HELPING YOUR PATIENTS WHEN YOU’RE NOT THERE: PREVENTING FALLS IN THE HOME

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For the past decade, healthcare facilities have been focusing in on fall prevention. With the realization that over 1 million patients fall in hospitals every year, renewed interest in nursing quality indicators and the need to reduce hospital costs has developed, which has in turn led to new fall prevention protocols and programs.1 (See Xtrawise 14.4) What we have learned is that with heightened awareness, thorough assessment, and consistent fall prevention measures, the number of falls and falls with injury can be reduced in our healthcare facilities. New healthcare directives force us to consider the full continuum of care and extend our safe practices outside of the healthcare structure and into the home environment.

We also know that every year 1 out of every 3 adults who are age 65 and older will fall. Fortunately, not all falls are fatal; but falls are the leading cause of injuries, both fatal and non-fatal, to adults in that age group.2 Many of these injuries, which totaled 2.3 million in 2010, were treated in emergency rooms, with slightly more than a quarter of those who fell actually admitted to the hospital.2 This care in the emergency room and care for those who are hospitalized are an added cost burden to our healthcare system. The direct medical costs for falls in that same year were approximately $30 billion for the US healthcare system.3 Our population is aging, hospitalized patients are being discharged to complete their recovery at home, and we are faced with the probable increase in falls and consequent increased medical costs. While it is believed that all falls cannot be eliminated in the hospital or in the home, we know that steps can be taken to lessen the number of falls and the severity of falls.

DIRECT IMPACT OF FALLS

Approximately one-third of older adults who fall in the home incur moderate to severe injury. The most common injuries are lacerations, fractures of the hip, and head trauma.4 In the past 10 years, the death rate from falls in the older population has risen sharply. In one year, over 20,000 older adults died from injuries sustained from a fall.4 Many times non-fatal injuries from falls result in hospitalization and loss of mobility. Perhaps the greatest impact on the older adult is the loss of independence that results from a fall. In addition, many who fall, injured or not, develop a fear of falling, which leads to decreased activity, increased problems with mobility and physical fitness, and an increase in their risk of falling.5 Once we acknowledge that our older adult population is at risk for falls and that falls have a direct impact on their quality of life (even if they are not injured by a fall), we can take what we have learned from addressing falls in our healthcare facilities and apply it to our community-based older adults. As stated previously, we must do the following: 1) create a heightened awareness of the problem of falls; 2) provide thorough assessment of all older adults to determine if they are at risk for falls; and 3) promote consistent fall prevention measures if we are to establish a fall prevention program for our older adults that will lead to less falls and help them maintain an active role in our communities. Fortunately for us there are others who have already laid the groundwork in all of these areas.

CREATING A HEIGHTENED AWARENESS

Although there are several organizations that strive to educate the community about falls and fall prevention, the National Council on Aging (NCOA) has one of the most comprehensive programs available. NCOA has led the Falls Free® Initiative, which seeks to address the growing public health issue of falls and fall-related injuries and deaths in older adults. This national network is dedicated to reducing the number of falls among older adults. NCOA has instituted a national Falls Prevention Awareness Day, which is celebrated on the first day of fall each September.

Older adults who understand the need for remaining active to promote fall prevention in their lives are looking for programs that work and have a proven positive outcome. Acknowledging the importance of evidence-based practice, NCOA has evidence-based programs and suggested activities that are listed on the website and made available to the community. Our responsibility as healthcare providers is to become aware of these programs in our communities and to promote these programs by informing the older adults we come in contact with about them. We can learn more about the NCOA and the evidence-based programs on the National Council on Aging Center for Healthy Aging website found at www.ncoa.org.

