

FALLS!

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Some material included in this presentation is adapted from: NICHE (2009). Geriatric Resource Nurse Core Curriculum [Power Point presentation]. New York: Hartford Institute for Geriatric Nursing, New York University College of Nursing

Old Age is Not for Sissies....



Old Age is Not for Sissies....



Objectives

1. Describe the significance of falls in older adults
2. Identify predisposing and precipitating fall risk factors
3. Identify core components of fall risk screening, fall assessment, post fall assessment, and assessment of the environment
4. Identify general safety measures to reduce fall risk
5. Describe nursing care strategies to reduce fall risk
6. Describe core components of secondary fall prevention

So Why Focus on Falls?

- 🌐 Falls are NOT inevitable, they ARE PREVENTABLE!
- 🌐 Falls will cost an estimated 32.4 billion dollars annually in 2020.
- 🌐 Risk of fall related injury increases with age
- 🌐 Most adults do not understand their risk to fall!
- 🌐 Falls are the most common cause of nonfatal injuries and hospital admissions for trauma

National Estimates of the 10 Leading Causes of Nonfatal Injuries Treated in Hospital Emergency Departments, United States – 2013

Rank	Age Groups										Total
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Unintentional Fall 134,229	Unintentional Fall 852,884	Unintentional Fall 624,890	Unintentional Struck By/Against 561,690	Unintentional Struck By/Against 905,659	Unintentional Fall 742,177	Unintentional Fall 704,264	Unintentional Fall 913,871	Unintentional Fall 930,521	Unintentional Fall 2,495,397	Unintentional Fall 8,771,656
2	Unintentional Struck By/Against 28,786	Unintentional Struck By/Against 336,917	Unintentional Struck By/Against 403,522	Unintentional Fall 558,177	Unintentional Fall 814,829	Unintentional Overexertion 638,745	Unintentional Overexertion 530,422	Unintentional Overexertion 461,114	Unintentional Overexertion 266,126	Unintentional Struck By/Against 281,279	Unintentional Struck By/Against 4,214,125
3	Unintentional Other Bite/Sting 12,186	Unintentional Other Bite/Sting 158,587	Unintentional Cut/Pierce 112,633	Unintentional Overexertion 294,669	Unintentional Overexertion 672,946	Unintentional Struck By/Against 599,340	Unintentional Struck By/Against 444,089	Unintentional Struck By/Against 390,931	Unintentional Struck By/Against 261,840	Unintentional Overexertion 212,293	Unintentional Overexertion 3,256,567
4	Unintentional Foreign Body 10,650	Unintentional Foreign Body 139,597	Unintentional Other Bite/Sting 107,975	Unintentional Cut/Pierce 114,285	Unintentional MV-Occupant 627,565	Unintentional MV-Occupant 526,303	Unintentional MV-Occupant 374,231	Unintentional Other Specified 385,221	Unintentional MV-Occupant 227,620	Unintentional MV-Occupant 197,646	Unintentional MV-Occupant 2,462,684
5	Unintentional Other Specified 10,511	Unintentional Cut/Pierce 83,575	Unintentional Overexertion 93,612	Unintentional Pedal Cyclist 84,732	Unintentional Cut/Pierce 431,691	Unintentional Cut/Pierce 402,197	Unintentional Other Specified 300,154	Unintentional MV-Occupant 343,470	Unintentional Other Specified 212,168	Unintentional Cut/Pierce 156,693	Unintentional Cut/Pierce 2,077,775
6	Unintentional Fire/Burn 9,816	Unintentional Overexertion 81,588	Unintentional Pedal Cyclist 74,831	Unintentional Unknown/Unspecified 84,668	Other Assault* Struck By/Against 381,522	Other Assault* Struck By/Against 342,514	Unintentional Cut/Pierce 297,769	Unintentional Cut/Pierce 282,353	Unintentional Cut/Pierce 189,440	Unintentional Poisoning 100,988	Unintentional Other Specified 1,767,630
7	Unintentional** Inhalation/Suffocation 8,294	Unintentional Other Specified 65,120	Unintentional Foreign Body 63,450	Unintentional MV-Occupant 73,692	Unintentional Other Specified 321,914	Unintentional Other Specified 336,990	Other Assault* Struck By/Against 207,287	Unintentional Poisoning 237,328	Unintentional Poisoning 153,767	Unintentional Other Bite/Sting 90,850	Other Assault* Struck By/Against 1,291,100
8	Unintentional Cut/Pierce 7,139	Unintentional Fire/Burn 52,884	Unintentional MV-Occupant 58,114	Unintentional Other Bite/Sting 64,848	Unintentional Other Bite/Sting 177,665	Unintentional Other Bite/Sting 180,922	Unintentional Poisoning 175,870	Other Assault* Struck By/Against 169,688	Unintentional Other Bite/Sting 97,474	Unintentional Other Specified 86,729	Unintentional Other Bite/Sting 1,174,267
9	Unintentional Unknown/Unspecified 5,735	Unintentional Unknown/Unspecified 41,297	Unintentional Dog Bite 43,499	Other Assault* Struck By/Against 62,829	Unintentional Unknown/Unspecified 163,923	Unintentional Poisoning 180,448	Unintentional Other Bite/Sting 138,410	Unintentional Other Bite/Sting 145,349	Other Assault* Struck By/Against 73,674	Unintentional Unknown/Unspecified 74,864	Unintentional Poisoning 1,055,960
10	Unintentional Overexertion 4,985	Unintentional Poisoning 32,443	Unintentional Unknown/Unspecified 35,303	Unintentional Other Transport 35,609	Unintentional Poisoning 152,962	Unintentional Unknown/Unspecified 129,308	Unintentional Unknown/Unspecified 106,498	Unintentional Unknown/Unspecified 110,102	Unintentional Unknown/Unspecified 67,974	Unintentional Other Transport 68,022	Unintentional Unknown/Unspecified 819,878

*The "Other Assault" category includes all assaults that are not classified as sexual assault. It represents the majority of assaults.

**Injury estimate is unstable because of small sample size.

Data Source: NEISS All Injury Program operated by the Consumer Product Safety Commission (CPSC).

Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.



Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

10 Leading Causes of Injury Deaths by Age Group Highlighting Violence-Related Injury Deaths, United States – 2012

Rank	Age Groups										Total
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Unintentional Suffocation 965	Unintentional Drowning 415	Unintentional MV Traffic 339	Unintentional MV Traffic 407	Unintentional MV Traffic 6,910	Unintentional Poisoning 7,737	Unintentional Poisoning 7,899	Unintentional Poisoning 10,340	Unintentional Poisoning 5,431	Unintentional Fall 24,190	Unintentional Poisoning 36,332
2	Homicide Unspecified 170	Unintentional MV Traffic 357	Unintentional Drowning 141	Suicide Suffocation 195	Homicide Firearm 3,931	Unintentional MV Traffic 5,949	Unintentional MV Traffic 4,620	Unintentional MV Traffic 5,359	Unintentional MV Traffic 4,543	Unintentional MV Traffic 6,378	Unintentional MV Traffic 34,935
3	Unintentional MV Traffic 68	Homicide Unspecified 153	Unintentional Fire/Burn 74	Homicide Firearm 124	Unintentional Poisoning 3,175	Homicide Firearm 3,427	Suicide Firearm 2,924	Suicide Firearm 4,113	Suicide Firearm 3,747	Suicide Firearm 4,796	Unintentional Fall 28,753
4	Homicide Other Spec., Classifiable 43	Unintentional Suffocation 138	Homicide Firearm 67	Unintentional Drowning 109	Suicide Firearm 2,218	Suicide Firearm 2,760	Suicide Suffocation 2,054	Suicide Suffocation 2,029	Unintentional Fall 2,168	Unintentional Unspecified 4,664	Suicide Firearm 20,666
5	Unintentional Drowning 43	Unintentional Fire/Burn 101	Unintentional Suffocation 34	Suicide Firearm 104	Suicide Suffocation 1,882	Suicide Suffocation 2,085	Homicide Firearm 1,887	Suicide Poisoning 1,974	Suicide Poisoning 1,485	Unintentional Suffocation 3,403	Homicide Firearm 11,622
6	Undetermined Suffocation 41	Unintentional Pedestrian, Other 98	Unintentional Other Land Transport 24	Unintentional Suffocation 45	Unintentional Drowning 540	Suicide Poisoning 852	Suicide Poisoning 1,251	Unintentional Fall 1,344	Suicide Suffocation 1,172	Unintentional Poisoning 1,655	Suicide Suffocation 10,088
7	Homicide Suffocation 26	Unintentional Struck by or Against 52	Unintentional Poisoning 21	Unintentional Other Land Transport 43	Homicide Cut/Pierce 386	Undetermined Poisoning 557	Undetermined Poisoning 640	Homicide Firearm 1,181	Unintentional Suffocation 677	Adverse Effects 1,639	Suicide Poisoning 6,729
8	Undetermined Unspecified 26	Homicide Other Spec., Classifiable 46	Homicide Unspecified 18	Unintentional Fire/Burn 36	Suicide Poisoning 364	Homicide Cut/Pierce 437	Unintentional Fall 458	Undetermined Poisoning 881	Homicide Firearm 589	Unintentional Fire/Burn 1,021	Unintentional Suffocation 6,238
9	Unintentional Natural/Environment 19	Homicide Firearm 45	Unintentional Pedestrian, Other 18	Unintentional Poisoning 30	Undetermined Poisoning 247	Unintentional Drowning 433	Unintentional Drowning 370	Unintentional Drowning 533	Unintentional Fire/Burn 493	Suicide Poisoning 799	Unintentional Unspecified 5,915
10	Unintentional Fire/Burn 17	Unintentional Natural/Environment 39	Unintentional Struck by or Against 17	Unintentional Firearm 22	Unintentional Fall 218	Unintentional Fall 319	Homicide Cut/Pierce 351	Unintentional Suffocation 451	Undetermined Poisoning 467	Suicide Suffocation 667	Unintentional Drowning 3,551

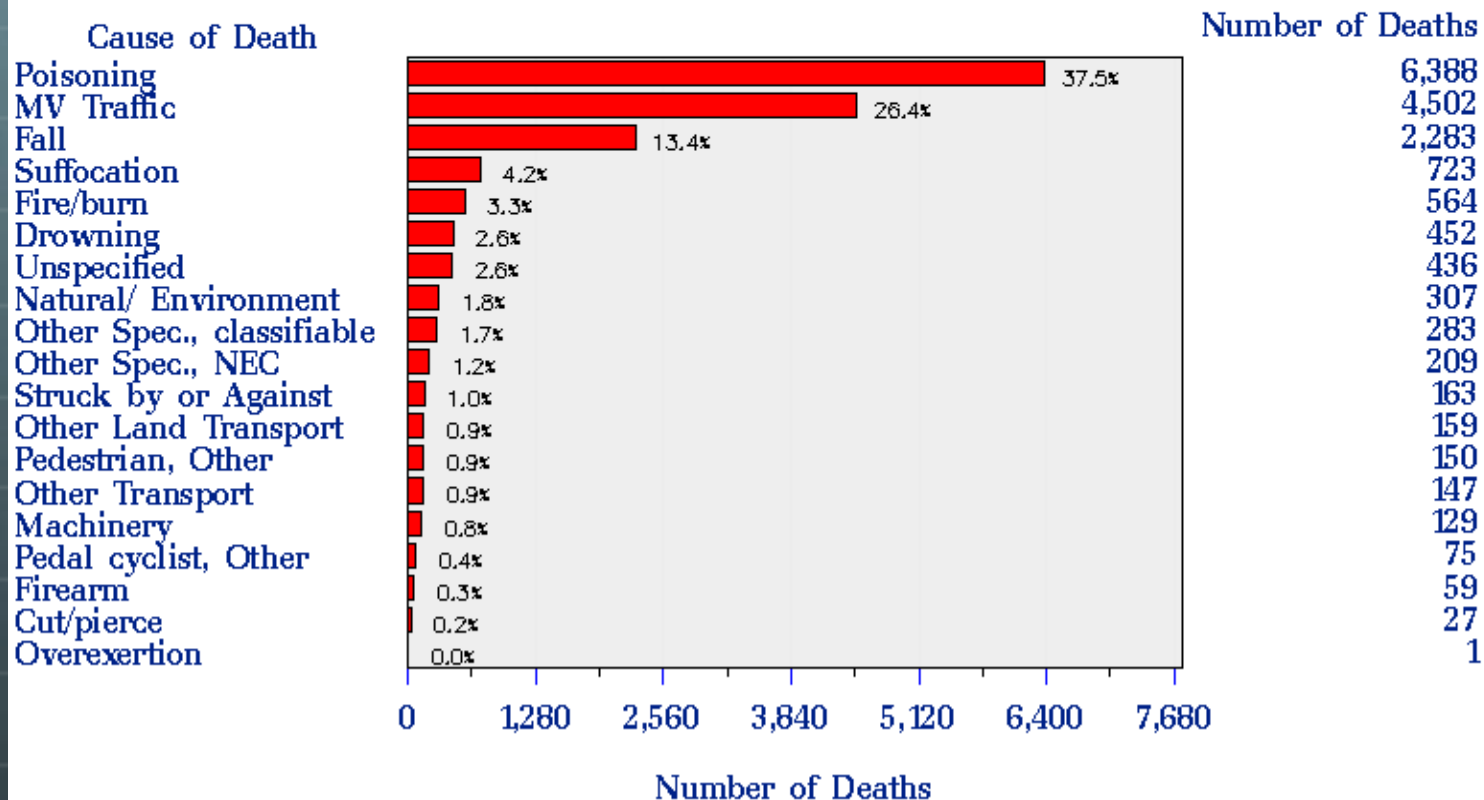
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.



