Falls

Literature Review

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FALLS

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Falls do not usually cause fear with those of the younger generation, but when it comes to the older generation, it can cause several health-related issues. "More than one in three people age 65 years or older fall each year. The risk of falling—and fall-related problems—rises with age" (National Institute on Aging, 2017, para. 1). Nurses have the responsibility of performing fall risk assessments on patients to determine if they're a fall risk or not. Learning whether the patient is a fall risk is a massive factor in the patients care. "If a patient is at risk for falling, a comprehensive assessment should be completed in order to initiate a multifaceted fall prevention program that is tailored to the individual" (Fall Prevention Task Force, 2019, para. 1). If improper fall risk assessments happen upon admission, it could result in a fall for the older generation. Fall risk assessments are usually done within a nursing home, assisted living communities, and hospital settings. It is a very crucial component of the admission process; if this does not happen correctly, the effects could be very severe. Falls could even result in deaths, broken bones, and more.

Reducing Fall Risk in Older Adults

"Falls are the leading cause of fatal injury and the most common cause of nonfatal trauma-related hospital admissions among older adults" (National Council on Aging, n.d., para. 3). The rates of medically treated falls are rising with the increase of the baby boomer generation becoming older, which could put a burden on health care if they do not do anything to prevent falls shortly. "Although falls among older adults are common, they can be prevented by targeting modifiable risk factors such as vestibular disorders, postural hypotension, vision impairment, foot problems, and medication adverse effects" (Haddad, Bergen, & Feijun, 2018, p. 21) There are many things that older adults could do to prevent falls, such as physical therapy or looking to

see if their medication could be a cause to them falling. There are many things that older adults could do to prevent falls, such as physical therapy or looking to see if their medication could be a cause to them falling. "More than half of older adults (53%) used at least one medication in 2013 whose adverse effects linked to falls (Haddad, Y, Bergen, B, & Feijun, 2018, p. 21). If we could identify these medications before patients start to take them and notify them what the adverse effects are, it could change falls.

Key Points

   Some of the critical points of this article are that they had linked patient falls to the deterioration of the body with age and also that the patient's medicine could also be a reason they're falling. There could be a big difference between the two types of reasons why patients have been falling recently, but they both can connect back to each other. We have learned in other classes how important it is to be able to prevent fall in the older generation because it could cause severe injuries or maybe even death.

Assumptions

Assumptions that the article stated are that all the older generation is experiencing falls due to these types of problems. There could be plenty of older adults who don't experience falls at all even though they're taking medicines that could cause adverse effects on them. As we get older, our muscles also deteriorate making use weaker, but that doesn't mean that this is a precursor to them experiencing falls.

 Deficit/Conclusion

     As nurses, we play a vital role in reducing the falls of our patients and being able to identify the medications that are associated with them as well. We could ask the physicians to change medicines so that it could prevent that aspect of falls altogether. "Minimizing older adults'

exposure to psychoactive medications is an important intervention to improve health outcomes and decrease falls" (Haddad, Bergen, & Feijun, 2018, p. 21).

<div align="center">**Assessing your patients' risk for falling**</div>

Nurses should always be trying to improve patient safety by performing proper fall risk assessments. The Morse Fall Scale consists of 6 sections these sections are "history of falling; immediate or within 3 months, secondary diagnosis, ambulatory aid (bed rest/nurse assist, crutches/cane/walker, furniture, IV/Heparin Lock, Gait/transferring (normal/bedrest/immobile, weak, impaired), and mental status (oriented to own ability or forgets limitations)" (Network of Care, n.d., para. 1). Once assessed, you are giving a score which puts you into either a no risk, low risk, or high-risk category. A fall assessment should be done upon arrival to a healthcare facility, transfer to a new unit, and after a fall. "When assessing a patient for a fall risk, check for: history of falling within the past year, orthostatic hypotension, impaired mobility or gait, altered mental status, incontinence, medications associated with falls (such as sedative-hypnotics and blood pressure drugs, and use of assistive devices" (Lunsford, & Wilson, 2015, para. 12). Nurses should also know there are three different types of falls these falls are anticipated physiologic falls, unanticipated physiologic falls, and accidental falls.

