assessments, and represent changes that occurred in a resident's clinical condition within 7 days of the report date.
- **New contributing risk factors elements** are considered secondary risk elements, referred to in *On-Time Falls Prevention* as new contributing risk factors or NCRFs; these elements are captured from multiple data sources within the facility's EMR, such as nurse assessments, within 7 days of the report date.

Residents are identified as at highest risk for falls based on well-defined rules. A resident must meet at least one of these rules to be displayed on the High-Risk Falls Report. Let's take a look at the rules.



Slide 11: Rule 1: High Risk Based on an Existing Condition Within 90 Days



SAY:

For a resident to be considered high-risk based on an existing condition within 90 days, he or she must have at least three of four high-risk existing conditions:

- Severe cognitive impairment or unsafe behaviors
- Gait and balance instability (including the presence of specific diagnoses such as Parkinson's disease that affect gait and balance)
- History of fall in the last 180 days
- Use of psychoactive medications (antipsychotics, antidepressants, sedative/hypnotics, antianxiety drugs) or other medications associated with fall risk (anticonvulsants, antihypertensives, diuretics, and opioids)

Data to populate the report include specific diagnosis codes, MDS assessment responses, and medication administration records.



Slide 12: Rule 2: High Risk Based on a Change of Status Within the Last 7 Days



SAY:

Certain changes or suspected changes in the resident's condition, which represent a potential decline in status during the last 7 days, are associated with fall risk. The presence of at least one high-risk change in condition factor combined with the presence of at least one high-risk existing condition indicates the resident is at high risk for injurious fall.

Each of these high-risk factors can be linked to a high-risk existing condition:

- Acute mental status change
- New unsafe behaviors
- New gait/balance problem or mobility device
- New fall
- New medication or dosage change
- Orthostatic hypotension/dehydration
- Vertigo/dizziness
- Syncope/fainting
- Hypoglycemia
- Possible infection
- New seizure activity
- New admission

Each facility will determine the best source of data to define each listed issue, except for new admission.



Slide 13: Rule 3: High Risk Based on New Contributing Risk Factor Within the Last 7 Days



SAY:

Contributing risk factors are captured from multiple data sources within the EMR. Like change of condition risk elements, these elements are not considered primary risk factors but contribute to and play a role in determining fall risk. The new contributing risk factor elements represent changes that occurred in a resident's clinical condition within 7 days of the report date.

Certain changes or suspected changes in the resident's condition, which represent a potential decline in status during the last 7 days, are considered contributing fall risk factors. The presence of at least one change in status that is a contributing fall risk factor is important but not enough to be considered as highest risk and therefore requires additional criteria to trigger for high risk.

A resident is considered high risk for falls if there is at least one new contributing risk factor in the last 7 days and at least one of the high-risk factors based on existing conditions present. Similar to the high-risk change of condition elements, facilities will work with their vendor to determine the source for the elements.

- New or uncontrolled pain
- New or increased urinary incontinence
- Increased independence in mobility
- Room change

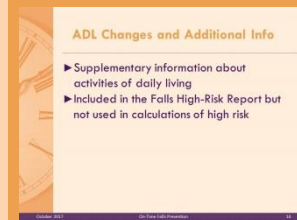


Slide 14: Activities of Daily Living Changes and Additional Information



SAY:

This section of the report does not contribute to fall risk rules; rather it provides additional information to clinicians using the reports. These data are captured from multiple data sources within the facility's EMR as determined by the facility.



Slide 15: Activities of Daily Living Changes and Additional Information



SAY:

This section includes the following changes in the resident's clinical condition that may have occurred in the last 7 days:

- Decline in bed mobility, transfer, or toileting
- Symptoms of depression
- Low body mass index
- Significant weight change
- An active physician's order for vitamin D
- Osteoporosis
- Diabetes
- Visual impairment

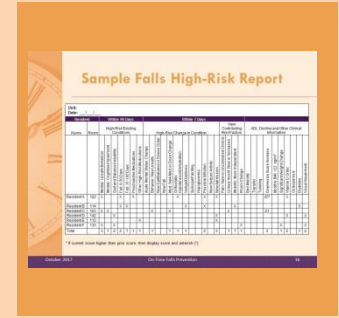


Slide 16: Sample Falls High-Risk Report



DO:

Instruct trainees to look at the Falls High-Risk Report handout. Review the report contents and point out special features.



Resident		Within 90 Days								Within 7 Days										ADL Decline and Other Clinical Information														
Name	Room	High-Risk Existing Conditions								High-Risk Change in Condition										New Contributing Risk Factors														
		Mental: Unsafe Behaviors	Mental: Cognitive Impairment	Gait and Balance Instability	Fall: 8-30 Days	Fall: 31-180 Days	Psychoactive Medications	Other High-Risk Medications	Acute Mental Status Change	Behavior: New Unsafe	New Gait/Balance or Device Order	New Fall	Med: New Med or Dose Change	Orthostatic Hypotension/Dehydration	Vertigo/Dizziness	Syncopal/Fainting	Hypoglycemia	Possible Infection	New Seizure Activity	New Admission	Pain: New or Uncontrolled Chronic	Urinary Incont: New or Increased	Mobility: More Independent	Room Change	Bed Mobility	Transfer	Toileting	Depression Score Increase	Monthly BMI <22 kg/m2	Significant Weight Change	Vitamin D Order	Osteoporosis	Diabetes	Visual Impairment
Resident A	122	X		X	X							X				X	X											25*		X				
Resident B	114			X	X								X			X						X										X		
Resident C	103	X	X						X		X										X						21							
Resident D	142		X																X										X				X	
Resident E	112						X												X															
Resident F	133	X	X																			X							X				X	
Total		3	1	2	2	1	1	1	1			1	1	1			2		3		1	1	1				2	1	2		1		2	

Slide 17: Falls High-Risk Report Calculation Details



SAY:

The On-Time software performs various calculations to display the relevant information. We will review how the different fields are determined.

