Editorial for the International Journal of Nursing Studies

Title: Older, in hospital and confused – the value of nursing care in preventing falls in older people with cognitive impairment

Falls and injury from falls are internationally recognised as an important health and safety matter for hospitals today and an indicator of the quality of nursing care (ANA, 2012; Burston et al., 2012). In the United States, the prevalence of in-hospital falls in a study of 315,817 falls over a 27 month period was 3.56 falls/1000 patient days, with 26.1% of these falls resulting in an injury (Bouldin et al., 2013). In England and Wales, over 280,000 hospital falls are reported each year (NPSA, 2010). And, in one Australian report, 10% of patient days for people over the age of 65 years were attributable to falls injury, reflecting 1.4 million patient days over the year, a doubling from 0.7 million in ten years earlier (AIHW, 2013).

Falls are rarely evenly distributed across units. In a longitudinal study of 8915 nursing units in the United States, the falls rates per 1000 patient days varied widely over several years (He et al., 2012). For example in 2008, it varied from 1.32 (±0.95) in critical care units, to 4.32 (±2.64) in medical units, to 7.06 (±3.61) in rehabilitation units (He et al., 2012). Fall rates are also much higher in older people with cognitive impairment, with 68% of in-hospital falls attributed to this group (Hill et al., 2007). Other research confirms that the prevalence of falls for people with cognitive impairment is significantly higher than for those at the same age without cognitive impairment (Harlein et al., 2011). In fact, in one American study, 96% of 252 patients who fell during their hospital stay were diagnosed with delirium at the time of the fall (Lakatos et al., 2009). Significantly, nurses report that this high risk group is the most challenging group with whom to implement falls prevention (Barker, 2012).
Falls can have a number of significant adverse consequences, especially for vulnerable groups. When an older person experiences an adverse event, such as an in-hospital fall, it can quickly lead to an irreversible decline in functional status (Thornlow et al., 2009; Chu et al., 2007), often delaying discharge home. Other adverse outcomes from falls include fractures, head injuries, other minor injuries such as bruises and abrasions, reduced mobility or limitations to activities, loss of independence, and need for nursing home placement (Terroso et al., 2014).

Given its high rate of occurrence, and significant consequences to patient, families and the health system, prevention is an international priority. For example, in Australia, falls prevention is one of the ten Australian National Safety and Quality Health Service Standards that are used to accredit hospitals (ACSQHC, 2011). There is general agreement that a combination of falls risk assessment and multifactorial interventions should be used to reduce the incidence of in-hospital falls (Cameron et al 2012; DiBardino et al 2012). Specific interventions to prevent in-hospital falls include early risk assessment using a validated instrument (Ivziku et al., 2011), followed by exercise (supervised/unsupervised), medication management, urinary incontinence management, fluid or nutrition therapy, psychosocial support and assistive technology, including personal mobility aids and anti-slip footwear, communication aids such as glasses and hearing aid, and education, including provision of written materials, videos, lectures (ProFaNE, 2013; NICE 2013).

There is agreement that multiple care interventions are required to address the various factors that contribute to falls (NICE, 2013). Strategically, these care interventions can be bundled. A care bundle is a structured group of interventions that have been shown to improve patient outcomes (IHI, 2013). They are designed to improve processes of care and encourage clinical practice guideline compliance.
Various care bundles have been developed for a variety of clinical populations and recently have been developed for patients at risk of falls (Healey et al., 2014; Neyens et al., 2011; Teresi et al., 2013; Milisen et al., 2013), showing some promising results.

Like those strategies to prevent falls, the strategies to prevent and manage cognitive impairment in older people while in hospital are also multi-faceted and target early ambulation, assistance with meals, social engagement, and cognitive stimulation (Inouye et al., 2006; ACSQHC 2014). Nursing care that is focused on adequate nutrition and hydration, ambulation, cognitive stimulation, and elimination is essential for older people with cognitive impairment who are at high risk of falling. Attention to essential nursing care is the responsibility of qualified nurses. But, for some older people with cognitive impairment, the system, and in particular nurses’ responses, are failing (Parke & Hunter, 2014).

While the vulnerability of older people in hospital is established, nurses do not explicitly acknowledge the risks of injury to older people while in hospital. Older person vulnerability is compounded by a dominant ageist attitude within society in general, and in health care services specifically. Older people are marginalised in hospital (Higgins et al., 2007), with, for example, staff generally accepting that falling is inevitable in older hospitalised people (Walker, 2004). Nurses perceive that older people stay too long and require more nursing time than is available (Parke & Hunter, 2014).

For older people with cognitive impairment, the vulnerability is intensified when they exhibit disruptive behaviours, lack of interest in their surroundings, and/or make incoherent noises. Such disruptive behaviours often lead to custodial, rather than nursing, care (Moyle et al., 2010). The valuing of young people over older people in hospital is ubiquitous (Scheunemann & White, 2011). Ageism contributes to
increased vulnerability for older people in hospital and this is an urgent problem for
the nursing profession.

There is emerging evidence that increases in patient acuity and skill mix also
have consequences for patient safety (Elnitsky et al., 2014; Duffield et al., 2011), with
nurses working in hospitals focusing care on medical treatments, and rationing care to
address immediate safety and health concerns rather than the relatively mundane
activities of daily living. The rise of health technology means that nurses are
increasingly focused on delivering medical treatments and therapies and managing
health equipment. This privileging of the medically-related care means that tasks
associated with medically-related care are rarely missed (Schubert et al., 2013) but
less ‘technical’, some would say essential, nursing care tasks are consistently missed.

Ambulation is one of the most missed nursing care activities (Kalisch et al.,
2012; Papastravrou et al., 2014). When ambulation interventions are not attended,
accelerated loss of function occurs in older people (Sinha & Detsky, 2012), increasing
the risk of falling when ambulant. Privileging medically-related tasks over other
nursing work, combined with a dominant ageist attitude and difficulty determining
care needs, has negative implications for health outcomes of older people with
cognitive impairment in hospital.

Rather than focus on tasks or interventions, it is timely to remind ourselves of
the values and principles of nursing. Person centred nursing care - to work with
patient’s beliefs and values, engage patients and families, share decision-making,
have a sympathetic presence, and provide for physical needs (McCormack &
McCance, 2006) - provides a suitable framework for advancing the care of older
people with cognitive impairment who are at risk of falling. We propose a low
intensity approach to falls prevention generally, and in older people with cognitive
impairment specifically. For us, a low intensity approach implies both individualised care and a stepped approach to nursing care, with increasing intensity based on patient condition, risk and need. A low intensity approach is focused on essential nursing care. While a low intensity approach has not been explicitly trialled in falls research to our knowledge, the principles of low intensity (individualised and stepped based on increasing interventions as risk increases) are clearly a cornerstone of all professional nursing practice, including falls.

In a low intensity approach, essential nursing care, such as ambulation, hydration, nutrition and elimination needs, is tailored to the individual patients’ needs, their values and their preferences; nursing care is person-focused. Greater attention to essential nursing care can prevent the development of delirium (Mudge et al., 2013) and falls and injuries from falls (D’Amour et al., 2014). Essential nursing care is a valuable resource that is absent when nurses ration care to favour medically related treatments. We invite the international nursing community to confront ageism and engage in dialogue to promote the value of essential nursing. Nursing is focused on wellness and aims to promote comfort, function, nutrition, hydration, and elimination. It is time to claim back these essential elements of nursing for the benefit of vulnerable older adults in our hospitals.
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