PROVIDING A THOROUGH ASSESSMENT OF FALL RISK

It is not enough to create an awareness of the potential for falls in our older adult population. Since we know that approximately one-third of older adults will fall each year, it stands to reason that we must encourage older adults to understand what may put...
IN-HOME MOBILITY – WHAT TO KNOW ABOUT YOUR PATIENT’S ASSISTIVE DEVICE

Whether the assistive device is a walker, cane, crutches, wheelchair, electric wheelchair (mobility device), or a lift, you will want to make sure that each device is in compliance with the following points:
1. Properly sized for height, weight, and width.
2. Instruction in use for patient and/or caregiver by physical therapist or trained individual.
3. Home inspected for patient’s ability to maneuver around with assistive device (ie, a home visit from physical therapist or other trained individual).
4. Contact information if assistance is needed.
5. Contact information in the event of malfunction, loss, or damage to assistive device.
6. Confirmed date for follow-up (to determine continued need and/or adjustment).

CONT. FROM PG. 1 >> ...them at risk for falling. Once an older adult is admitted into a healthcare facility, the fall risk assessment becomes a tool for fall prevention while he or she is a patient. The information gained from that at-risk assessment should be incorporated into our discharge planning. Whether or not they were at risk prior to admission, their at-risk status may have changed due to their illness or general lack of activity during hospitalization. The patient must be made aware of the potential for falling in and around the home. If the patient uses a cane, walker, or wheelchair while in the facility, his or her home should be evaluated prior to discharge to ensure that the patient can move about the home using the assistive device properly.

Not all older adults are admitted to hospitals or other healthcare facilities, but most have regular visits to their physician. This may be the optimal opportunity to evaluate their fall risk. The CDC has several Fall Risk Assessment Guides, which are available through the STEADI (Stopping Elderly Accidents, Deaths & Injuries) program. All of the materials can be downloaded from the STEADI Tool Kit found on the CDC website (see Pulse on Resources, pg. 4). The CDC also provides materials that can assist the older adult in assessing the home for hazards that may cause potential for falls. We can assist in the thorough fall risk assessment of older adults by informing the physician’s office of the availability of these materials.

PROVIDING A THOROUGH ASSESSMENT OF FALL RISK

Fall prevention measures may differ from person to person depending upon risk score, age, and agility, but there are four main points stressed by the CDC and others when it comes to simple, consistent fall prevention for the older adult. They are the following:

1. **Begin a regular exercise program.**
   Remaining active is the best prevention. Exercise that improves balance and coordination is important. The NCOA lists several evidence-based exercise programs on its website.

2. **Have your healthcare provider review your medications.**
   All medications should be reviewed with a physician, including all over-the-counter medications taken on a regular basis. Knowing when to take medications, what the possible side effects of medication can be, and how the medicines interact with each other are just some of the items that can be discussed. Any change in medications should result in a new medication review.

3. **Have your vision checked.**
   Older adults should have their vision checked every year. Wearing old and/or ill-fitting glasses can be the cause of a fall.

4. **Make your home safe.**
   Approximately half of older adult falls occur in and around the home. There are many things to consider when “fall-proofing” the home. A list of concerns can be found on the CDC website, as well as on other websites mentioned in this article (see References and Pulse on Resources for Fall Prevention in the Home on Page 4).

A FINAL CONSIDERATION

All too often our patients are discharged to home with a need for home medical equipment. While these devices and equipment are necessary for recovery or for maintenance of health, the patient may not be prepared for using them in the home environment. Prior to discharge, the home must be evaluated to ensure that the equipment/assistive device can be safely used in the home and the patient must educated in proper use of the equipment/assistive device. In addition, proper selection of the Home Medical Equipment HME supplier is required. The HME supplier should be carefully selected based on experience, safety, and knowledge of both patient needs and equipment capabilities. (Please see page 3 for a list of suggested qualities of a HME supplier.)