Centers for Disease
Control and Prevention
National Center for Injury
Prevention and Control

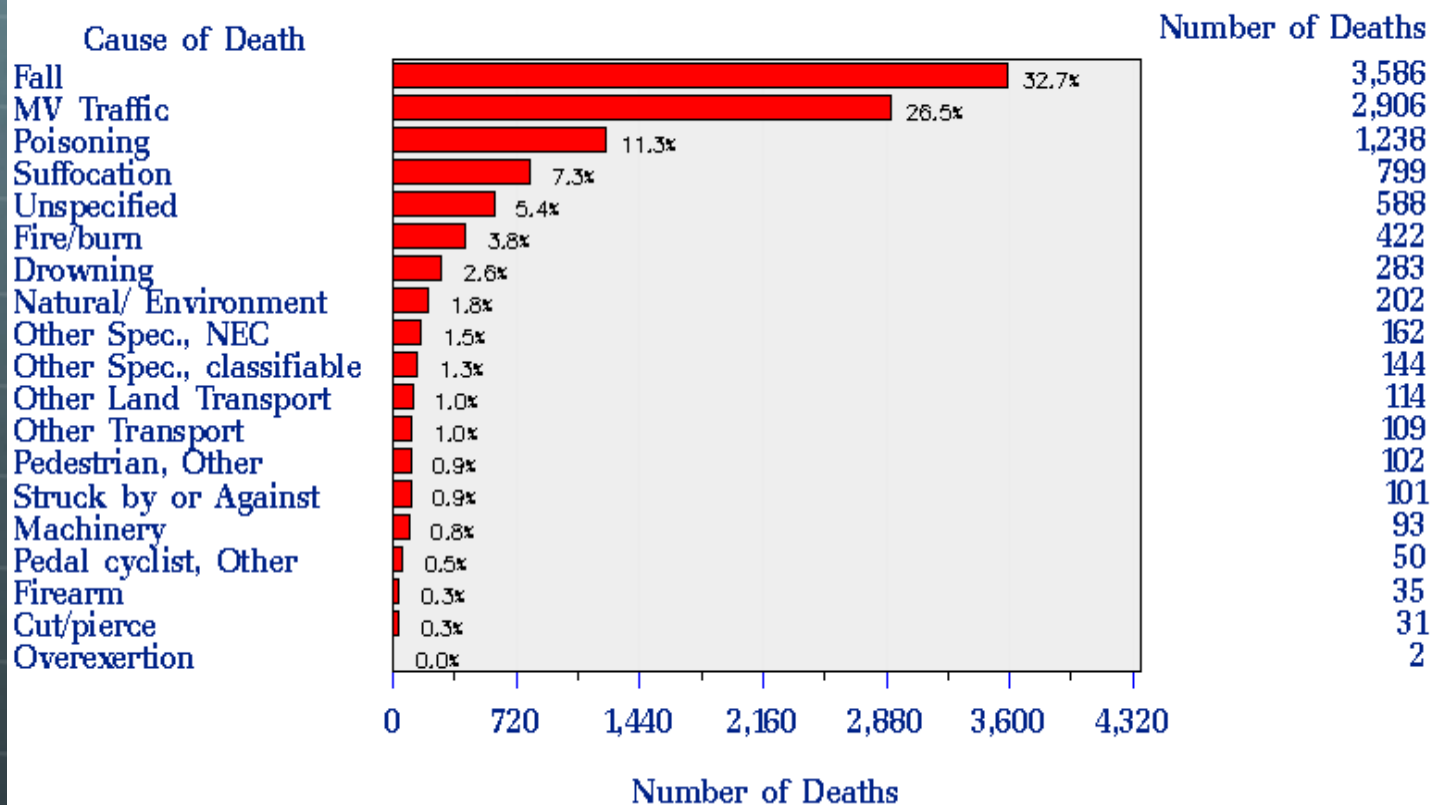
2013, United States
Unintentional Injuries
Ages 55–64, All Races, Both Sexes
Total Deaths: 17,057

Click on the colored bars to drill down to the ICD code level



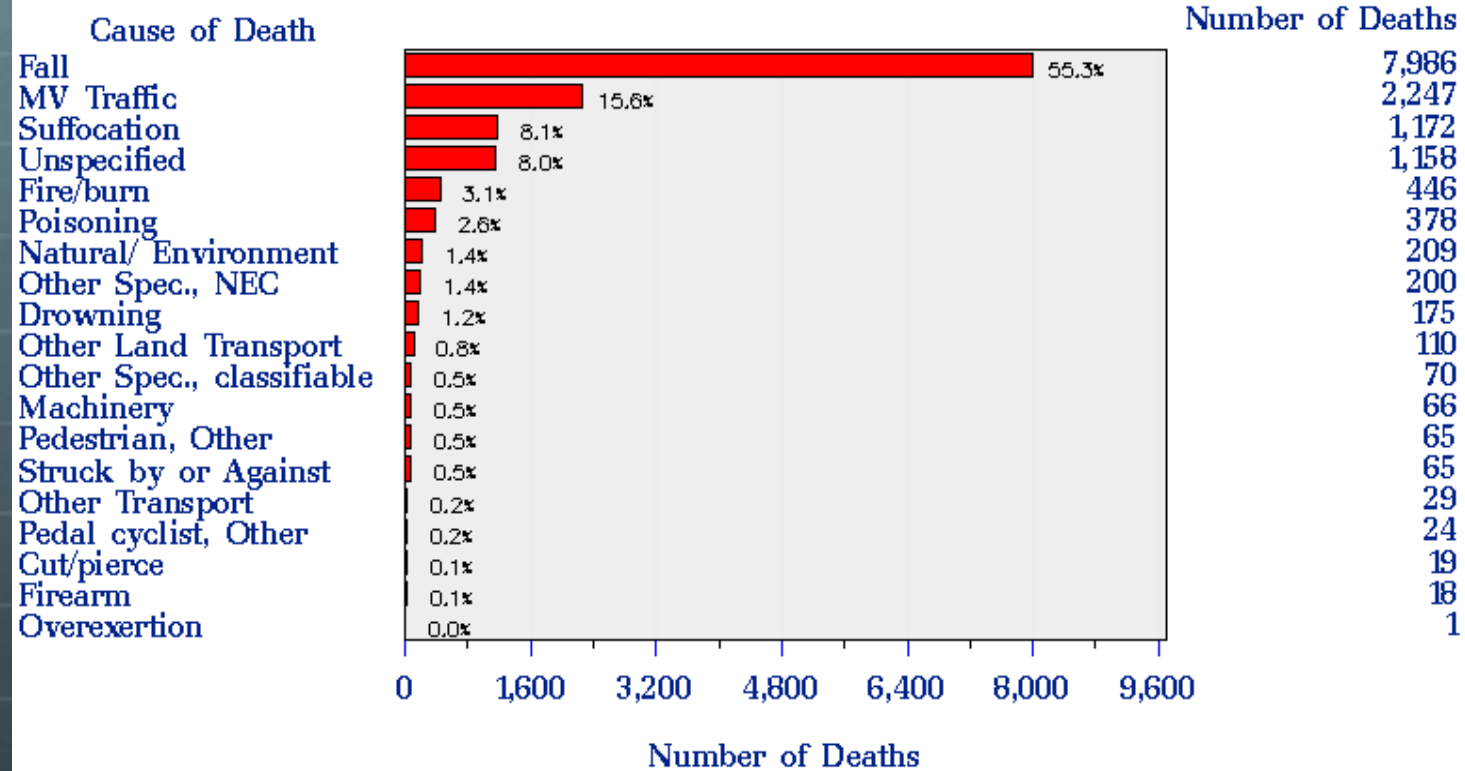
2013, United States
Unintentional Injuries
Ages 65–74, All Races, Both Sexes
Total Deaths: 10,967

