

REDUCING THE RISK OF FALLING FOR OLDER PEOPLE LIVING IN THE COMMUNITY

INTRODUCTION

Falling is common in people aged 65 years and over, and can have devastating and far reaching consequences including loss of confidence, serious physical injury and even death (Bradley & Harrison, 2007). The incidence of falls and fall related injuries for people aged over 65 years in Australia is increasing (AIHW, 2007). The public health response advocates falls risk screening for early identification of people at risk and implementation of falls prevention intervention. Home healthcare professionals are identified as being well placed to conduct falls risk screening with older people in their homes (Williams, 2005). The existing falls risk screening tools generally rely on a question and answer format. But is this the best way of screening for falls risk with older people? This article reports the findings of research undertaken with RDNS nurses to identify the most effective method for district nurses to screen the falls risk for older people living in the community.

What is the issue?

People falling is a serious public health issue. Previous investigations have shown a third of individuals aged over 65, and nearly half of those over 80, fall each year, and of those individuals, nearly one quarter experience serious injury. Recent analysis identifies falls as the largest category of accidental death, exceeding even road traffic accidents. Defining a fall is difficult due to the multitude of situations in which a fall can occur and differing perceptions about what constitutes a fall. Falls are often regarded as 'accidents', however statistics demonstrate that falls are often not random events. The World Health Organisation ((WHO 2008) offers the following definition: *"A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level."* The experience of community nurses is that older people may end up leaning against the wall as a result of falling. This is a common occurrence which can disguise that the person has fallen. People themselves may not consider they have had a fall and therefore do not report it.

Why do older people fall?

Falling is not an inevitable part of ageing; however the evidence indicates that the risk of falling increases as people become older (NPHP, 2005). Furthermore, all older persons are not equally at risk. Particular factors increase

the risk of falling, the most common being:

- Older age (over 65 years)
- Confusion and disorientation
- Taking certain types of medication
- Physical weakness or poor coordination
- A past history of falling (Jordan, 2006).

Not surprisingly, older people who have multiple risk factors for falling are more likely to fall. The risk factors for falls are diverse and multifaceted with many of them being potentially modifiable (NICE, 2004; Todd & Skelton, 2004). There are a multitude of risk factors for community dwelling older people including:

- intrinsic factors such as being female, living with chronic illness, and living alone
- extrinsic factors such as poor lighting, slip and trip hazards in and around the home and inappropriate walking aids
- exposure to risk, such as using ladders or step ladders, wearing unsuitable footwear and unsafe practices when exercising
- psychological factors such as fear of falling, confusion and depression.

(NICE, 2004; Todd & Skelton, 2004).

Older People's Perceptions of Falls

Older people perceive that those who fall are considered by others to be frail and decrepit. This perception may lead older people to be unwilling or fearful about admitting to falls. This presents healthcare professionals with a conundrum. Health promotion for older people advocates early identification for people who are at risk of falling in order to intervene to prevent falls. Yet older people at risk for falls may withhold information about past falls or avoid divulging certain facts about their abilities. Protecting one's identity may be prioritised over minimising the risk of falling (Yardley 2006). This is considered to be important to keep in mind when caring for older people who are at risk of falling. Non-confrontative approaches are advocated which convey falls prevention strategies positively, as important to healthy aging and maintaining good quality of life (Yardley 2006).

How was the research conducted?

The research aim was to identify a falls risk assessment tool appropriate for RDNS clients over the age of 65 years and living in the community. In order to meet this aim it was necessary to understand the factors that affect falls risk and scope national and international falls risk assessment tools with a view to identifying a falls risk assessment tool to support best practice. A literature

review was undertaken at the outset, incorporating published literature and national and international projects on falls risk screening and assessment. Qualitative data was collected by semi-structured face to face interviews with 12 RDNS SA District Nurses of diverse levels and specialities working in the Northern and Southern Divisions of RDNS. Questions were asked about the nurse's experience of falls, knowledge about falls, attitudes toward the introduction of a falls risk screening tool and referral practice once a person is identified at falls risk. Interviews were audio-taped and transcribed so that the data could be analysed by the research team to identify common themes and understandings.