WORKING TOWARD A FALL-FREE FUTURE

We understand that not all falls can be prevented, but we know that we have to begin the process of reducing the falls that do occur. If we follow the steps that have proved successful in our healthcare facilities, we may indeed be on our way to fewer falls and fewer deaths from falls in our older adult population. After all, we too will be older adults someday and we will want our future to be fall-free. ☺
EXTENT & SIGNIFICANCE OF COMMUNITY FALLS

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Falls in the community-dwelling older adult can be a major threat to independent living. Every 17 seconds, an older adult will be treated for injuries related to a fall. Every 30 minutes, an older adult will die from injuries related to a fall. As of 2011, 10,000 individuals turn 65 years old daily. As the population continues to age, the rate of fall-related deaths among older adults in the United States has also risen. As the Baby Boomer generation joins the ranks of older adults, the economic burden of falls will rise dramatically. By 2020, it is estimated that direct medical costs will be close to $55 billion annually.

Even though 1 in 3 adults 65 years of age and older fall each year, less than half discuss their fall with their healthcare provider. A fall not only results in physical and emotional pain, but also often the fall victim requires long-term care as a result of the fall, leading to loss of independent living. In 2007, there were 281,000 hospital admissions for hip fractures in older adults. Over 90% of those hip fractures were a result of a fall—a common cause of disability and death in older adults. Many individuals never return home; instead they must be admitted to a long-term acute care center (LTAC) or skilled nursing facility (SNF). In addition, 20% of older adults who suffer a hip fracture will die within a year due to a downward spiral of functional decline.

Fortunately, most falls are preventable. There are various fall prevention programs available to older adults living in the community setting (See Pulse, page 4). However, as falls are multi-factorial in nature, a multifaceted approach is required. Although studies agree that some combination of education and/or activity program should be implemented, there is not a consensus on the “recipe” that should be followed. By disseminating community-based fall prevention program information, it is possible to reduce community falls and help older adults live long, healthy lives.

IDENTIFIED RISK FACTORS FOR COMMUNITY FALLS

Intrinsic Risk Factors

Many of the risk factors for falls are invisible to the naked eye. Normal age-related changes such as a muscle weakness and hearing/vision changes, in addition to underlying comorbidities, contribute to older adults being at-risk for falls. Furthermore, recent illness and injury place older adults at a significant risk for falls.

Many older adults suffer gait and balance deficits from strokes or musculoskeletal pathologies requiring the use of assistive devices. Any lower extremity disability (loss of strength, orthopedic abnormality, or poor sensation) is associated with an increased risk of falling. Difficulty rising from a chair is also associated with greater risk. Patients who limit their mobility due to physical limitations...

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TOP 5 CONSIDERATIONS WHEN DISCHARGING YOUR PATIENT

1. Fall prevention must be discussed and printed materials be provided.
2. Review of medications with emphasis on interactions, need for adequate amount of fluid intake with medications, and review of side effects that may interfere with mobility and/or create a fall risk.
3. Assessment of footwear—lightweight, supportive, properly fitted, non-slip on shoes.
4. Proper instruction in use of assistive device (walker, cane, crutches) if assistive device is being used, even if the patient brought it into the hospital.
5. Reinforcement of need for exercise to enhance mobility—list of appropriate exercises provided through physical therapy, demonstrated to and with patient if possible.