Click on the colored bars to drill down to the ICD code level



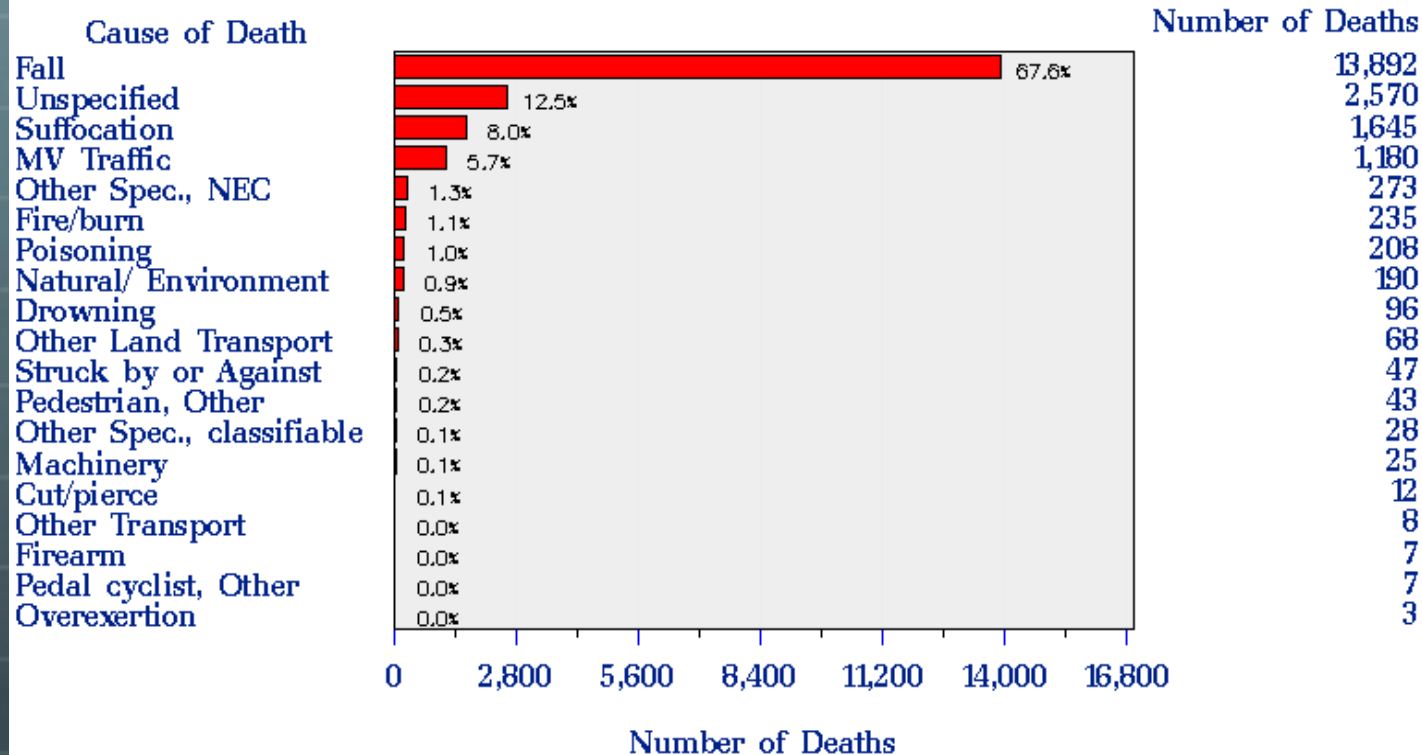
2013, United States
Unintentional Injuries
Ages 75–84, All Races, Both Sexes
Total Deaths: 14,438

Click on the colored bars to drill down to the ICD code level



2013, United States
Unintentional Injuries
Ages 85–85+ , All Races, Both Sexes
Total Deaths: 20,537

Click on the colored bars to drill down to the ICD code level




SO... How does
RI do in all this
for FALLS?

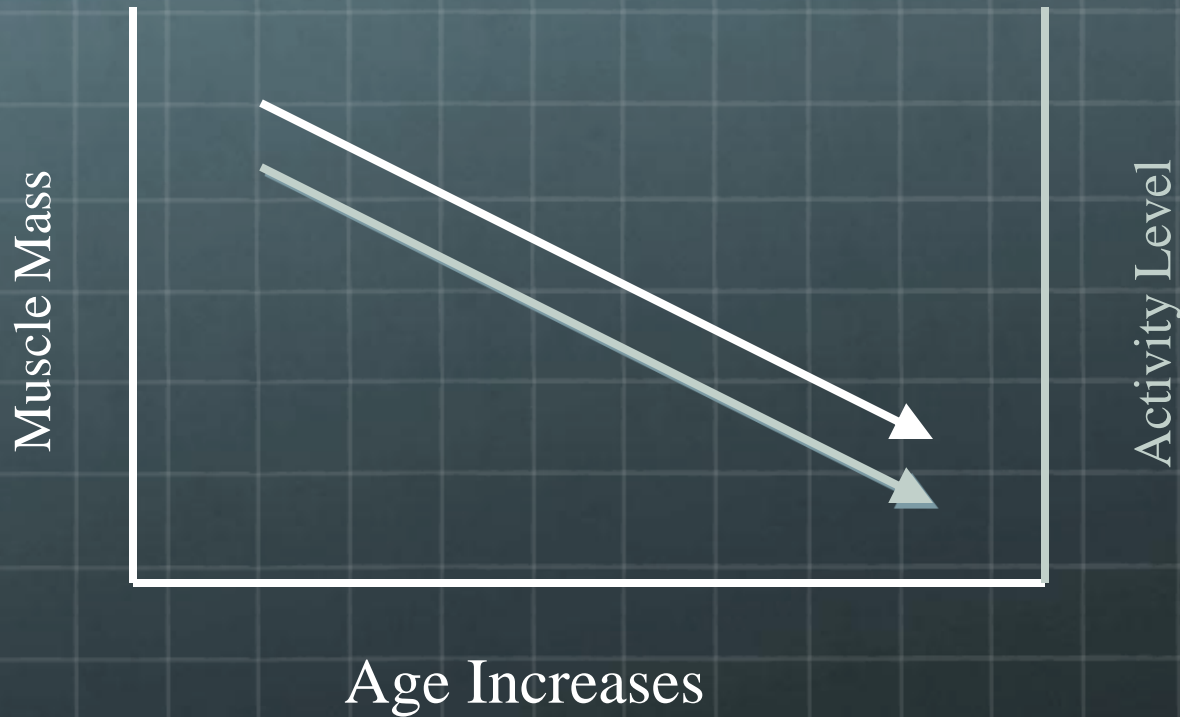
[http://www.health.ri.gov/data/
olderadultfalls/](http://www.health.ri.gov/data/olderadultfalls/)