You will see in the sample report that X's appear in some of the columns for each resident on the report. If any of the following rules are true for a given resident, an X will be displayed for that resident in the corresponding column. If the rule is not met, the space will remain blank.

When the source is an MDS assessment element, the most recent MDS assessment with an assessment reference date within less than 90 days of the report date will be used. However, when an electronic postfall assessment is available, it will be used as the primary source instead of the MDS source option.

Let's start toward the left of the report with the High-Risk Existing Conditions.

Mental: Unsafe Behaviors. The resident has physical behaviors directed toward others, verbal behaviors directed toward others, other behavior symptoms not directed at others, rejection of care, or wandering recorded at any frequency on the MDS assessment.

Mental: Cognitive Impairment. This condition is determined by the Brief Interview for Mental Status (or BIMS) score for interviewable residents and the Staff Assessment for Mental Status for noninterviewable residents as captured by the MDS assessment. If the BIMS score is equal to or less than 7, the resident meets the definition of cognitive impairment. If the BIMS was not completed, any of the following from the staff assessment would count: impairment in ability to make self-understood, short-term memory, long-term memory, or cognitive skills for daily decision making.



Gait and Balance Instability is considered to be true if at least one of the following is true:

- **Balance During Transitions and Walking.** The resident is unsteady during any of the following transition or walking activities as documented by the MDS assessment: moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface to surface transfer.
- **Functional Limitation in Range of Motion.** The MDS assessment documents a range of motion limitation of the lower extremity on one or both sides.
- **Mobility Device.** The MDS assessment includes documentation that a cane/crutch or walker was used.
- **Active Diagnoses** is considered true if any of the following diagnoses that affect gait or balance are coded as active diagnoses on the MDS assessment:
 - Cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke
 - Hemiplegia or hemiparesis
 - Paraplegia
 - Multiple sclerosis
 - Huntington's disease
 - Parkinson's disease
 - Seizure disorder or epilepsy

Fall Within 30 Days is considered true if either or both of the following are true:

- There are any fall dates within 8-30 days of report date. Falls that occur within 1-7 days of the report date will be noted in high risk based on change of condition within the last 7 days.
- The MDS documents a fall in the month prior to admission and the MDS has an assessment reference date less than or equal to 7 days prior to the report date.

Fall Within 31-180 Days is considered true if either or both of the following are true:

- There are any fall dates within 31 to 180 days of report date. Falls that occur within 1-7 days of the report date will be noted in high risk based on change of condition within the last 7 days.
- The MDS documents a fall in the month prior to admission and the MDS has an assessment reference date less than or equal to 7 days prior to the report date.

Psychoactive Medications. The medication administration record demonstrates at least one of the following medications was active within the last 7 days or the MDS assessment documents the use of at least one of the following medications:

- Antipsychotics
- Antidepressants
- Sedative/hypnotics
- Antianxiety drugs

Other High-Risk Medications is considered true if either or both of the following is true:

- The medication administration record demonstrates at least one of the following medications was active within the last 7 days
 - Anticonvulsants
 - Antihypertensives
 - Diuretics
 - Opioids
- The MDS assessment documents the use of at least one of the following medications:
 - Anticoagulant
 - Diuretic
 - Insulin

Slide 18: Falls High-Risk Report Calculation Details: High-Risk Change in Condition



SAY:

Let's move on now to the High-Risk Change in Condition calculation details.

Acute Mental Status Change. The facility will determine the best data source for acute mental status change.

Behavior: New Unsafe. The facility will determine the best data source to use to trigger documentation of new unsafe behavior.

New Gait/Balance or Device Order. The facility will determine the data source for this item and can use a physician's order; however, if a physician order is the source on which this rule depends, the order must be in effect, or active, within 7 days and prior to the report date for this rule to be true.

New Fall. Information about new falls will come from the postfall assessment or other source as specified by the facility. If the resident has a fall documented and the date is within 7 days and prior to the report date, then this rule is true.

Med: New Med or Dose Change. Physician orders or the medication administration record (MAR) will serve as the data source for this item. Either of these sources must display a new medication order or change in medication dose for an order that is in effect, or active, within 7 days and prior to the report date for this rule to be true.

Orthostatic Hypotension/Dehydration. The facility will determine the best data source for orthostatic hypotension/dehydration.

Vertigo/Dizziness. The facility will determine the best data source for vertigo/dizziness.

Syncope/Fainting. The facility will determine the best data source for syncope/fainting.

Hypoglycemia. The facility will determine the best data source for hypoglycemia.



Possible Infection. The facility will determine the best data source for possible infection.

New Seizure Activity. The facility will determine the best data source for new seizure activity.

New Admission. Registration information serves as the source for this item. If the resident was admitted or readmitted within 7 days prior to the report date, the rule is true.



Slide 19: Falls High-Risk Report Calculation Details: New Contributing Risk Factors



SAY:

Next, let's review the New Contributing Risk Factors included in the Falls High-Risk Report.

Pain: New or Uncontrolled Chronic. The facility specifies whether they will use nurse documentation or another documentation source for this item and will work with the vendor to determine the rule related to it.

Urinary Incontinence: New or Increase. Nursing assistant documentation will serve as the source for this rule. This rule will be true if either or both of the following are true:

- An increase in the number of urinary incontinence episodes by shift is present. This rule is true if the number of shifts that a resident had at least one episode of urinary incontinence as documented by the nursing assistant during the current week is at least three shifts greater than the number of shifts on which the resident had at least one episode of urinary incontinence the previous week.
- An increase in urinary incontinence by the number of times per shift is present. This rule is true if the number of urinary incontinence episodes as documented by the nursing assistant increases by 12 or more from the previous week to the current week.

Mobility: More Independent. The facility will specify how an increase in mobility will be captured.

Room Change. This information will come from the registration system and the facility will determine exactly what input option or options will be used. If the resident has had a room change within 7 days of the report, the rule is met.



