VHA EXTERNAL PEER REVIEW PROGRAM
FALL ASSESSMENT MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
1	falldone	**__ Fall Assessment review was previously completed for this case for the same episode of care.** **If checked, disable Fall Assessment Module.** **If not checked, enable Fall Assessment Module.**		
2	asesfall	Does the medical record document the patient was assessed for risk of falls using the Morse Fall Scale during this hospital stay?	1, 2 If 2, auto-fill morscore as zzz, mfsdt as 99/99/9999, and mfstm as 99:99, and go to fallplan	The Morse Fall Scale (MFS) is comprised of six subscales used to assess a patient's fall risk factors. The MFS assesses the patient's history of falling (immediate or within past 3 months), secondary diagnosis, ambulatory aid, IV/heparin lock, gait/transferring, and mental status. **Episode of care can begin up to 24 hours prior to admission (Examples: patient admission to an observation bed, surgery in the ambulatory setting, patient held in ED awaiting bed.)** **Do not include a Morse Fall Scale done in the NHCU.**
3	morscore	Enter the total score of the <u>first</u> Morse Fall Scale documented in the record.	__ __ __ **Abstractor can enter zzz** Will be auto-filled as zzz if asesfall = 2 If > = 45, auto-fill anyscr45 as 95, mfs45dt as 99/99/9999 Whole numbers 0 - 150	The Morse Fall Scale score may range from 0 - 150. Enter the total score of the **<u>first</u>** Morse Fall Scale score documented in the record. If the MFS score is not documented, enter default zzz. Fall risk is a defined level at which patients are determined to be at risk of experiencing a fall. Per recommendation from Janice Morse, the Office of Nursing Services has established the following scores. **Universal Fall Precautions Include:** **Patient Education:** • Orient to surroundings • Purpose and use of call light

Risk Level	MFS Score	Action
Low Risk	0 - 24	Implement Universal Fall Precautions
Moderate Risk	25 - 44	Implement Universal Fall Precautions Implement Additional Interventions Based on Area of Risk
High Risk	>= 45	Implement Universal Fall Precautions Implement Additional Interventions Based on Area of Risk

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				• Use of non-skid slippers or gripper socks • Request assistance for daily activities (such as getting out of bed, toileting, transfers) • Purpose and use of assistive devices and mobility aides if needed **Environment of Care** • Place patient articles within easy reach • Call light (if applicable) in easy reach and answered promptly • Place bed in low position when in bed • Lock bed wheels • Lock wheelchair wheels if applicable • Provide proper lighting (night lights) • Keep floor free of clutter • Clean up spills immediately Modify environment for safe transfers
4	mfsdt	Enter the date the first Morse Fall Scale was completed.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if asesfall = 2 <= 24 hours prior to or = admit dt and <= disch dt	The first Morse Fall Scale may be completed prior to formal admission. The software will allow entry of a date and time within 24 hours prior to date of formal admission. Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.

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5	mfstm	Enter the time the <u>first</u> Morse Fall Scale was completed.	_____ UMT Will be auto-filled as 99:99 if asesfall = 2 If morscore > = 45, go to fallplan < = 24 hours prior to or > admit time, If mfsdt = disch dt, < disch time	**Enter the time the first Morse Fall Scale note was completed and signed.** A Morse Fall Scale may be completed prior to formal admission. The software will allow a time within 24 hours prior to the time of formal admission.
6	anyscr45	At anytime during the hospital stay, does the record document a Morse Fall Score of 45 or greater? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if morscore > = 45 If 2, auto-fill mfs45dt as 99/99/9999 and go to fallplan	The Morse Fall Scale score may range from 0 - 150. Look for the total score documented in the record.
7	mfs45dt	Enter the earliest date the Morse Fall Score was documented as 45 or greater.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if morscore > = 45 or anyscr45 = 2 >= admit dt and <= disch dt	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.

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8	fallplan	Does the record document a care plan to minimize the risk of fall/injury?	1, 2 If 2, auto-fill falplndt as 99/99/9999 and falplntm as 99:99, and go to hadfall	Look for documentation of a plan of care for the prevention of falls or a fall prevention protocol. Answer this question regardless of whether a Morse Fall Scale was documented in the record. As the Morse Fall Scale may be completed prior to formal admission, a fall/injury care plan noted as part of the acute care stay and within 24 hours prior to the date of formal admission is acceptable. The software will allow entry of a date and time within 24 hours prior to date of formal admission. Suggested Data Sources: nursing admission note, nursing notes, nursing plan of care note
9	falplndt	Enter the date the **first** fall/injury care plan was documented in the record.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if fallplan = 2 <= 24 hours prior to or = admit dt and <= disch dt	Enter the date the first fall/injury care plan was documented the record. The software will allow entry of a date within 24 hours prior to date of formal admission. Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.
10	falplntm	Enter the time the **first** fall/injury care plan was documented in the record.	____ UMT **Abstractor can enter 99:99** Will be auto-filled as 99:99 if fallplan = 2 < = 24 hours prior to or > admit time, If falplndt = disch dt, < disch time	Enter the earliest time the first fall/injury care plan was documented the record. The software will allow entry of a time within 24 hours prior to the time of formal admission. If the time of the first fall/injury care plan is not documented, enter 99:99.