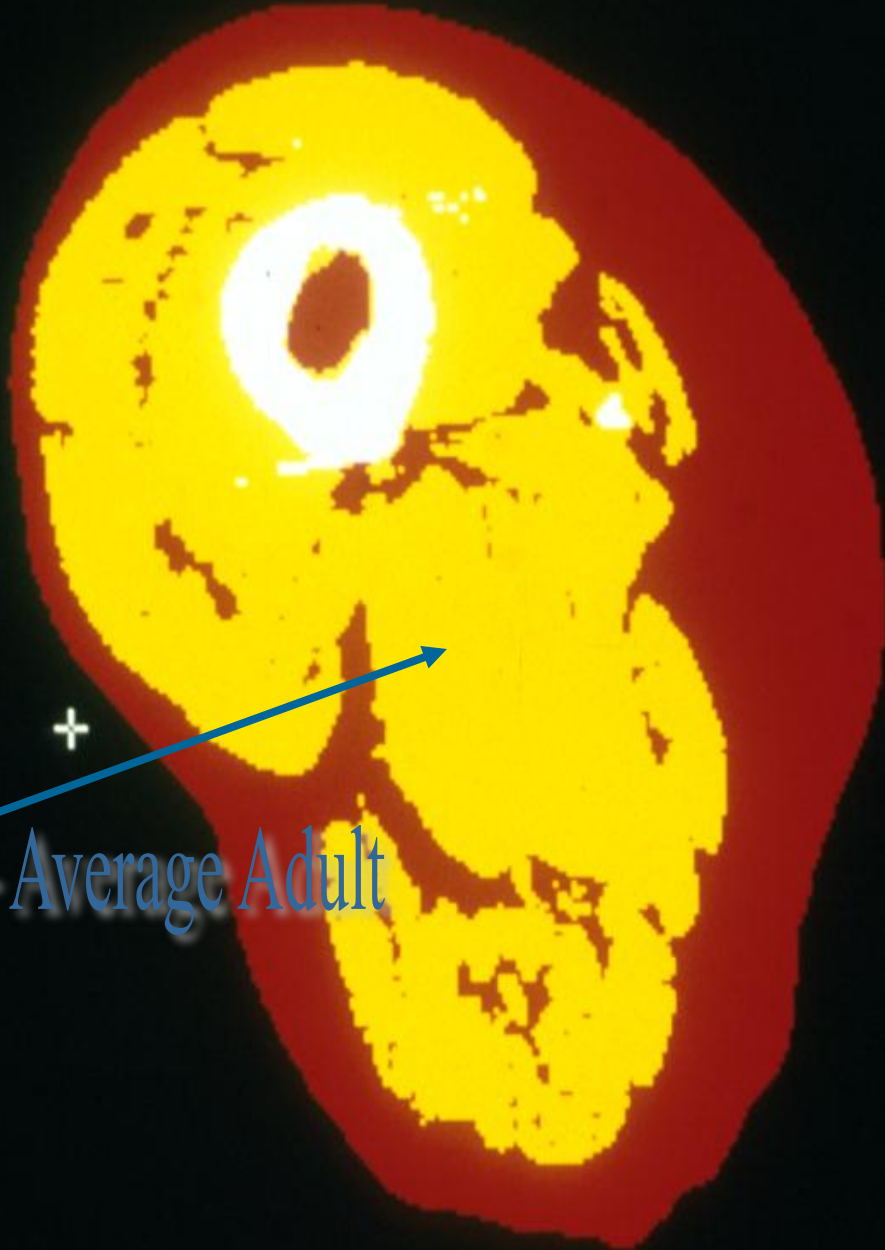


Even without injury...

-  *falls may lead to fear of falling with self imposed restriction of activity and reduced social interaction resulting in a decreased quality of life.*

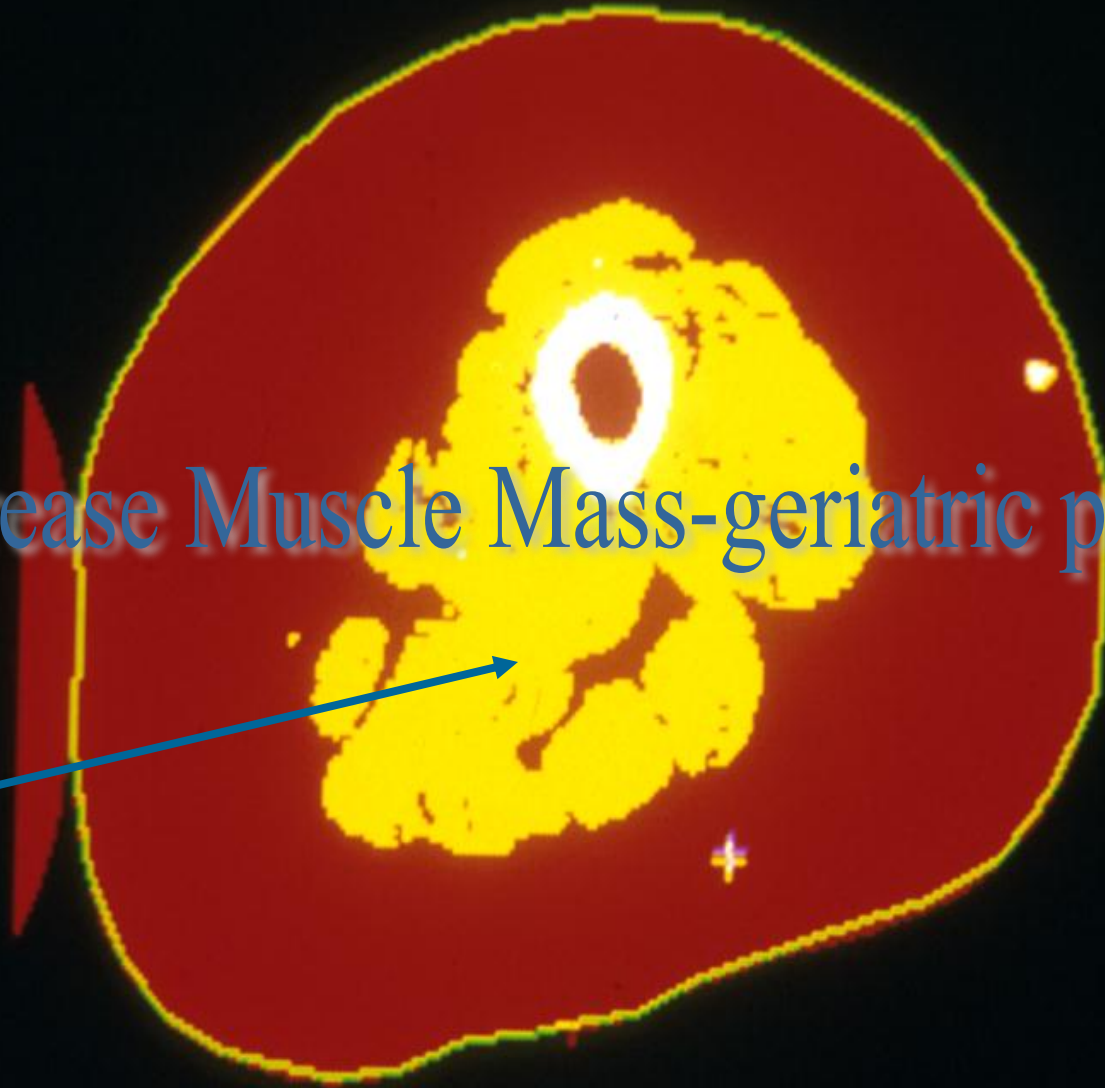
Muscle Loss and Aging.....