Slide 20: Falls High-Risk Report Calculation Details: ADL Changes and Additional Clinical Information



SAY:

The information in this section of the report does not contribute to fall risk rules but provides additional information to the clinicians. These data are captured from multiple data sources within the facility's EMR and represent changes that may have occurred in a resident's clinical condition within 7 days of the report date or clinical conditions that exist.

Bed Mobility Decline. The nursing assistant documentation of self-performance is the source for this item. If the completeness of activities of daily living documentation for this ADL is <75% for the current or prior week, then a dash will be displayed for the resident. The current and prior week values are determined by taking the highest (or worst) ADL self-performance score recorded for the week. If the current week value is higher than the prior week value, then ADL Decline: Bed Mobility is true.

Transfer Decline. Calculated the same as Bed Mobility Decline.

Toileting Decline. Calculated the same as Bed Mobility Decline.

Depression Score (PHQ-9 or PHQ-9OV) Increase. For this item to be true, the MDS assessment must have an assessment reference date, or ARD, less than or equal to 7 days prior to the report date. The score will be displayed if the ARD is within 7 days. If the current PHQ-9 or PHQ-9OV score is higher than the prior score, then the report will include the score and an asterisk.

Monthly BMI <22 kg/m². The system computes the resident's body mass index based on the most recent height and weight. If it is less than 22 kg/m², the rule is met.



Significant Weight Change. The system will compute weight change based on the resident's weights over the past 30 days by comparing the most recent weight to the 3 prior weeks (e.g., weeks 2-4). The rule will be true if the resident has had weight loss equal to or greater than 5 percent in the past 30 days.

Vitamin D. If a physician order for Vitamin D is active during the report week (e.g., does not have a discontinue date), then the rule is true.

Osteoporosis. The source for this item is either an active physician diagnosis showing the appropriate diagnosis code for osteoporosis during the report week or the MDS assessment documenting an active diagnosis of osteoporosis. If either or both is present, the rule is true.

Diabetes. The source for this item is either an active physician diagnosis showing the appropriate diagnosis code for diabetes during the report week or the MDS assessment documenting an active diagnosis of diabetes. If either or both is present, the rule is true.

Visual Impairment. If the resident's most recent MDS demonstrates any level of visual impairment, this rule is true.



Slide 21: Check Your Understanding: Falls High-Risk Report Quiz



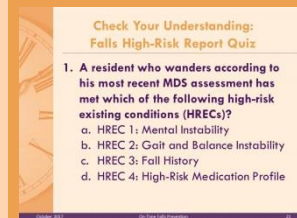
DO:

Ask participants to answer the quiz questions independently and then discuss as a group.

Question #1: A resident who wanders according to his most recent MDS has met which of the following high-risk existing conditions (HRECs)?

- a. HREC 1: Mental Instability
- b. HREC 2: Gait and Balance Instability
- c. HREC 3: Fall History
- d. HREC 4: High-Risk Medication Profile

The correct answer to question #1 is "a," HREC 1: Mental Instability. Behaviors and cognitive impairment issues are captured in this item.

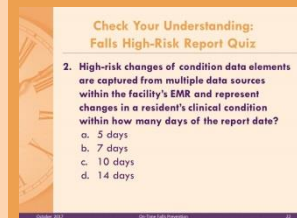


Slide 22: Check Your Understanding: Falls High-Risk Report Quiz

Question #2: High-risk changes of condition data elements are captured from multiple data sources within the facility's EMR and represent changes in a resident's clinical condition within how many days of the report date?

- a. 5 days
- b. 7 days
- c. 10 days
- d. 14 days

The correct answer to question #2 is "b," 7 days.



Slide 23: Check Your Understanding: Falls High-Risk Report Quiz

Question #3: Which of the following sources is used to determine changes in levels of urinary continence and activities of daily living?

- a. Nurses' notes
- b. MDS assessments
- c. Nursing assistant documentation
- d. Therapy notes and evaluations

The correct answer to question #3 is "c," Nursing assistant documentation. This real-time information allows the team to use On-Time to identify subtle changes in the resident's status.



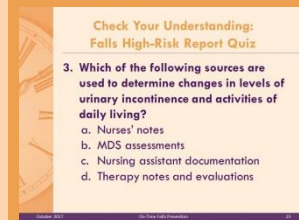
ASK:

Are there any questions regarding the Falls High-Risk Report?



DO:

Address any questions and clarify any issues before moving on to the next section.



Slide 24: Summary of Falls Risk Factors Report



SAY:

Now let's look at the next report, the Summary of Falls Risk Factors report.

The Summary of Falls Risk Factors Report provides information about the number and percentage of falls that have occurred for residents who have fallen, with each risk factor included in the Falls High-Risk Report. Nursing leaders and multidisciplinary quality improvement teams can use these reports to identify trends and patterns, support root cause analysis, and target areas for improvement.

Using the reports, teams will be able to:

- Identify trends and patterns by nursing unit and target followup with staff, provide educational inservices as needed, and develop new or adjust existing prevention strategies,
- Compare trends across nursing units to identify variations in trends and understand causes of variance,
- Identify resident risk factors that may have caused a fall,
- Improve timeliness of root cause analysis and the audit process, and
- Provide summarized fall data to improve prevention practices, implement timely interventions, and identify a need for programmatic changes.



Slide 25: Summary of Falls Risk Factors Report



SAY:

The report displays falls information for a specific nursing unit or facility trended for 1 month or 3 months. The report can be used to monitor the overall prevalence and trends of resident risk factors associated with falls on a specific nursing unit or facilitywide. It displays the number of falls that occurred and the risk factors associated with the falls.

Each resident who experienced a fall likely had one or more risk factors. These risk factors are recorded for each fall and are displayed in this report.



Slide 26: Summary of Falls Risk Factors Report Calculation Details



DO:

Review the calculation details with facilitator trainees.



