Massachusetts Organization of Nurse Executives
Strategies on Fall Prevention
May 2008

Inpatient falls have become the leading cause of injury related death for elderly patients. Seniors often have health concerns that create physical immobility and balance problems. When a fall happens in the hospital, there are concerns inherent in the elderly populations that are combined with institutional factors. Since most hospital falls happen within the first few days of admission, the characteristics of many elderly such as weakness, alterations in medications, and confusion often compound their risk for fall.

Upon assessment, the highest risk factor is history of a previous fall. Therefore, fall prevention education and strategies are to individualize the patient's interventions to their fall risk. (Salsbury Lyons, 2005) There are many evidenced based risk fall assessments and many that are customized. The best screening tools have these following elements: history of falls, difficulty in transferring, assessment for dizziness and balance issues, assessment for confusion, assessment for visual impairment, medication analysis, and incontinence and frequency. This may sound easy but understanding where your institutions fall program needs improvement takes some investigating.

Patient falls have been studied and preventive strategies are widely known and implemented in various methods in the acute care setting. Once the patient or caregiver reports a previous fall, a more comprehensive screening needs to be done in order to identify the risk factor(s) and therefore place the correct strategies to the patient. There are several proven fall assessments. Some of the more widely known are the Morse Fall assessment, the Schmid fall assessment scale and the Hendrich II Model.

What are the intrinsic risk factors that put patients at risk for fall? Some literature says that women fall more than their male counterparts and other literature says that men fall more often. (Eldridge, 2004)(McFarlane-Kolb, 2004). Falls are most common in people over 65 years of age and white men have the highest rate of fall-related deaths. Previous fall has a very high predictability factor and family history of falling also plays a role.

There are many medications that make the elderly population at risk for falls. There are too many to name, but any person over 70 taking 4 or more medications have a higher rate of falling. Since drug excretion is slower in the elderly, doses that are sometimes normal for a younger healthy adult are too high for the elderly. Depressive medications also pose a fall risk for many elderly. There is much data that shows that elderly patients who are on tricyclic antidepressants or serotonin reuptake inhibitors, which are all classified as psychotropic drugs can create a major fall. Medication management must always be examined when a patient enters the acute care setting and has a history of reoccurring falls. (Eldridge 2004)

Patients with dementia suffer many more falls than their counterpart who do not have dementia. Risk factors from those with dementia include: wandering, agitation, perceptional difficulties (in maneuvering their environment), lack of fear, balance impairments, and gait impairments.(Eldridge 2004) Interventions that assist patients with dementia include removing clutter, having familiar pictures in view, verbal cueing to stay seated and giving them diversional activities. (Conedera, 2004)

After surveying many hospitals in the state through the Management of Practice Committee, from The Massachusetts Organization of Nurse Executives, I found that most hospitals assessed patients for high risk for fall, performed frequent toileting, comfort checks, and monitoring. These interventions were critical interventions since they helped to avoid the unintended ambulating without assistance. Bed and chair alarms are also common tools since they alerted the staff when away from their patient. All hospitals had avenues to visually identify the patient who rated high risk for fall by a colored bracelet, slippers, socks etc all help to alert staff to keep an extra watch for these patients who may be attempting to get out of bed or chair. Some of the more unique interventions included "purposeful rounding" which solidified how frequent monitoring would be done along with easy frequent documentation of their rounding. Some institutions had comprehensive educational programs for the patient and family members which made the patient and family more involved in developing strategies to reduce risk for them self or loved one.

The literature emphasizes that applying the correct intervention to the correct risk factor is where we sometimes fail in development of an individualized fall care plan for our patients. Fall prevention programs are often applied broadly therefore missing the educational competency that must include the critical thought process of the care providers. The staffs' competence in the development of an individualized care plan for each patient that is rated high risk for fall becomes a crucial part of a fall prevention program.

All institutions collect data examining their fall rate along with how many of those patients where rated high risk for fall. Many institutions also gather the time from the last assessment before the fall occurred. These are key elements to consider in your own institution since it can provide insight on where to focus efforts in improving your own fall rates and care for patients. Institutions that are not capturing all of their fallen patients in their screening assessments may want to critically study their screening tool to ensure that evidenced based predictive elements are existent in their tool i.e.; history of fall, cognitive impairment, mobility impairment (gait, transferring, elimination) and the examination of medications. They may also want to survey how the screening tool is used and examine the inter-rater reliability of the assessment. Is the tool used in your institution capturing subjective data by interviewing the patient or family or capturing objective data by observation when the patient is ambulating?

Communication of a patients' fall risk is equally as important as the assessment and interventions. Identifiers on the patient, room and chart can be one method for alerting staff to a patients' fall risk. Clinical audits examining the consistency of the applied interventions and having a team approach in studying this data can keep fall prevention strategies fresh in the care givers mind. Documentation of fall risk, an actual fall and post fall interventions all assist in communicating strategies used by each caregiver. (McCarter-Bayer, 2005) Post fall huddles are becoming more popular with institutions since they attempt to develop the critical thought process of care providers offering real time case studies for the staff to learn. These huddles assist in completing the post fall investigation. Current fall data should be reported routinely to staff by unit so that they can trend their own fall rates. (McCarter-Bayer, 2005)

Patient falls continue to be a challenge to manage and financially burdensome in our current health care environment. Institutional sharing of data and strategies that reduce fall rates need to be continued and reported. Only through thorough investigation of fall data can we respond to our own fall prevention opportunities.

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