
Elizabeth Capezuti
PhD, RN, FAAN


Sarah Hope Kagan
PhD, RN, FAAN


Mary Beth Happ
PhD, RN, FAAN


Lorraine C. Mion
PhD, RN, FAAN

Not Preventing Falls—Promoting Function

Sarah H. Kagan, PhD, RN, FAAN, and Alicia A. Puppione, MSN, RN

Among the hallmarks of good geriatric care lies—my pun is intended!—fall prevention. Preventing in-hospitals falls may be among the most controversial, frustrating, and stagnant aspects of geriatric acute care nursing practice. Think back to the last time you and your colleagues talked about falls on your unit. Sentiments such as, "What should we do now?", "What can we do differently?", and "How can we see a real difference?" almost certainly emerged in that conversation. Most fall prevention activities aim at establishing a predictive approach to sorting out when and how older patients will fall, avoiding risks associated with those factors, and keeping our patients stationary to prevent them from falling and injuring themselves. Contrary to all that we espouse about function and older adults, most falls prevention programs rely on an intricate set of capacity assessments, risk categories, and alert systems with little effort to correct or modify the patient's functional disability. At best, some may prescribe basic physical therapy. However, many falls programs we have observed seem in reality to be anti-activity programs for hospitalized elders. The anti-activity nature of fall prevention efforts seems counterintuitive, despite being reassuring and comforting in a "wrapped in cotton wool" sort of way and predictably futile. There has been no substantial progress in preventing falls and keeping patients safe.[1]

Even a cursory review of current hospital falls literature quickly reveals that most fall prevention programs offer equivocal results at best.[1-4] Even larger trials with capacity to reduce fall rates are unlikely to see reduction in the holy grail of fall-related injury rates.[4,5] In fact, reviews published in the past decade conclude that problems with definitions, methods, and interventions contribute to outcomes that remain largely unchanged no matter what program is implemented.[1,4,6] No wonder nurses, patients, and their families, to say nothing of hospital administrators and regulators, are discouraged. Fall prevention programs often do not prevent falls. Falls result in fear, the possibility of injury, and liability for nurses and other clinicians.

Perhaps these stagnant outcomes in fall prevention arise directly from a perspective that emphasizes avoiding motion and risk aversion to prevent falls. Fall prevention assumes that no fall is acceptable and consequently implies less motion—not more—is the means to avoid any fall. As geriatric clinical nurse specialists, we certainly have witnessed the consequence of this sequence of assumptions in practice. Walk past the hospital room of a patient judged to be at risk for falls and observe the lack of mobility. In bed or in the chair, signs and now even color-coded socks and blankets bear testament to increased risk so that the patient is unlikely to be engaged in functional gross motor activity. Our efforts to prevent older patients from falling in our hospital wards creates restricted mobility, limited function, and likelihood of exacerbating factors that actually lead to falls.

Nurses need to shift our frame on the problem radically from prevention to promotion, learning to tolerate certain sorts of falls while reducing the chances of any falls-related injury. Avoiding injury instead of avoiding falls acknowledges that people—young and old alike—actually will fall as they move about their environments. Falls, in and of themselves, risk 2 outcomes of consequence to older people. The first risk is that people who fall often come to fear falling. This fear can isolate and immobilize people who do not understand how to fall safely rather than offer support in feeling confident in falling and limiting both falls and risk of injury. The second risk is

that people who fall will injure themselves. Injury escalates fear of patients and their loved ones and motivates clinicians to try to limit opportunities to fall. Unfortunately, limiting opportunities to fall generally translates to moving a lot less.

The manner in which patients, their loved ones, and clinicians alike interpret real or potential fall outcomes leads to paradoxical responses that more often than not create risk of falling. Those who fear falling often become less fluid as they rise, walk, turn, and climb stairs.[7] Recall the last time you tried to walk across an icy patch of pavement and you will soon recollect that fear and its impact on your own mobility. Older people who are immobile quickly lose function. Although they may retain some ability to ambulate, associated capacities such as core strength, balance, and coordination may quickly dissipate, leaving older people who have been immobile or strictly limited in function for even a short hospital stay challenged by what is now intrinsic risk for falls. In short, responses that avoid risk, avoid mobility, and limit functional activities ironically promote risk of further falls.