SAY:

High-Risk Existing Condition (HREC). For each element listed, the software will use the source used for the Falls High-Risk Report for the calculation. For each of the months (1 or 3) included in the report, any fall that occurred before the report date and within 30 days will have the number of HRECs associated with it counted and displayed in the appropriate cell. For each count of conditions, the percentage of all falls with which that risk factor was associated will be displayed in the appropriate cell.

High-Risk Change of Condition (HRCC) Within 7 Days of Fall. For each element listed, the software will use the source used for the Falls High-Risk Report for the calculation. For each of the months (1 or 3) included in the report, any fall that occurred before the report date and within 30 days will have the number of HRCCs associated with it counted and displayed in the appropriate cell. For each count of conditions, the percentage of all falls with which that risk factor was associated will be displayed in the appropriate cell.

New Contributing Risk Factors (NCRFs) Within 7 Days of Fall. For each element listed, the software will use the source used for the Falls High-Risk Report for the calculation. For each of the months (1 or 3) included in the report, any fall that occurred before the report date and within 30 days will have the number of NCRFs associated with it counted and displayed in the appropriate cell. For each count of conditions, the percentage of all falls with which that risk factor was associated will be displayed in the appropriate cell.



Additional Info. The rules and calculations for the Falls High-Risk Report will be used for this information. For each fall with a fall date prior to and within 30 days of the report date, count the number of additional elements associated with each fall and display sum in appropriate cell.

Injury. The postfall assessment is the data source for injury information. If the postfall assessment is not completed, then cells using the postfall assessment as data source will be blank on the report.

Falls With Major Injury. For each fall with a fall date prior to and within 30 days of the report date, the number of major injury elements associated with each fall will be displayed in the appropriate cell.

Major injuries include:

- Hip fractures,
- Other bone fractures,
- Joint dislocations,
- Closed head injuries with altered consciousness, and
- Subdural hematomas.

For each count, the percentage of all falls will be computed and the sum will be displayed in the appropriate cell.

Falls With Minor Injury. For each fall with a fall date prior to and within 30 days of the report date, the number of minor injury elements associated with each fall will be displayed in the appropriate cell.

Minor injuries include:

- Skin tears,
- Abrasions,
- Lacerations
- Superficial bruises,
- Hematomas,
- Sprains, and
- Other injuries that causes the resident to complain of pain.

For each count, the percentage of all falls will be computed and the sum will be displayed in the appropriate cell.

Note that one fall may have major and minor injuries; in such a case, only the major injury will be displayed. Likewise, if multiple minor injuries occur, they will only be counted as one and if multiple major injuries occur, they will only be counted as one.

Slide 27: Sample Summary of Falls Risk Factors Report



DO:

Instruct trainees to look at the [Facility-Level Quarterly Summary of Falls Risk Factors handout](#). Review the report contents and point out special features, including that the report can include all units in a facility (i.e., be facilitywide) or can be run by individual unit.

Also point out that the report can be run to include 1 month of information (i.e., a Monthly Summary) or 3 months of information (i.e., a Quarterly Summary). Point out that the report sample is a Facility-Level Quarterly Summary of Falls Risk Factors.

The thumbnail shows a report titled "Sample Summary of Falls Risk Factors Report". It includes a header with "Facility Name", "Reporting Period", and "Report Date". Below the header is a large table with multiple columns, likely representing different risk factors and their occurrences across various units or time periods. The table is dense with data, and the report appears to be a detailed summary of falls risk factors.

Slide 28: Check Your Understanding: Summary of Falls Risk Factors Report Quiz

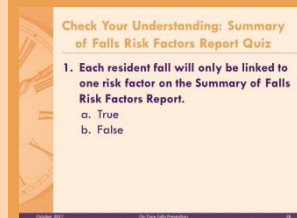


DO:

Ask participants to answer the quiz questions independently and then discuss as a group.

Question #1: True or False: Each resident fall will only be linked to one risk factor on the Summary of Fall Risk Factors Report.

The correct answer to question #1 is False. Each resident who experienced a fall likely had one or more risk factors. These risk factors are recorded for each fall and are displayed in this report.



Slide 29: Check Your Understanding: Summary of Falls Risk Factors Report Quiz

Question #2: For a high-risk change of condition (HRCC) to appear on the report, it must have been noted within how many days of the fall?

- a. 14 days
- b. 5 days
- c. 7 days
- d. 10 days

The correct answer to question #2 is "c," within 7 days of the fall.



Slide 30: Check Your Understanding: Summary of Falls Risk Factors Report Quiz

Question #3: A resident's postfall assessment documents a hematoma on his head, a dislocated hip, and a laceration of his thigh. Which of the following best represents how these injuries will appear on the Summary of Falls Risk Factors Report?

- a. Fall with major injury = 1 and fall with minor injury = 0
- b. Fall with major injury = 2 and fall with minor injury = 1
- c. Fall with major injury = 1 and fall with minor injury = 2
- d. Fall with major injury = 2 and fall with minor injury = 0

The correct answer to question #3 is "a," Fall with major injury = 1 and fall with minor injury = 0. Remember that if there are multiple injuries at one level, only one will appear and if there are minor or major injuries, only major injury will appear.



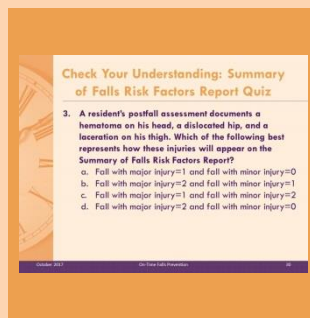
ASK:

Are there any questions regarding the Summary of Falls Risk Factors Report?



DO:

Address any questions and clarify any issues before moving on to the next section.



Slide 31: Contextual Factors Report

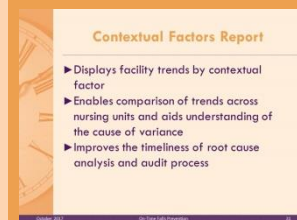


SAY:

Now let's begin by going over the Contextual Factors Report.