Key Points

Some of the critical points are that they split the falls into three separate categories. These three categories separate the difference between the history of falling, syncopal episodes, and things like tripping or slipping. As nurses, we should know that all falls aren't just because someone is weak, and they can't stand any longer. The article also stated, "Even if the patient has a low score, don't let this distract you from implementing interventions to reduce the risk of falling if the patient has identifiable and preventable risks" (Lunsford, & Wilson, 2015, para. 18)

This is very important because even if a patient is unlikely to fall, they could trip over something in their room and that would put them at a higher risk for falls later on.

Assumptions

Assumptions the article stated are that every health care facility has the time to do a proper fall risk assessment every time a patient needs one. Facilities may be understaffed, which could lead to an improper fall assessment. In a busy schedule, nurses need to make time for these fall risk assessments because in doing so, they prevent future injury and possible death in the older adults.

Deficit/Conclusion

Performing proper fall risk assessments allows our patients to not only be safe in our care, but it prevents them from further injury. "A critical step in this multifaceted process is communicating the patient's fall risk and required interventions to colleagues, the patients and family, and significant others who need to support the interventions. Using a systematic process to identify and address the fall risk can nearly eliminate anticipated falls, prevent unanticipated falls from recurring, and significantly decrease accidental falls" (Lunsford, & Wilson, 2015, para. 19). If proper fall risk assessments and communication between collogues occur, but for falls to be prevented.

5 hospital-proven strategies to prevent falls

Nursing interventions are one of the many ways to prevent our patients from falling. The Mayo Clinic (2016) states these as there six fall-preventions, "make an appointment with your doctor, keep moving, wear sensible shoes, remove home hazards, light up your living space, and using assistive devices." As nurses, if we use these six of these, it could easily prevent falls within the health care community. "Hospitals that have had the most success with reducing

patient falls share two common traits: they take the time to measure and analyze specific contributing factors that led to falls, and they also have a culture that supports 'zero falls'" (MacDonald, 2016, para. 1). By providing a "zero falls" environment in a hospital that allows patients to feel more comfortable but also will enable nurses to assess fall risk patients and follow through with fall risk interventions for each patient. "Five hospitals participated in a program that featured a report and were able to share their best practices to successfully reduce patient falls these are: a unit-wide educational effort for staff and patients and "Call, Don't Fall campaign, interventions to improve communication and use of call lights, creating a culture that reinforced a no one walks alone approach, and standardized fall safety messages" (MacDonald, 2016, para. 4). If patients are told to use their call and where they didn't walk alone, that could easily prevent falls throughout all of the healthcare field across the United States.

Key Points

Some of the critical points the article stated are that five hospitals are implementing these new interventions, and they seem to be working. This research allows for others to be able to see the significance of these and how they could implement these into their facilities. We should treat patients like "every patient on the unit is considered a fall risk, regardless of age, and as a result bed alarms are set in every room so all patients must be assisted each and every time they leave their bed for any reason" (MacDonald, 2016, para. 8). If we teach our workers to do this, we could prevent simple fall risk due to orthostatic hypotension or just because they lose their balance when getting out of bed.

Assumptions

Due to understaffing at many healthcare facilities, these interventions might not be able to be implemented into every facility. These interventions could be very impactful to a lot of

health care facilities. Another hospital also used a "video monitoring system," as a part of the nursing community. Video monitoring could easily violate the patient's privacy through HIPAA. Patients privacy should also be one of our top priorities, as well.

Deficit/Conclusion

These interventions have had a positive effect on the five hospitals that have implemented them. With more research, these interventions could be researched more then brought into other facilities. The hospital that performed the "Call, Don't Fall" campaign reduced falls by a total of 43 percent. The hospital that implemented the "standardized fall safety messages" reduced falls by a total of 50 percent (MacDonald, 2016). If these hospitals can reduce falls that much so can other facilities as well.

Conclusion

In conclusion, it is crucial to perform proper fall risk on all our patients upon admission to a healthcare facility. The CDC (2017) states, "Over 800,000 patients a year are hospitalized because of a fall injury, most often because of a head injury or hip fracture." Knowing what medications our patients are on as well could also help prevent falls. If we notice they are on a medication that causes them to be dizzy, we should immediately call the doctor and ask them to change the prescription. Performing a proper MFS (Morse Fall Scale), allows us to know what risk a patient is at for a fall these risks could help us identify specific interventions for these patients. As nurses, we need to remember, "Falls are a serious health issue among seniors. While falls in the general population usually come about due to dangerous work or leisure activities, seniors are at greater risk of falling in their day-to-day activities" (Aging.com, 2017, para. 1).

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