

Tailoring falls-prevention interventions to each patient

Instead of relying on universal fall precautions, customize care to each patient's unique fall risk.

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Falls result from an unsafe environment or known risk factors that haven't been addressed. Although most patient falls are preventable, falls are the top-reported adverse events in hospitals. A leading cause of injury in adults aged 65 and older, falls are the number-one cause of unintentional injury deaths in persons aged 85 and older. In 2010, 45% of the U.S. inpatient hospital population was aged 65 and older. Among these patients, 19% were ages 75 to 84, and 9% were ages 85 and older.

Obviously, preventing falls is a high patient-safety priority. As a nurse, your knowledge, skills,

and expertise are vital to protecting patients from falls and preventing or minimizing injuries caused by falls. Changing our practices and focusing on reversible risk factors can make a big difference.

However, while preventing a fall avoids patient harm, not all falls can be prevented. Protecting patients from falls and resulting injuries requires a population-based approach. That means we can't assume all patients have the same fall risk. As you reexamine your approach to core interventions for falls prevention and surveillance, consider the following do's and don'ts.

Fall risk assessment

DO design and implement an individualized plan of care for preventing falls. Screen patients for risk factors using a valid and reliable risk tool. Follow up with comprehensive nursing and interdisciplinary assessment (such as medical record review, fall and injury history, and cognitive, physical, and function evaluation) and care planning based on fall and injury risk factors.

DO use a team approach. Strong, sustained evidence supports falls prevention based on an interdisciplinary, multifactorial approach to assessment, intervention, and evaluation.

DO evaluate the types of risk factors found. Some individual fall risk factors can be modified; with others, the patient and family or home caregiver must learn to compensate. Defined fall risk factors serve as the patient's "diagnosis list." For each fall risk factor, list specific interventions linked directly to the risk. Then engage the patient and family or home caregiver in care planning.

DO schedule time with the patient and family to review re-



sults of the nursing and interdisciplinary fall risk assessment and defined fall risk factors. Besides engaging them, this educates them about why the patient is at risk for falls and about interventions to mitigate, eliminate, or compensate for each risk factor.

DO provide time for patients to discuss their concerns about falling, identify fall risk factors not on the list, confirm their understanding of their risk factors and interventions, and ask if they have concerns or questions. Make sure all communications with the patient, nurse colleagues, and other team members address *actual* fall risk, not the level of fall risk or a score.

DON'T simply tell a patient he or she is at risk for falls, apply an armband, post a no-falls sign, and report to the next shift that a patient is a high fall risk. These actions alone are inadequate.

DON'T rely only on universal fall precautions. Although these standard strategies help create a safe environment that reduces accidental falls and delineates core preventive measures for all patients, each patient has a unique fall risk based on individual assessment. No evidence supports implementing universal fall precautions alone as the key best practice for reducing fall risk. You must evaluate interventions listed in universal fall precautions for each patient. For instance, not all patients

When to use a low bed

Low beds are designed to reduce the distance a patient falls after rolling out of bed. Although these beds don't prevent a fall, they reduce the distance of a fall, helping to decrease trauma and injury. (Haines et al. found low beds don't reduce falls or injuries from falls compared to matched controls. However, larger studies are needed to determine the effect of these beds on fall-related fractures.)

Keep these do's and don'ts in mind for patients with low beds.

DO place the bed in a low position when the patient is resting in bed or if you're concerned the patient might roll out of bed.

DO use a floor mat at the bedside to reduce impact from a fall.

DO raise the bed to the proper height for the patient to transfer or stand up from the bed.

DON'T leave the bed in a low position at all times. A patient who is 6' tall with weak leg muscles who tries to sit on the bed from a standing position is likely to fall onto the bed, because it's too low for him to lower himself safely. Similarly, if he tries to get up from a low bed without assistance, he's likely to fall back down onto the bed or miss the bed and fall onto the floor.

should be placed in a low bed. (See *When to use a low bed*.)

Proper footwear

Nonskid socks are meant to prevent the feet from sliding. They're used in many clinical settings, probably because going barefoot or wearing standard socks is linked to a much higher fall risk. However, Chari et al. compared slip resistance during mobilization, incline, and descent in patients with bare feet to patients wearing nonskid socks or compression stockings. They found bare feet provide better slip resistance than nonskid socks during mobilization and incline.

DO have patients wear proper footwear. Use nonskid socks to prevent from the feet sliding upon standing. How-

ever, for ambulation, encourage patients to wear appropriate, well-fitting shoes—not nonskid socks.

DO teach patients, families, and home caregivers about footwear recommendations, because financial and comfort aspects are likely to outweigh safety considerations for older patients' footwear.

DON'T put nonskid socks on a patient with a shuffling gait or on a foot with foot drop (impaired dorsiflexion).

Fall surveillance methods

Surveillance systems enable staff to monitor patients before a fall through direct or indirect observation or notification.

DO observe. Rounding allows direct visual observation; cam-

eras provide remote observation. Alarm features on beds and chairs also provide notification. Many hospitals use movement alarms, although evidence on their effectiveness is still emerging.

DO measure the effectiveness of fall surveillance by timeliness of response to a patient's attempts to get up without assistance—*not* by reduction of overall fall rates.

Bed alarms

Bed alarms act as early-warning systems to alert nursing staff that a patient is starting to get up from bed without assistance. They're designed to promote timely rescue, not to prevent falls from bed. Shorr et al. found no statistical difference in fall reduction between units with bed alarms and control units. Bed alarms may even cause harm stemming from false alarms, alarm fatigue, and placing alarms on the wrong patient, so they must be used appropriately. Also, we need more research on bed alarms, in addition to well-designed evaluation of their implementation and effectiveness.

DO consider using bed alarms for patients who are unable to use the call light to call for help, fail teach-back strategies, can't participate in fall-prevention care, or are mobile enough to get up from bed. However, evaluate whether sound from the alarm may cause more harm than benefit.

DO orient patients and family


members to the alarm sound, how it's triggered, and alarm alternatives that could agitate or scare the patient. Alternatives include alarms with voice-over recordings by a family member, integration into a call light or smartphone app to eliminate alarm sounds, and real-time surveillance camera technology that is alarm free but features continuous observation.

DON'T place bed alarms on patients who are immobile, unable to get out of bed, or deemed at high fall risk based on assessment or fall risk score.

DON'T assume one type of alarm technology works for all patients.

Nurses can lead interdisciplinary efforts

As nurses, we must advance falls-prevention practices beyond universal fall precautions based on each patient's score or a level of risk. Use your clinical judgment and expertise when selecting core interventions to protect patients from falling.

As nurses, we're called on to lead nursing and interdisciplinary approaches that individualize plans of care based on actual fall and injury risk factors. Doing this requires nursing leadership within an interdisciplinary approach to care. 

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