The purpose of the report is to display facility trends by contextual factor. Similar to the Summary of Fall Risk Factors Report, this report will enhance teams' ability to:

- Identify trends and patterns by nursing unit and target followup with staff, provide educational inservices as needed, and develop new or adjust existing prevention strategies.
- Compare trends across nursing units to identify variances in trends and understand causes of variance;
- Identify resident contextual factors that may have caused a fall;
- Improve timeliness of root cause analysis and audit processes; and
- Provide summarized fall data to improve prevention practices, implement timely system interventions, and identify any need for programmatic changes.



Slide 32: Contextual Factors Report



SAY:

The Contextual Factors Report displays information for all residents who fell during a given month. It includes the total number of falls and associated contextual factors, including day of week, shift, time of day, and fall location. This report can be generated for a single nursing unit or for the entire facility and can display a quarterly or monthly view.

The report uses information gathered as part of resident postfall assessments to display the following information for each fall with fall date prior to and within 30 or 90 days of report date (depending on whether the monthly or quarterly report is chosen):

- Day of week on which the fall occurred,
- Shift during which the fall occurred,
- Time at which the fall occurred,
- The location of the fall, and
- If the resident had a room change within 30 days of the fall.

The report also displays the total number of residents who fell, the total number of residents who had more than one fall, and the total number of falls for the report period.

Contextual Factors Report

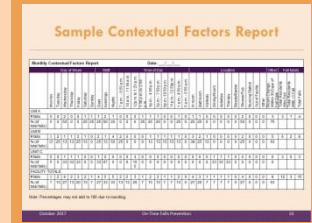
- ▶ Displays information on day of the week, shift, time of day, and location of fall and if the resident had a room change in last 30 days
- ▶ Uses information collected during resident postfall assessments
- ▶ Can be generated for a single unit or for the facility as a whole
- ▶ Can show data trended for 1 month or 3 months

Slide 33: Sample Facility-Level Contextual Factors Report by Month



DO:

Instruct trainees to look at the Facility-Level Contextual Factors Report by Month handout. Review the report contents and point out special features. Remind trainees that the report can also be run to display a unit rather than the entire facility and that it can be run for a quarter rather than a month. In addition, it can be run for just injurious falls if desired rather than including all falls.



Monthly Contextual Factors Report

Date: ___/___/___

	Day of Week							Shift			Time of Day							Location							Other	Fall totals									
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Days	Evenings	Nights	7 a.m. - 9:59 a.m.	10 a.m. - 11:59 a.m.	12p.m. to 1:29 p.m.	1:30 p.m. to 2:59 p.m.	3p.m. - 4:59 p.m.	5p.m. - 7:59 p.m.	8p.m.-10:59 p.m.	11p.m.- 12:59p.m.	1 a.m.- 4:59 a.m.	5 a.m. - 6:59 a.m.	In room	Bathroom	Hallway	Dining Room		Activities	Therapy	Beauty/Barber	Shower/Tub	Nursing Station	Out of Facility	Other	Room Change Within 30 Days of Fall Date	Total Residents Who Fell	Total Residents With > 1 Fall
Unit A																																			
# falls	0	0	2	0	0	1	1	1	2	1	0	0	0	1	1	1	0	0	1	0	1	1	1	0	0	0	0	2	0	0	0	3	3	1	4
% (of total falls)	0	0	50	0	0	25	25	25	50	25	0	0	25	25	25	0	0	25	0	25	25	25	0	0	0	0	50	0	0	0	75				
Unit B																																			
# falls	1	2	1	1	2	1	0	2	3	3	2	0	0	0	1	1	1	1	1	1	3	2	1	0	0	0	0	2	0	0	0	5	6	2	8
% (of total falls)	13	25	13	13	25	13	0	25	38	38	25	0	0	0	13	13	13	13	13	13	38	25	13	0	0	0	25	0	0	0	63				
UNIT C																																			
# falls	0	0	1	1	1	0	0	3	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	3	0	0	3
% (of total falls)	0	0	33	33	33	0	100	0	0	0	0	100	0	0	0	0	0	0	0	0	0	0	0	33	33	33	0	0	0	0	0	100			
FACILITY TOTALS																																			
# falls	1	2	4	2	3	2	1	6	5	4	2	0	3	1	2	2	1	1	2	1	4	3	1	1	1	1	0	4	0	0	0	8	12	3	15
% (of total falls)	7	13	27	13	20	13	7	40	33	27	13	0	20	7	13	13	7	7	13	7	27	20	7	7	7	7	0	27	0	0	0	53			

Note: Percentages may not add to 100 due to rounding.

Slide 34: Contextual Factors Report Calculation Details



DO:

Review the calculation details with facilitator trainees.



SAY:

Day of Week: Monday – Sunday. The date from the Postfall Assessment is the source of this information. The system then determines the days of the week from the fall date. The sum for each day of the week is displayed.

Shift: Days, Evenings, Nights. The time from the Postfall Assessment is the source of this information. The system then determines the shift from fall time of day with consideration of the shifts used at the facility. For example, the facility may use 8- or 12-hour shifts. The sum for each shift is displayed.

Time of Day. The time from the Postfall Assessment is the source of this information. Time categories (or ranges) are used to display the time of day information for falls. For instance, one time range is 12 p.m. to 1:30 p.m., which would likely capture lunchtime, whereas 3 p.m. to 4:59 p.m. would provide valuable insight as to whether falls were occurring during change of shift.

Location. The location from the Postfall Assessment is the source of this information.

Other: Room Change Within 30 Days of Fall Date. The system computes this information and will report a resident room change less than 30 days from the most recent fall date.

Total Residents Who Fell. The system computes the number of unique residents who fell during the report period. The report could be run by selecting only residents with injurious falls rather than all falls, if desired.

Total Residents With >1 Fall. The system computes the number of residents who had at least two falls in the report period.

Total Falls. The system computes the total number of falls for the report period.