Muscle Mass - Average Adult

Decrease Muscle Mass-geriatric patient





So What Is A Fall?

How do we define it?

Definition:

- **An unexpected event in which a person comes to rest on the ground floor or lower level**
- **May be witnessed or unwitnessed**
- **May be noninjurious or result in injury or death**
- **May involve patient being lowered to floor with assistance**
- **May occur during ambulation or during transition to bed, toilet, chair, or stretcher**

Injuries and Falls

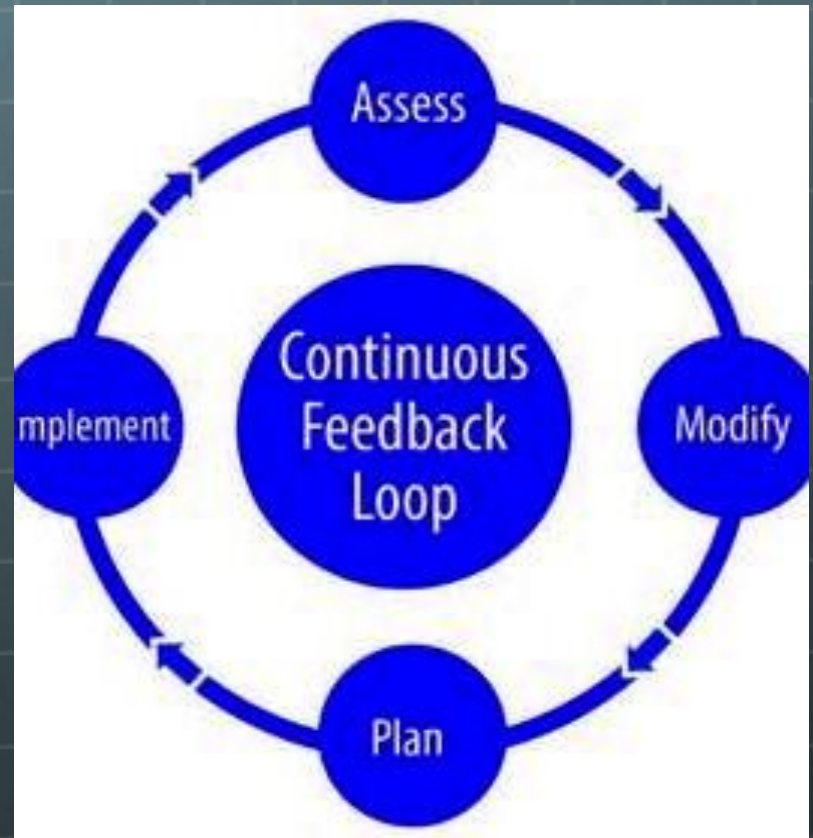
- 🌐 Who is **MOST AT RISK** for fall with injury....
- 🌐 Think A,B,C
 - 🌐 Age
 - 🌐 Bones
 - 🌐 Coagulation

Benchmarking


- 🌐 Most organizations follow a standard definition for benchmarking purposes.....
- 🌐 Data collection and outcomes evaluation are standard practices across all settings
 - 🌐 This is NOT just an inpatient quality indicator
 - 🌐 Although, CMS is looking more in-depth for pay-for-performance at falls and falls with injury
 - 🌐 Quality Indicators and benchmarking are now moving into ED and Ambulatory areas also

Benchmarking Allows ...

- Evaluation of:
 - Programs that effectively reduce fall risk use clinical practice guidelines & sound clinical judgment within a multifactorial approach.
 - A continuous feedback loop among team members is necessary because fall etiology is complex and patient risk fluctuates during their lifetime and setting.



Fall Risk Factors

-  Etiology of falls in older adults includes both predisposing and precipitating causes. Risk factors are classified as:
 - **Extrinsic** – those factors or conditions that occur in the person's environment, with equipment, or in a situational context
 - **Intrinsic** – those factors or conditions that occur within the person
 - **Underlying medical illness or presence of chronic disease**
 - **Physical status and age related changes**
 - **Use of high risk medications**

Extrinsic Risk Factors

- Lack of stair handrails in home
- Poor stair design in home
- Floor surfaces – slippery, wet, glare, uneven, cracked
- Obstacles or tripping hazards on floors
- Cluttered pathways in home, basement or garage
- Inadequate/dim lighting or glare
- Unsafe bathrooms – lack of support rails or bars, lack of nonskid floor surfaces and mats
- Unsafe footwear - loose fitting, no tread, barefoot, higher heels
- Improper use of assistive devices
- Elderly pets....(what can I say, Fido gets old too!)
- Psychoactive medications

Intrinsic Risk Factors

- History of falls
- Advanced age
- Lower extremity weakness
- Gait or balance deficit
- Use of assistive device
- Visual deficits
- Arthritis
- Dependency in transferring and mobility
- Cognitive impairment
- Urinary incontinence or frequency
- High risk medications

Medical Events and Diseases Associated With Falls in Older Adults

- Dizziness, syncope, poor balance, unsteadiness
- Mental confusion, delirium, dementia
- Generalized weakness, fatigue
- Arrhythmias
- Seizure
- Gait ataxia
- Dyspnea
- Lower extremity weakness, numbness, joint pain
- Unilateral weakness from TIA or CVA

SO MANY!!

What is the NUMBER ONE
PREDICTOR OF A FALL?

PREVIOUS HISTORY OF A FALL!!!



To prevent falls, providers should focus **FIRST** on these modifiable risk factors:

- 🌐 Lower body weakness
- 🌐 Difficulties with gait and balance
- 🌐 Postural dizziness
- 🌐 Poor vision
- 🌐 Problems with feet and/or shoes
- 🌐 Home hazards
- 🌐 **LAST MEDICATION ADDED!!!!**
 - 🌐 Use of psychoactive medications
 - 🌐 OTC, Prescribed and “Borrowed”

Most Common High Risk Medications

- **Psychotropic agents**
 - Benzodiazepines
 - Sedatives and hypnotics
 - Antidepressants
 - Neuroleptics (antipsychotics)
- **Anti-arrhythmics**
- **Digoxin**
- **Diuretics**

American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

The American Geriatrics Society 2012 Beers Criteria Update Expert Panel

Potentially inappropriate medications (PIMs) continue to be prescribed and used as first-line treatment for the most vulnerable of older adults, despite evidence of poor outcomes from the use of PIMs in older adults. PIMs now form an integral part of policy and practice and are incorporated into several quality measures. The specific aim of this project was to update the previous Beers Criteria using a comprehensive, systematic review and grading of the evidence on drug-related problems and adverse drug events (ADEs) in older adults. This was accomplished through the support of The American Geriatrics Society (AGS) and the work of an interdisciplinary panel of 11 experts in geriatric care and pharmacotherapy who applied a modified Delphi method to the systematic review and grading to reach consensus on the updated 2012 AGS Beers Criteria. Fifty-three medications or medication classes encompass the final updated Criteria, which are divided into three categories: potentially inappropriate medications and classes to avoid in older adults, potentially inappropriate medications and classes to avoid in older adults with certain diseases and syndromes that the drugs listed can exacerbate, and finally medications to be used with caution in older adults. This update has much strength, including the use of an evidence-based approach using the Institute of Medicine standards and the development of a partnership to regularly update the Criteria. Thoughtful application of the Criteria will allow for (a) closer monitoring of drug use, (b) application of real-time e-prescribing and interventions to decrease ADEs in older adults, and (c) better patient outcomes. *J Am Geriatr Soc* 2012.