Findings from the Literature Review

The literature review revealed some important information including:

- Falls risk screening tools were usually developed around common risk factors and adopted a question and answer format. Most fell short of being evidence based and were not considered to be appropriate for the RDNS client group.
- Falls risk screening is a recommended intervention in the literature (Hill et al., 2004; NICE, 2004).
- Home healthcare professionals are considered to be well placed to conduct falls risk screening activities (Williams, 2005).
- There is now a considerable body of evidence based on the findings of randomised controlled trials involving community dwelling older people regarding the benefits of falls prevention programs and specific interventions (Clemson et al., 2004; Tinetti, Baker, McAvay et al., 1994; NICE, 2004; Gillespie, Gillespie, Robertson et al., 2003; Todd & Skelton, 2004; ASCQHC, 2008; Close, Ellis, Hopper et al., 1999; Day, Fildes, Gordon et al., 2002).
- Multidisciplinary interventions targeting multiple risk factors are effective in reducing the incidence of falls however single interventions targeting one risk factor are less effective (Gillespie et al., 2003).
- Muscle strengthening, combined with balance retraining that is individually prescribed at home by a trained health professional, is effective (NICE, 2004; Gillespie et al., 2003).
- Home hazard assessment and modification by a health professional may reduce falls particularly for people with a history of falling (Gillespie et al., 2003; Tse, 2007; Chircop, 2004). However there is no evidence to suggest that this is an effective intervention is isolation (Hill et al., 2004; Feder et al., 2000).
- Review and modification of medication related to falls needs to be conducted as part of a multi-factorial falls prevention intervention (NICE, 2004; ACSQHC, 2008).
- Individually tailored interventions delivered by a health professional are more effective than standard or group programs.
- An effective multi-factorial intervention program commonly includes:

- o Strength and balance training
 - o Home hazard assessment and intervention
 - o Vision assessment and referral
 - o Medication review with modification/ withdrawal
- (NICE, 2004)

Findings from interviews with District Nurses

Four main themes were identified from data analysis. These included:

1. Finely honed assessment and monitoring skills
2. Re-engineering the environment
3. Just filling in another form
4. Referral-not a straightforward path.

Finely honed assessment and monitoring skills

District Nurses have expertise in ongoing assessment and monitoring of clients in their homes. This is considered to be an essential part of caring for people. Risk for falls is one of many aspects of client health that is continuously being monitored. During a home visit the nurse scans the home environment for signs such as clutter, rugs or mats, bruises on legs, and engages the person in casual conversation about what has been happening since the last visit. The familiar relationship the nurse has established with the client provides a basis of trust enabling the client to be relaxed with the nurse. The nurse is sensitive to the anxieties or fears that discussion of falls can trigger for older people and she or he tries to approach these situations gently in a positive and constructive manner that conveys fall strategies as ways to maintain independence and quality of life. One nurse's said:

... you might go into someone's home and you might see them on their feet... that's the best... really almost the best way of assessing if they're at risk of falling: How mobile are they; how safe are they on their feet; what aids have they got; are they able to get up those three flights of steps from the sunken lounge to the fridge? Are they complaining that they're dizzy, or they get terrible headaches, or are they waking up at night and getting confused? I mean they're the types of things where people fall over.

Re-engineering the environment

Falls often occur as accidents such as tripping over a rug on the floor. Environmental hazards are a risk factor for falling. The home environment may not have been set up with falls risk in mind and older people may not be able to keep the home tidy as they once did. Further, they may not be aware of how home modifications can make the home safer in terms of preventing falls. Removing obstacles, re-organising furniture and advocating for home modifications are all things the nurse can do immediately to make the home environment safer. However, as a visitor in the person's home, nurses are mindful of respecting the person's private space and they work with the person to gain their approval for any changes before they are made. The options are presented as suggestions initially as evidenced by this nurse's explanation:

"Let's move that pot-plant because it could [cause you to trip]..." "How about we get the grab rail at the back door for you?" "You've got 3 steps there,

maybe we could look at you just using this door...we talk about re-engineering the environment...

Home hazard identification and modification is a key strategy recommended in most falls prevention programs.

Just filling in another form

Nurses interviewed considered it to be futile to introduce a falls risk screening tool. The opinion was repeatedly expressed that a falls risk screening tool would add one more piece of paper to an already burdensome pile. Nurses considered that a falls risk screening tool would have limited value given the superficial, direct questioning approach and the tendency for older people to withhold or distort information about falls or abilities. Some nurses questioned the point of another assessment when there were so few places to refer to when a person had been identified as being at risk. A small number of nurses preferred that it be incorporated into the Client Assessment Dependency Instrument (CADI) prompting a more in-depth assessment if the person was identified at risk.

If there's a point to it, if we are identifying this person... 'Yes, they are highly at risk of falls,' what are we going to do with that information?... are we going to refer them on to some falls group, or something that's actually going to help? Otherwise it's just filling in another form, ... that doesn't get used for anything.

Referral:-not a straightforward path

According to District Nurses, referral to another service can be fraught with difficulties. District Nurses perceive that they have a very limited number of referral points available to them from which to gain assistance with people who are at risk of falling. As one nurse explains:

It's just knowing where to [go]... as a nurse, knowing where to go to find information... that's my biggest problem.

A familiar referral point is Domiciliary Care, however this can be problematic due to long waiting lists that are inappropriate when a person's wellbeing is immediately threatened by falls risk:

... if you go to see someone and you walk in and they're unsteady on their feet, they've got trouble getting out of their chair and they don't seem to have any aids, you can make those referrals to Dom Care, but they're not acted on for a long time... we don't have the resources in the community for urgent things to be addressed like that... some things that you'd like addressed within a couple of days, may take a week or two weeks or longer.