Slide 35: Sample Contextual Factors Graph

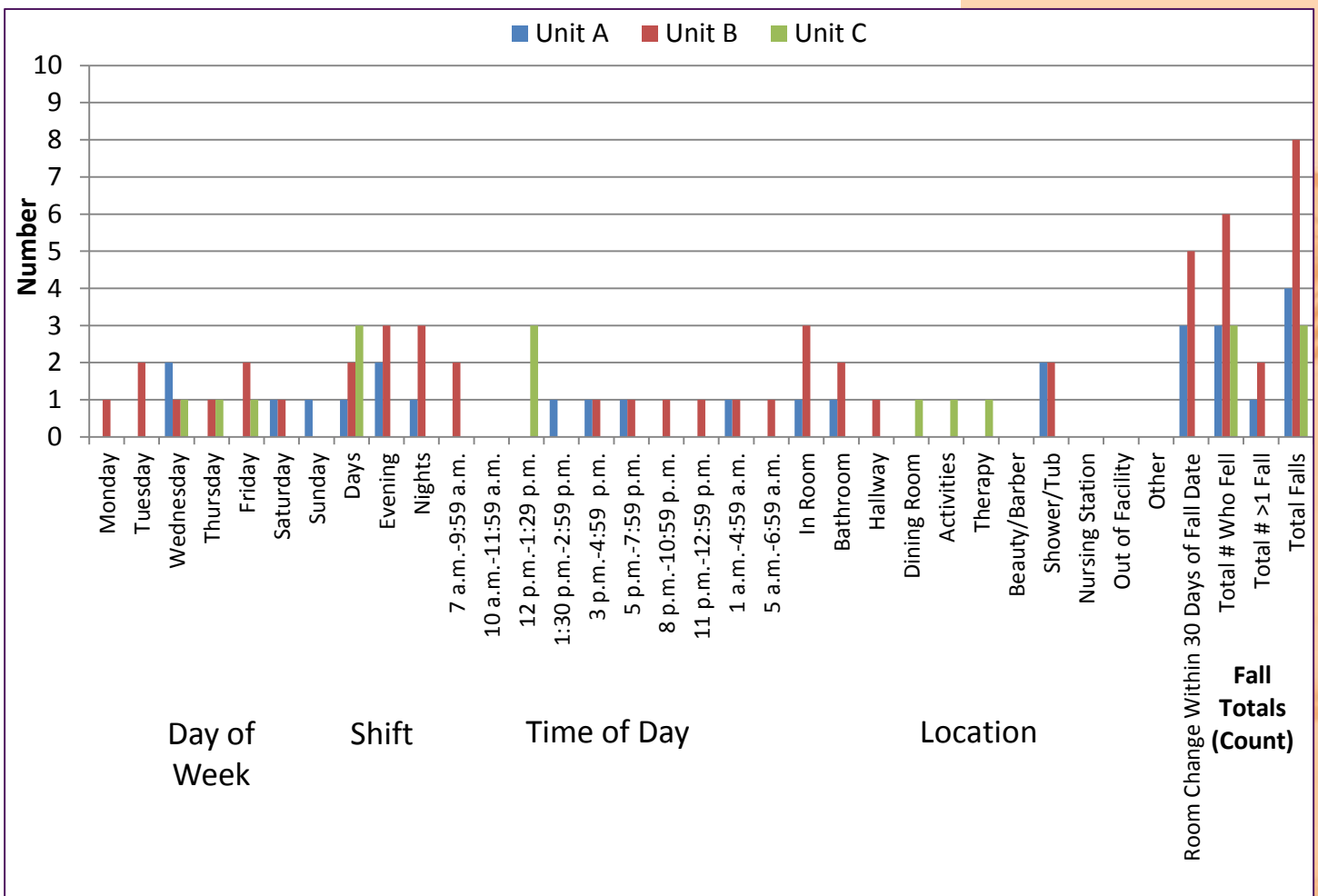
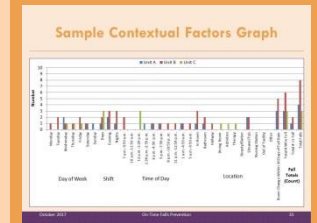


DO:

Explain that most vendors can furnish graphs for reports and that the sample graph shows contextual factors for a facility.

Answer any questions regarding the sample graph.

Number of residents hospitalized with a previous hospitalization in last 3 days



Fall Totals (Count)

Slide 36: Check Your Understanding: Contextual Factors Report Quiz



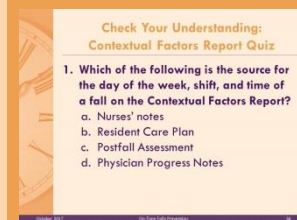
DO:

Ask participants to answer the quiz questions independently and then discuss as a group.

Question #1: Which of the following is the source for the day of the week, shift, and time of a fall on the Contextual Factors Report?

- a. Nurses' notes
- b. Resident Care Plan
- c. Postfall Assessment
- d. Physician Progress Notes

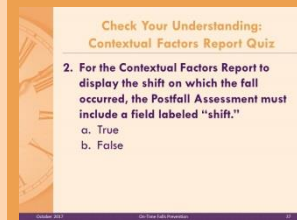
The correct answer to question #1 is "c," Postfall Assessment. This is the source of this information on this report, as well as the location of the fall.



Slide 37: Check Your Understanding: Contextual Factors Report Quiz

Question #2: True or False: For the Contextual Factors Report to display the shift on which the fall occurred, the Postfall Assessment must include a field labeled "shift."

The correct answer to question #2 is "False." The system computes the shift based on the time entered on the Postfall Assessment and the shifts used at the facility.



Slide 38: Check Your Understanding: Contextual Factors Report Quiz

Question #3: Within how many days of a resident fall must a room change occur in order for it to be associated with a fall in the quarterly Contextual Factors Report?

- a. 7
- b. 14
- c. 30
- d. 90

The correct answer to question #3 is "c," 30 days. Regardless of whether the report is monthly or quarterly, a room change must occur within 30 days of the fall to be included on the report.