Key words: Beers list; medications; Beers Criteria; drug; older adults

Medication-related problems are common, costly, and often preventable in older adults and lead to poor out-

comes. Estimates from past studies in ambulatory and long-term care settings found that 27% of adverse drug events (ADEs) in primary care and 42% of ADEs in long-term care were preventable, with most problems occurring at the ordering and monitoring stages of care.^{1,2} In a study of the 2000/2001 Medical Expenditure Panel Survey, the total estimated healthcare expenditures related to the use of potentially inappropriate medications (PIMs) was \$7.2 billion.³

Avoiding the use of inappropriate and high-risk drugs is an important, simple, and effective strategy in reducing medication-related problems and ADEs in older adults. Methods to address medication-related problems include implicit and explicit criteria. Explicit criteria can identify high-risk drugs using a list of PIMs that have been identified through expert panel review as having an unfavorable balance of risks and benefits by themselves and considering alternative treatments available. A list of PIMs was developed and published by Beers and colleagues for nursing home residents in 1991 and subsequently expanded and revised in 1997 and 2003 to include all settings of geriatric care.⁴⁻⁶ Implicit criteria may include factors such as therapeutic duplication and drug-drug interactions. PIMs determined by explicit criteria (Beers Criteria) have also recently been found to identify other aspects of inappropriate medication use identified by implicit criteria.⁷

As summarized in two reviews, a number of investigators in rigorously designed observational studies have shown a strong link between the medications listed in the Beers Criteria and poor patient outcomes (e.g., ADEs, hospitalization, mortality).⁸⁻¹⁴ Moreover, research has shown that a number of PIMs have limited effectiveness in older adults and are associated with serious problems such as delirium, gastrointestinal bleeding, falls, and fractures.^{8,12} In addition to identifying drugs for which safer pharmacological alternatives are available, in many instances a safer nonpharmacological therapy could be substituted for the use of these medications, highlighting that a "less-is-more approach" is often the best way to improve health outcomes in older adults.¹⁵

Since the early 1990s, the prevalence of PIM usage has been examined in more than 500 studies, including a number of long-term care, outpatient, acute care, and community settings. Despite this preponderance of information, many PIMs continue to be prescribed and used as first-

From The American Geriatrics Society, New York, New York.

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DOI: 10.1111/j.1532-5415.2012.03923.x

AGS BEERS CRITERIA

- In 2012, AGS UPDATED BEERS CRITERIA FOR POTENTIALLY INAPPROPRIATE MEDICATION USE IN OLDER ADULTS
- 1991 Original Beers Criteria Evaluate drugs considered inappropriate for NH residents in “common” situations, but under “certain circumstances” might be appropriate (e.g., using amitriptyline to treat pt with both Parkinson’s disease and depression)
 - Clinical research on use of PIMs
 - QA/QI
 - Education of students, residents

BEERS CRITERIA

Table 2. 2012 American Geriatrics Society Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

Organ System or Therapeutic Category or Drug	Rationale	Recommendation	Quality of Evidence	Strength of Recommendation
<i>Anticholinergics (excludes TCAs)</i>				
First-generation antihistamines (as single agent or as part of combination products)	Highly anticholinergic; clearance reduced with advanced age, and tolerance develops when used as hypnotic; greater risk of confusion, dry mouth, constipation, and other anticholinergic effects and toxicity.	Avoid	Hydroxyzine and promethazine: high; All others: moderate	Strong
Brompheniramine				
Carbinoxamine				
Chlorpheniramine				
Clemastine				
Cyproheptadine	Use of diphenhydramine in special situations such as acute treatment of severe allergic reaction may be appropriate			
Dexbrompheniramine				
Dexchlorpheniramine				
Diphenhydramine (oral)				
Doxylamine				
Hydroxyzine				
Promethazine				
Triprolidine				

BEERS CRITERIA







Pain Medication Use in Elderly Patients

Drug or Drug Class	Comments	Severity (High or Low)
Amitriptyline*	Anticholinergic effects and sedation	High
Indomethacin	Produces the most CNS ADRs compared with other NSAIDs	High
Ketorolac	Avoid due to underlying and often asymptomatic GI conditions in the elderly	High
Long-term use of non-selective NSAIDs (naproxen, oxaprozin, piroxicam)	Can cause GI bleeding, renal failure, HTN, and heart failure	High
Meperidine	Ineffective oral analgesic; causes confusion, neurotoxicity	High
Muscle relaxants	Poorly tolerated in elderly patients; have anticholinergic effects, cause sedation	High
Pentazocine	CNS ADRs including hallucinations and confusion	High
Propoxyphene/propoxyphene-containing products	No advantages over APAP with ADRs similar to narcotics	Low

High Risk Medications....
**....How do you keep up to
date?**

Yes, there is an APP for that!

AGS BEERS CRITERIA

 Beers Criteria >	 LithiumOL*
 Geriatrics Cultural Navigator >	Geriatric Dosage 150 - 1,000 mg/d (therapeutic level 0.5 - 0.8 mEq/L)
 GeriPsych Consult >	Adverse Events Nausea, vomiting, tremor, confusion, leukocytosis, gait ataxia
 Guide to Common Immunizations >	Comments Poor tolerability in older adults; toxicity at low serum concentrations; monitor thyroid and renal function
 Management of Atrial Fibrillation >	*Approved by FDA for treatment of bipolar disorder, OL = Off-label









BEERS Criteria Update News

Screens for Fall Risk

- Limitations of fall screening tools
 - Brief
 - Lack sufficient detail about fall history, situational context, patient symptoms, and examination findings
 - What setting were they validated in?
- Use risk assessment + sound clinical judgment
- Include direct observation of gait and mobility
- Always ask about previous history of falls

Many published tools are available to assist clinicians in fall risk screening.

Examples include:

-  Morse Fall Scale
-  Hendrich Fall Risk Model
-  Timed Get Up and Go
-  STRATIFY
-  Patient Fall Questionnaire
-  Berg Balance Test
-  Assessment of High Risk to Fall
-  Johns Hopkins Tool

Try This Series



 <http://hartfordign.org>

 http://hartfordign.org/Resources/Try_This_Series/

Comprehensive Fall Risk Assessment

- 🌐 Fall risk screening is the first step in a comprehensive fall reduction program.
- 🌐 For those patients identified at high risk, screening must be followed by a comprehensive, interdisciplinary assessment
- 🌐 National guidelines for the prevention of falls in older adults recommend screening for fall risk among all older adults admitted to a medical facility.
- 🌐 For those determined to be at high risk or who have recently experienced a fall, a more comprehensive multidimensional assessment by an interdisciplinary team is appropriate.

