OASIS Alert

Falls Prevention: 8 OASIS ITEMS HELP YOU PREDICT FALLS RISK FACTORS

Here's how to use your OASIS assessment more effectively.

Take advantage of data you already have to ramp up your falls prevention program.

Falls are the leading cause of nonfatal injuries in the United States. In 2006, nearly 8 million people were treated in emergency departments (EDs) for falls injuries, according to the **Centers for Disease Control and Prevention**.

The new OASIS C assessment will include process items addressing falls risk. The assessment will ask if you gave the patient a "multi-factor falls risk assessment," if the plan of care included falls prevention interventions, and if you implemented these interventions. But don't wait until you begin using OASIS C to address this issue.

Falls prevention in home care is a challenge because so much in the patient's environment is out of your control. And falls risk assessment tools used in hospitals don't necessarily work well at home, according to **Gale Bucher,** a nurse with **Christiana Care VNA** in New Castle, Del. But you can assess many aspects of falls risk with M0 items you arealready using.

In reviewing falls risk, three factors stand out as the most frequent reasons for falling, CCVNA reports. These are medication issues, limitations in mobility, and impairment of vision. Other risk factors include prior falls, orthostatic hypotension, mental issues, and elimination problems, such as bowel or bladder incontinence.

The following OASIS items are effective in identifying falls risk, Bucher points out:

• **M0660 (Ability to dress lower body).** Focus on the patient's balance, especially when lifting feet one at a time to place them in the garment.

• **M0690 (Transferring).** When a patient is not independent but is able to assist in the transfer, focus on how steady the patient is during the pivoting process.

• **M0700 (Ambulation/locomotion).** If you select response 2 indicating the patient needs assistance to ambulate, remember that this patient may try to ambulate without assistance, resulting in a fall.

• **M0560 (Cognitive function).** A patient with orientation difficulties or memory deficits may not follow safety instructions.

• **M0570 (Confusion).** A confused patient has decreased awareness of environmental hazards and a decreased perception of his abilities.

• **M0520 (urinary incontinence) and M0540 (bowel incontinence).** A patient with incontinence may rush to the toilet and increase falls risk.

• **M0390 (Vision).** Impaired vision makes safe mobility difficult.

Resources: See the special falls risk assessment tool for home care on page 71. The tool includes an algorithm for referrals. It also includes references to appropriate M0 items. This assessment is available at www. medQIC.org and is in the public domain, so feel free to use it.

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