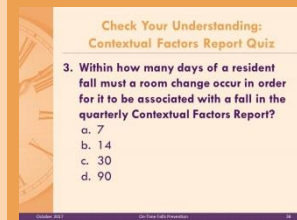
ASK:

Are there any questions regarding the Summary of Fall Risk Factors Report?



DO:

Address any questions and clarify any issues before moving on to the next section.



Slide 39: Postfall Assessment Summary Report

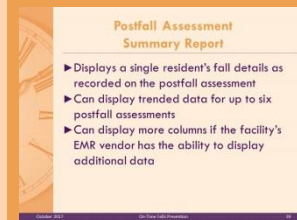


SAY:

Now let's begin by going over the Postfall Assessment Summary Report.

The Postfall Assessment Summary Report displays a single resident's fall details as recorded on the Postfall Assessment.

This resident-level report displays data for up to six Postfall Assessments completed after each fall. The trended view will enable clinicians to see patterns and trends for residents with multiple falls. More columns can display if the vendor has the ability to display additional Postfall Assessments.



Slides 40–42: Sample Postfall Assessment Summary Report



DO:

Instruct trainees to look at the [Postfall Assessment Summary Report handout](#). Review the report contents and point out special features.

Sample Postfall Assessment Summary Report

Section	Item	Y	N	U	NA
Patient Data	Case #				
	Unit				
	Room				
	Admission Date				
	Discharge Date				
	Admission Type				
	Admission Source				
	Admission Reason				
	Admission Status				
	Admission Date				
Admission Time					
Fall Data	Fall Date				
	Fall Time				
	Fall Location				
	Fall Description				
	Fall Witness				
	Fall Injuries				
	Fall Cause				
	Fall Prevention				
	Fall Assessment				
	Fall Summary				

Sample Postfall Assessment Summary Report: Injury Section

Section	Item	Y	N	U	NA
Injury Data	Injury Date				
	Injury Time				
	Injury Location				
	Injury Description				
	Injury Witness				
	Injury Injuries				
	Injury Cause				
	Injury Prevention				
	Injury Assessment				
	Injury Summary				

Sample Postfall Assessment Summary Report: Notifications Section

Section	Item	Y	N	U	NA
Notification Data	Notification Date				
	Notification Time				
	Notification Location				
	Notification Description				
	Notification Witness				
	Notification Injuries				
	Notification Cause				
	Notification Prevention				
	Notification Assessment				
	Notification Summary				

Resident Name: _____

Fall Date	Date	Date of Fall					
		10/4/13	1/16/14	2/11/14	2/27/14	3/6/14	4/17/14
Fall Day	Day of week	Saturday	Thursday	Tuesday	Thursday	Thursday	Thursday
Fall Time	Time or "not known"	6:35 a.m.	5:35 a.m.	7:15 a.m.	6:50 a.m.	6:10 a.m.	5:15 a.m.
Shift	Shift	N	N	D	N	N	N
Fall Witnessed?	Yes/no	N	N	Y	Y	N	N
If yes, who witnessed?	Staff, family, visitor, volunteer, other	Staff	Staff	Family	Staff	Staff	Family
Witness Type	If fall not witnessed, then name of person who found the resident.						
Fall Location	Fall location: room; bathroom; hallway; dining room; activities; therapy; beauty parlor; shower/tub; nursing stations; out of facility; other	Bathroom	Bathroom	Room	Room	Bathroom	Bathroom
Resident Position When Found	Position when found: supine, lying left, lying right, sitting, other	Supine	Sitting	Lying right	Supine	Sitting	Sitting
Resident Activity at Time of Fall	Activity prior to fall: walking; transferring; toileting; in bed; in chair; other	Toileting	Toileting	Walking	Walking	Toileting	Toileting
Potential Causes of Fall	Unknown						
	Behavior – agitation/other						
	Loss of balance (reaching, turning, sudden movement, other)						
	Gait/balance instability			X	X		
	Bowel/bladder: trying to get to bathroom on own	X	X	X	X	X	X
	Personal device or equipment (cane, walker, crutch) – improper use			X	X		
	Equipment failure, bed, chair, floor mat alarms						
	Potential medication issue: new med/dose change/suspected reaction						

	Resident chooses not to follow recommendations: alert and oriented						
	Resident unable to follow recommendations: cognitively impaired						
	Other, please describe						
Fall Comments	Free text						
Fall Injury?	Yes/No	N	N	Y	Y	Y	N
If yes, what type of injury?							
Injury Type: Major	Fracture: hip				X		
	Fracture: other						
	Joint dislocation						
	Closed head injury with altered consciousness						
	Subdural hematoma						
Injury Type: Minor	Skin tear	X					
	Abrasion			X			
	Laceration					X	
	Superficial bruises, hematomas			X		X	
	Sprain						
	Other injury that causes pain						
Injury Site	Head Upper extremity (UE) Lower extremity (LE)	LE	LE	LE	LE	LE	UE
Injury Assessment	ROM upper: full/decreased	Full	Full	Full	Full	Full	Decr
	ROM lower: full/decreased	Decr	Decr	Decr	Decr	Decr	Full
	Loss of consciousness: yes or no	No	No	No	No	No	Yes
	Neuro status: usual or not usual (changes noted)	Usual	Usual	Usual	Usual	Usual	Not usual
	Bleeding: none, minor, significant	None	None	None	None	None	None
	Other						
	Free text						