Further, clients may not attend appointments as agreed or they may not co-operate with the professional's advice or treatment when they do attend. Then there can be problems associated with transport to appointments and the associated costs incurred, as many people receive multiple services and cannot afford additional costs.

Development of the "Promoting Falls Prevention" Tool

District nurses can play a critical role in ongoing monitoring and assessment of clients to enable people who are at risk for falls to be identified. This research has affirmed the strengths of district nursing practice as the most effective way to work with older people around issues such as falls. District Nurses have honed monitoring and assessment skills related to ensuring older people maintain health and quality of life. Some falls prevention strategies are already being carried out by District Nurses, such as monitoring the person's mobility capacity and use of mobility aids, making referrals for home modifications and assessing the person's home environment to identify and remove hazards. RDNS has a method of screening for falls risk in place via the district nursing relationship and visits. As indicated by the literature and district nursing interviews, there needs to be a more systematic, multifaceted approach to the development and implementation of a falls prevention plan. Part of this depends upon a more informed RDNS referral pathway. The "Promoting Falls Prevention" tool has been developed as an outcome of this research to provide District Nurses with some options to support decision making and points of referral is considered necessary.

What to do when risk is identified using the Promoting Falls Prevention tool

- Talk with the client about falls and falls risk. Provide the opportunity for conversation about falls.
- Together with the client/family, consider risk factors existing for the person and develop a tailored multifaceted intervention plan which minimises or addresses the risk factors, taking account of the person's preferences and motivations. e.g. incontinence can be a risk factor
- There maybe some actions that can be taken right away by the District Nurse to reduce falls risk, e.g. incontinence - consider commode by bed, encourage toileting regime and ensure supply of continence aids
- Referral to other health professionals may also be necessary to access assistance with reducing risk factors, e.g. referral to GP and/or referral to continence nurse specialist
- Monitor and repeat screening process at regular intervals during client contact
- Document the assessment, recommended action and outcomes.

The "Promoting Falls Prevention" tool can be found overleaf.

The "Falls Prevention Resource Directory" is available on request to the RDNS Research Unit.

References

A complete list of references is available on request to the RDNS Research Unit:

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PATHWAY FOR PROMOTING FALLS PREVENTION

Actions	Intervention Goals	Referral Pathway
<p>Consider hip protectors/ padding for head elbows knees. Increase sunlight exposure and intake of vitamin D. Provide information sheet (available in Division).</p>	<p>Minimise falls and injuries</p>	<p>Refer to GP. Refer to physiotherapist. Consult the Falls Prevention Resource Directory.</p>
<p>Review footwear needs. Review walking aids. Educate about optimal nutrition and fluid intake. Provide information sheet (available in Division).</p>	<p>Ensure safe mobility, increase muscle strength and balance</p>	<p>Refer to GP for assessment. Refer to physiotherapist, OT, podiatry, dietician. Consult the Falls Prevention Resource Directory.</p>
<p>Ensure adequate lighting day/ night. Ensure glasses or hearing aid is working effectively. Provide information sheet (available in Division).</p>	<p>Promote safe environment to accommodate sensory impairment e.g. poor vision, hearing, vertigo etc.</p>	<p>Refer to GP for assessment Refer to Optometrist. Refer to Audiologist. Refer to OT. Consult the Falls Prevention Resource Directory.</p>
<p>Consider commode by bed. Encourage toileting regime. Ensure appropriate continence aids. Colour prompts/signage. Provide information sheet (available in Division).</p>	<p>Ensure safe environment while managing continence</p>	<p>Refer to GP for assessment. Refer to continence nurse advisor for management plan.. Consult the Falls Prevention Resource Directory.</p>
<p>Education about strategies to reduce effects of postural hypotension. Provide information sheet (available in Division).</p>	<p>Minimise the effects of medications on safe mobility</p>	<p>Refer to GP for Home Medication Review (HMR).</p>
<p>Suggest removing clutter and obstacles. Provide equipment. Family involvement. Undertake environmental assessment. Provide information sheet (available in Division).</p>	<p>Promote feeling of security & safe environment for people with cognitive impairment, confusion or dementia</p>	<p>Refer to GP for assessment. Refer to Housing SA for home modification.. Consult the Falls Prevention Resource Directory.</p>
<p>Undertake environmental assessment. Review environment. Suggest modifying environment, eg rugs. Minimise slippery surfaces. Suggest remove clutter. Provide information sheet (available in Division).</p>	<p>Ensure safe home environment</p>	<p>Refer to OT. Consult the Falls Prevention Resource Directory.</p>
<p>CLIENT CHOICE</p>		<p>CLIENT CHOICE</p>