Always Investigate

A Fall Can Be A Symptom of Something Else

- Blood sugar?
 - Stroke?
 - Infection?
- New medication?
- Oxygenation?

Remember, most adults DO NOT understand their risk to fall!

Always do a “Post Fall Huddle” as we call them in the hospital



Post Fall Assessment

- 🌐 Never underestimate the importance of getting all the details!
- 🌐 Considered secondary fall prevention
- 🌐 Includes intrinsic and extrinsic risk factors, functional assessment, medical problems, and medications

A FALL CAN BE A SYMPTOM OF SOMETHING ELSE

What to look for...

- Ask patient for symptoms and details of fall incident
 - “Can you tell me what happened” “What were you doing”
- Ask about location, activity, position of patient, and time of fall
- Assist for further evaluation, diagnosis, and treatment
- Evaluate environment and surroundings
- Review underlying illness
- Assess sensory, psychological, and functional status
- Review medications

What to look for...

- Engage family or caregivers to :
 - Assess/monitor cognitive, functional, and /or emotional status watch for confusion, mental changes, delirium, or changes in mobility
 - Continue to observe for pain and signs of injury
 - Following a fall the presence of injury may not be apparent until days or even weeks later. When cognitive impairment exists, the accuracy of self reported pain immediately after the fall may be questionable.

What to look for...

- Observations of functional status with attention to any subtle or blatant changes in mobility can signal an underlying fracture or an unstable joint that was not previously reported.
- All patients should be closely monitored for 48 hours after an observed or suspected fall.
- The development of an acute delirium or post fall confusional state could signal the possibility of injury.

Individualized Plan of Care

Summary of the Updated American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons

Developed by the Panel on Prevention of Falls in Older Persons, American Geriatrics Society and British Geriatrics Society

The following article is a summary of the American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons (2010). This article provides additional discussion of the guideline process and the differences between the current guideline and the 2001 version and includes the guidelines' recommendations, algorithm, and acknowledgments. The complete guideline is published on the American Geriatrics Society's Web site (http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2010/). *J Am Geriatr Soc* 2010.

perience, and publications in fall prevention and care of older patients. Panel members included experts in physical therapy, pharmacy, orthopedics, emergency medicine, occupational therapy, nursing, home care, and geriatric clinical practice. The literature search included meta-analyses, systematic literature reviews, randomized controlled trials (RCTs), controlled before-and-after studies, and cohort studies published between May 2001 and April 2008. (The panel reviewed the RCTs published between April 2008 and July 2009 and concluded that the additional evidence did not change the ranking of the evidence or the guideline

Individualized Plan of Care

- Modify high risk medications
- Use precautions for orthostatic hypotension
- Address underlying medical conditions
- Talk to families/caregivers about providing anticipatory care (i.e., toileting, pain control for patients with cognitive impairments)
- Identify patients requiring additional precautions:
 - Those with impaired judgment or thinking
 - Those with osteoporosis who are at risk for fracture
 - Those with current hip fracture
 - Those with current head or brain injury
 - Those on anticoagulants or with a bleeding disorder

Putting It All Together

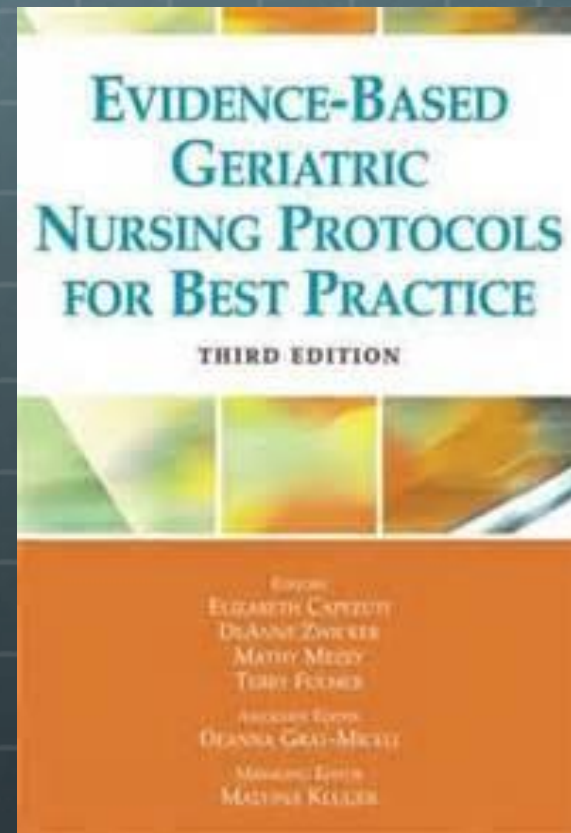
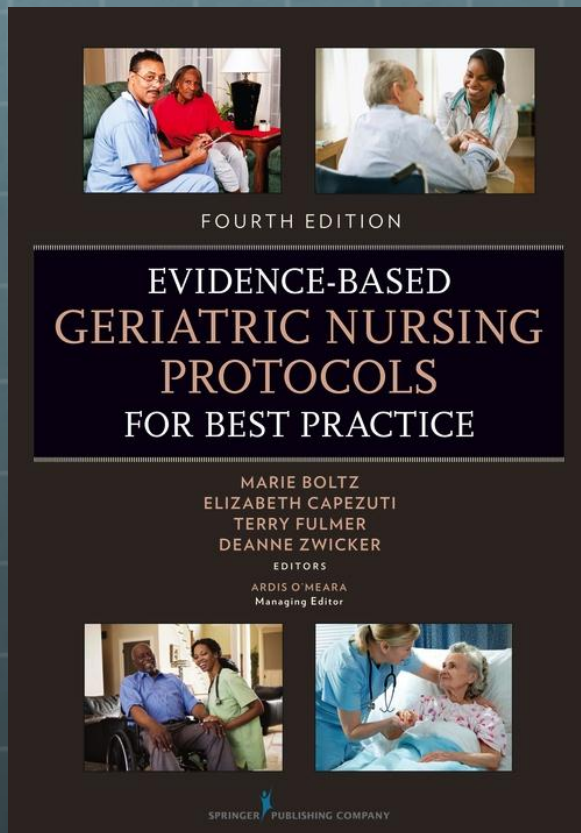
Expected Outcomes For All Settings:

1. Accurate and comprehensive screening for risk status, clinical assessment of fall risk, post fall assessment, and assessment of the environment and equipment
2. Use of general and individualized strategies for fall prevention
3. Accurate documentation of the assessment process and plan of care
4. Communication with all members of care team
5. Patient, family, and caregiver education


Old Age is Not for Sissies...



Resources...



Resources...

- Hartford Institute for Geriatric Nurses
<http://www.hartford.org/>
- ConsultGerIRN.org <http://www.consultgerirn.org>
- *Try This: Best Practices in Nursing Care to Older Adults*
<http://www.hartfordign.org> and
<http://www.ConsultGerIRN.org>
- *How to Try This Series*
<http://www.nursingcenter.com/ajncolderadults>
- American Association of Colleges of Nursing
 <http://www.aacn.nche.edu/Education/Hartford/index.htm>
- The Geriatrics and The Advanced Practice Curriculum
http://www.hartfordign.org/case_study/

Thank you!



Growing Old Is Not For Sissies