Where Resident Was Treated	Facility, ER, hospital admit	Facility	Facility	ER	ER	Facility	Facility
PCP Notified?	Yes/no	Y	Y	Y	Y	Y	Y
MD Notified	Physician name	Brewer	Brewer	Cannon	Jackson	Brewer	Brewer
PCP Notification Date	Date	10/4/13	1/16/14	2/11/14	2/27/14	3/6/14	4/17/14
PCP Notification Time	Time	7:00 AM	7:00 AM	8:00 AM	7:00 AM	7:00 AM	6:30 AM
Family Notified?	Yes/no	Y	Y	Y	Y	Y	Y
Family Notified	Family name/relationship	Daughter	Daughter	Son	Son	Son	Son
Family Notification Date	Date	10/4/13	1/16/14	2/11/14	2/27/14	3/6/14	4/17/14
Family Notification Time	Time	8:00 AM	8:00 AM	8:30 AM	7:30 AM	8:00 AM	8:00 AM
PCP Exam Performed?	Yes/no	Y	Y	Y	N	Y	Y
PCP Exam Date	Date	10/6/14	1/17/14	2/12/14		3/6/14	4/17/14
PCP Exam Time	Time	8:00 AM	8:00 AM	8:30 AM		8:00 AM	8:00 AM
PT Notified?	Yes/no	Y	Y	Y	N	Y	Y
PT Consult	Date	10/4/13	1/16/14	2/11/14		3/6/14	4/17/14

Slides 43–44: Postfall Assessment Summary Report Calculation Details



SAY:

The elements on the Postfall Assessment Summary Report come from information that staff input on the Postfall Assessment. I outlined the information included in the Postfall Assessment in the beginning of our time together but we'll look at it a bit more closely now, in the context of the Postfall Assessment Summary Report.

Fall Date. The date is entered by the staff and displayed in the vendor's standard date format. From this, the system computes the day of the week.

Fall Time. The time or "not known" is entered and is displayed using the vendor's standard time format. From this, the system computes the shift.

Fall Witness. Whether a witness was present is answered with a yes or no.

Witness Type. Valid responses for the witness type include staff, family, visitor, volunteer, or other. If other is selected, text is entered.

Witness Name. If there is a witness, the name of the person is documented.

Found By. If there is not a witness, the name of the person who found the resident is documented.

Fall Location. Staff can pick from multiple options for fall location, including resident room, bathroom, hallway, dining room, activities, therapy, beauty/barber, shower/tub, nursing station, out of facility, and other. If other is selected, text is entered.

Position When Found. The position in which the resident is found is documented through selecting prone, supine, lying left, lying right, sitting, or other. If other is selected, text is entered.



Activity at Time of Fall. This field reflects what the resident was doing at the time of the fall. Options include walking, transferring, toileting, in chair, bed, or other. If other is selected, text is entered.

Suspected Cause of Fall. Multiple options are available for potential causes of the fall, including behavior, loss of balance, trying to get to the bathroom, and many others. There is also an “other” option that triggers the assessor to describe the cause with free text. The assessor will choose all that apply.

Fall Comments. Will reflect any other comments the assessor made to describe the fall.

Fall Injury. Whether there is an injury is indicated in this area with a yes or no.

Injury Type Major. Options for Major Injury include hip fracture, other fracture, joint dislocation, closed head injury with altered level of consciousness, and subdural hematoma.

Injury Type Minor. Options for Minor Injury include skin tear, laceration, abrasion, discoloration/bruising, and other.

Injury Site. The assessor can check all that apply for injury site, including head, lower extremity, or upper extremity.

ROM Upper. The assessor will indicate full or limited for upper extremity range of motion.

ROM Lower. The assessor will indicate full or limited for lower extremity range of motion.

Loss of Consciousness. The assessor chooses yes or no to indicate whether the resident had a loss of consciousness.

Neurological Status. Options for neurological status include usual or changes noted.

Bleeding. Options for bleeding include none, minor, and significant.

Injury Assessment Notes. The assessor can make free text notes to indicate anything relevant related to the injury assessment.

Treatment Location. The options for treatment location include the facility or the emergency room.

Physician Notified. The assessor indicates whether the physician was notified with a yes or no.

Physician Name. The name of the physician notified will be displayed in the preferred facility format.

Physician Notification Date. The date of the physician notification will be displayed in the usual facility date format.

Physician Notification Time. The time of the physician notification will be displayed in the usual facility time format.

Family Notification. The assessor indicates whether the family was notified with a yes or no.

Family Relationship. Options for family relationship include daughter, son, spouse, or other.

Family Notification Date. The date of the family notification will be displayed in the usual facility date format.

Family Notification Time. The time of the family notification will be displayed in the usual facility time format.

Physician Exam. The assessor indicates whether the physician examined the resident with a yes or no. If yes, the date and time of the exam are entered.

PT Consult. The assessor indicates whether a physical therapy consult occurred for the resident after the fall with a yes or no. If yes, the date and time of the consult are entered.



Slide 45: Check Your Understanding: Postfall Assessment Summary Report



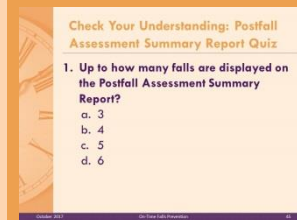
DO:

Ask participants to answer the quiz questions independently and then discuss as a group.

Question #1: Up to how many falls are displayed on the Postfall Assessment Summary Report?

- a. 3
- b. 4
- c. 5
- d. 6

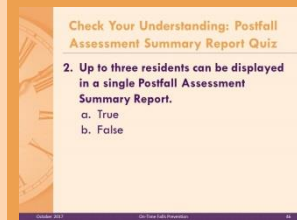
The correct answer to question #1 is "d"; up to 6 falls are included in the report.



Slide 46: Check Your Understanding: Postfall Assessment Summary Report

Question #2: True or False: Up to three residents can be displayed on a single Postfall Assessment Summary Report.

The correct answer to question #2 is False; the information for only one resident is shown on a Postfall Assessment Summary Report.



Slide 47: Check Your Understanding: Postfall Assessment Summary Report

Question #3: True or False: Suspected Cause of Fall will display one causative factor for each fall.

The correct answer to question #3 is False. There are multiple options for potential causes of falls and the assessor will choose all that apply.



ASK:

Are there any questions regarding the Postfall Assessment Summary Report?



DO:

Address any questions and clarify any issues before closing the session.