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11	hadfall1 hadfall2 hadfall3 hadfall99	Is there documentation that the patient had at least one fall during this hospital stay? **Indicate all that apply:** 1. Patient fall documented or noted in post fall assessment note 2. Bone fracture acquired during this hospital stay 3. Subdural hematoma acquired during this hospital stay 99. None of the above	1, 2, 3, *99 ***If hadfall99 = -1, go out of module, else go to fstfaldt** Cannot enter 99 with any other number	Fall is defined as an unplanned descent to the floor (or extension of the floor, e.g. trash can or other equipment) with or without injury to the patient. Suggested Data Sources: nursing notes, post fall assessment note, physician notes
12	fstfaldt	Enter the date the **first** fall/injury was documented in the record.	mm/dd/yyyy >= admit dt and <= disch dt	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.
13	fstfaltm	Enter the time the **first** fall/injury was documented in the record.	____ UMT >= admit dt/admit tm and <= disch dt/disch tm	Enter the earliest time the first fall/injury was documented the record.
14	modcare	After the patient's **first** fall, does the record document a fall care plan or modification of a pre-existing fall care plan? 2. Fall care plan documented 3. Pre-existing fall care plan modified 4. No fall care plan documented	2, 3, 4	After documentation of the first fall/injury, look for documentation of a fall care plan in the record or documentation that a change or modification was made to a fall care plan that was in place prior to the first fall. Suggested Data Sources: nursing admission note, nursing notes, nursing plan of care notes

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15	extinjur	Does the record document the extent of injury experienced by the patient as a result of the **first** fall? 0. None 1. Minor 2. Moderate 3. Major 4. Death 99. Unable to determine	0, 1, 2, 3, 4, 99	For this purposes of this question, the following designations apply: **0. None** = patient had no injuries resulting from the fall **1. Minor** = resulted in application of a dressing, ice, cleaning, of a wound, limb elevation, or topical medication **2. Moderate** = resulted in suturing, application of steri-strips/skin glue, or splinting **3. Major** = resulted in surgery, casting, traction, or required consultation for neurological or internal injury **4. Death** = the patient died as a result of injuries sustained from the fall (do not select this option if dying caused the fall) **The extent of the injury may not be known at the time of the initial fall report. It may be necessary to review nursing and physician notes within the first 24 hours following the fall to determine the extent of injury. Select the most severe level of injury documented.** Suggested Data Sources: nursing and/or physician post fall assessment note, nursing notes, physician notes, consultations (e.g., neurology, orthopedics), x-ray reports following the fall
16	wherfall	Which unit was the patient assigned to when the **first** fall occurred? 1. Medical 2. Surgical 3. Mixed Medical/Surgical 4. Critical Care 5. Step down 6. Other	1, 2, 3, 4, 5, 6	A fall could occur on a unit other than the assigned unit or in a non-nursing department. Select the unit to which the patient was assigned when he/she fell for the first time. This location may not be the same nursing unit/department where the fall took place.
17	mor1fall	Is there documentation that the patient had more than one fall during this hospital stay? 1. Yes 2. No	1, 2 If 2, auto-fill wher2fal as 95, falpln2 as 95 and go out of module	Fall is defined as an unplanned descent to the floor (or extension of the floor, e.g. trash can or other equipment) with or without injury to the patient. Suggested Data Sources: nursing notes, post fall assessment note, physician notes

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18	wher2fal	Which unit was the patient assigned to when the **second** fall occurred? 1. Medical 2. Surgical 3. Mixed Medical/Surgical 4. Critical Care 5. Step down 6. Other 95. Not applicable	1, 2, 3, 4, 5, 6, 95 Will be auto-filled as 95 if mor1fall = 2	A fall could occur on a unit other than the assigned unit or in a non-nursing department. Select the unit to which the patient was assigned when he/she fell for the second time. This location may not be the same nursing unit/department where the fall took place.
19	falpln2	After the first fall but prior to the second fall, is there documentation of a fall care plan in the record? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if mor1fall = 2	In order to answer "1," a fall care plan or a fall prevention protocol must be documented in the record following the first fall but prior to the occurrence of the second fall. Suggested Data Sources: nursing admission note, nursing notes, nursing plan of care notes