RECOMMENDED QUALITIES FOR AN HOME MEDICAL EQUIPMENT (HME) SUPPLIER

1. The HME supplier should be accredited by a nationally recognized organization.
2. Staff should pass background checks, be professionally dressed, exhibit a nametag (some states like Florida require special name badges), and clearly identify themselves and their company before being allowed into the home. Their vehicles should be clearly identified and be neat in appearance.
3. Staff should have documented training on various types of equipment and should be able to produce ongoing proficiency assessments if asked. They should also have training regarding sensitivity for the home patient, cultural considerations, and how to identify and report suspected areas of concern.
4. The supplier should be known to the patient’s medical professionals, or at least willing to work with them in a multidisciplinary manner, to help understand what equipment may best accommodate the patient’s condition. They should be willing to provide a home evaluation to better understand each patient’s unique situation, and communicate those findings with the physicians, nurses, and therapists involved in the patient’s care.
5. The supplier should have a medical professional on staff available for assistance in unusual or particularly challenging situations.
6. Staff should be well versed in their area of expertise, with documented industry training and participation, and willing to refer to other specialty providers when the patient’s needs fall outside their realm of expertise.
7. The supplier needs to have a skilled billing team that is able to work with the patient’s insurance company to determine coverage for various durable medical equipment (DME) items, and be willing and able to bill the insurance carriers directly in most circumstances.
increase functional decline, become weaker and increase their risk for subsequent falls. Studies have shown one of the consequences of falls to be fear of falling (FOF) [12, 13]. FOF among community-dwelling older adults has been shown to be a common fear [12, 13]. Furthermore, in addition to being a consequence of a fall, it is also an independent risk factor for future falls [14]. FOF affects up to 92% of patients that have fallen as well as up to 65% of people who have never experienced a fall firsthand yet know someone who has fallen and the consequences that have occurred for this person [15]. Reduced physical and functional activity is associated with fear and anxiety about falling. The psychological consequences associated with FOF include decreased falls-related self-efficacy [16], fear of loss of independence [17], fear of institutionalization, increased social isolation [18], functional decline [19], depression and/or anxiety [20], embarrassment [21], loss of confidence [22], self-imposed activity restrictions [23] and decreased quality of life [24]. FOF may be more disabling to a person than the physical disability caused by the fall itself due to self-imposed activity restrictions, functional decline, increased risk of falls, and loss of independence. Any age group is susceptible to developing FOF; but it more common in the elderly due to vulnerability related to pre-existing risk factors for falls. Older adults tend to have comorbid conditions, take multiple medications, and may have some type of sensory impairment such as changes in vision and/or hearing. Furthermore, they may have experienced a fall, have changes in their peripheral and central nervous systems, and have decreased muscle mass/strength and bone density. Many medications prescribed to older adults increase their risk for falling. A significant risk of falling has been associated with use of medications such as psychotropics, class 1a anti-arrhythmic medications, digoxin, diuretics, sedatives, and benzodiazepines [25-27]. The use of four or more medications is associated with a nine-fold increased risk of cognitive impairment and fear of falling [28]. Additional side effects of medications include drowsiness, confusion, loss of balance, incontinence, and orthostatic hypotension, which are contributing factors to falling. Age-related visual changes include reduced accommodation to light and changes in depth perception. An older adult is less able to appropriately interpret their environment, and will be less likely to accommodate to changes in the flooring or swift changes in lighting. Along with muscles of the extremities, muscles of the eye also weaken. Visual impairments may include changes in visual acuity, contrast sensitivity, visual field changes, cataracts, glaucoma and age-related macular degeneration, which all contribute to risk of falls [29]. Bilateral and transitional glasses can impair depth perception and edge-contrast sensitivity at critical distances for detecting obstacles in the environment. Because of changes in depth perception of aging eyes, a phenomenon called “visual cliffing” may occur. This is where a change in color or texture is perceived to be a change in elevation or depth. Visual cliffing may actually cause a fall due to the misinterpretation of the environment, resulting in fear of falling (FOF). Patients with dementia and other neurological diseases may have poor memory recall and impaired judgment. Their environment may become unfamiliar to them and result in risk for falling. They may also suffer from agitation, aggression, and impulsivity. Due to these characteristics, their aggressive behaviors and the lack of asking for assistance with ambulation is another risk factor for falling.

EXTRINSIC RISK FACTORS

Place and space are important in the identification of our homes and perhaps become more so as people's needs change with age [30]. Environmental factors often have a tremendous influence on safety in the home. Older adults may also have problems with slipping or tripping secondary to lacking good balance or corrective mechanisms that allow them to prevent a fall. Environmental hazards including poor lighting, slippery floors, or uneven surfaces are easily identifiable as risk factors for a fall (22). Ill-fitting footwear and loose clothing can also contribute to risk for falling, especially in an older adult who has an unsteady gait. Poor lighting, cluttered walkways, children's toys, and small animals afoot are other extrinsic risk factors for a fall.