The current frame for understanding falls fails to acknowledge that people will fall, whether or not we keep them as motionless as we can. The solution then lies in better movement and safer mobility. Avoiding fall-related injury suggests that exercise is the answer to avoid falls and consequent injury. Stronger people still fall, but they fall more safely. Almost any competitive sporting event easily reveals this principle. Shifting our frame from preventing falls to promoting function avoids realizing in practice exactly what we wish to avoid. To reduce fall-related injury, we need to reject restricting movement in an effort to limit the potential for a fall and learn to tolerate risk for falls with the aim of helping patients become stronger, less likely to fall, and better able to avoid injury if they do fall.

Several steps are necessary to take the idea of promoting function through exercise as a substitute for limiting mobility to prevent falls a reality.

- First, exercise needs to be available in hospitals. Many hospitals face limited availability of physical therapists and, for most, those therapists are the only providers of supervised exercise for patients. Additionally, this set of limitations often generates an evaluative focus for physical therapy. We assess a patient against criteria necessary for discharge home or rehabilitative potential but less often aim for fitness goals matched to falls risk. Nurses must advocate for more physical therapy colleagues and for their thoughtful deployment on nursing units. We must also educate our patients and their families about the value of exercise and physical therapy.
- Second, more hospital staff members need to be able and available to supervise exercise. Cameron et al'[8] recent Cochrane review clearly outlines the value of exercise in preventing falls among hospitalized patients. The evidence supporting the effect of exercise in limiting falls among hospitalized patients is somewhat limited in aims, scope, and methods.[8] Nevertheless, benefits of exercise clearly offer advantages in regaining lost functional capacity and likely mitigate risk of falls and risk of injury with a fall for hospitalized patients.[8] This is likely true even for very frail and physically vulnerable individuals such as those in intensive care.[9,10] Nurses must champion the value of exercise to promote function and regain or retain mobility to hospital administrators, patients, families, and even insurance companies.
- Third, we need to challenge the accepted value of nursing practices that are explicitly "anti-activity." Phrases such as "out of bed with assistance only," "only get up with assistance," "call for help but don't get out of bed," and "call light in reach" populate our conversations with and documentation of patient and family education to prevent falls. Just as admonishing patients not to manipulate tubes and catheters about which they are curious or that bother them does not work to prevent them exploring and removing them, neither will instructions aimed at controlling behavior and preventing falls. Nurses need to make their care more logical, not more restrictive and limiting for older people who need their intervention to live safer, healthier, more fulfilling lives.
- Fourth, we must carefully judge how we gauge the risk of falls for individual older patients. Increasingly, evidence from critical evaluation of fall risk assessment tools suggests that many are published without adequate appraisal of validity and reliability, lack sensitivity, and present the double-edged threat of identifying high numbers of hospitalized patients as being at risk.[11,12] Although there is opportunity to intervene in knowing risk, having every

patient at risk makes it impossible to justly and safely deploy nursing and other resources. Making patients safe is our first priority. As a result, the argument to promote exercise requires much more sensitive assessment tools and discrete understandings of the elements of function necessary to a safe and secure gait. These elements include strength, balance, and coordination.[13,14] Assessment of these and other risk factors for falls require careful individualization in light of the potential severity of injury. Nurses need education and support to make clinical judgments of individual patients that result in plans of care that are evidence-based and in improved outcomes for patients who are encouraged to be as functional and mobile while remaining safe in the hospital and at home.

In many ways, discarding fall prevention in favor of promoting function is long overdue. Public health education obviously directs older adults themselves to exercise as a means to improved health and to limit risk of falls. In a prelude to a slide show on balance exercises, the Mayo Clinic website (*www.mayoclinic.com/health/balance-exercises/SM00049*) reminds older adults that better balance may result in greater independence. The National Institutes of Health Senior Health website (*http://nihseniorhealth.gov/exerciseforolderadults/balanceexercises/01.html*) goes a step further and suggests that balance exercises may actually help reduce injurious falls. Exercise redirects falls prevention from a risk profile to an opportunity to intervene with older people and especially those bearing the vulnerability of hospitalization. So then we ask what sensible geriatric nurse would ever espouse limiting function and restraining patients in favor of promoting health, function, and well-being? None whom we know would willingly take this position, yet nurses advance this view every time we see a typical fall prevention program as a viable solution to the problem. Seeing the lack of logic in our current approach to fall-related injury and changing how we frame the problem allows us to advance the broader aims of better care for hospitalized older adults.

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SARAH H. KAGAN, PhD, RN, FAAN, is Lucy Walker Term Professor of Gerontological Nursing and Clinical Nurse Specialist at the Abramson Cancer Center, University of Pennsylvania, Philadelphia, PA. ALICIA A. PUPPIONE, MSN, RN, is the John Douglas French Geriatric Clinical Nurse Specialist at St. John's Health Center, Santa Monica, CA.

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