



Reimagining Injurious Falls and Safe Mobility

A provocative call for practice change.

ABSTRACT: Injurious falls remain among the most common, dangerous, and costly adverse events in hospitals, despite the widespread implementation of fall prevention programs. Many current health care system policies and nursing practices oversimplify fall prevention by focusing on limiting the person's mobility and making the environment safer, or simply documenting a fall risk score. But most falls are caused by factors intrinsic to that individual; merely limiting their mobility can increase preventable hospital complications and readmissions, and still leaves them at risk for falls. This article proposes a new approach to reducing injurious falls in older adults—one grounded in evidence-based protocols known to positively impact the health of older adults. The approach, called by the acronym ERA—**E**lectronic health record integration, **R**isk factors that matter, **A**ssessment and care plans—allows nurses to use a validated fall risk assessment tool to reframe fall risk factors as part of the comprehensive care plan, and to map modifiable risk factors to interventions that address the underlying causes of falls and promote safer mobility. The ERA approach can help nurses use their time more effectively by focusing on targeted actions that improve patient outcomes, working in coordination with an interprofessional, cross-continuum care team.

Keywords: fall prevention, fall risk assessment, falls, injurious falls, modifiable fall risk factors, multifactorial fall interventions, older adults, safe mobility

The time has come for a radical transformation of current practices aimed at reducing injurious falls. For too long, nurses and providers have been viewing fall prevention through the lens of reducing environmental (extrinsic) factors. Risk-reduction interventions have focused on strategies that often limit a person's independence and mobility. These have included using visual identifiers such as armbands and nonslip socks for patients at higher fall risk; monitoring patients via the use of bed alarms, cameras, and sitters; and implementing bed rest orders and timed toileting. Yet the root causes of most falls, both inside and outside the hospital setting, are the intrinsic risk factors unique to each individual, which stem from

aspects of mood or memory, pathophysiology, and functional status.

To address these root causes, we need to take a relational, longitudinal approach, tailoring interventions to the individual's fall risk assessment findings and mobility goals, and mapping their modifiable risk factors to effective and evidence-based interventions. In short, we must create a "next era" of practice, reimagining fall prevention through the lens of what matters to the person—maintaining mobility and independence—and redesigning the care model accordingly. To this end, a patient's modifiable fall risk factors must be included on the medical problem list and made an integral part of the overall care plan. Given the high demands on nurses' time in today's hospital environment, the ERA approach

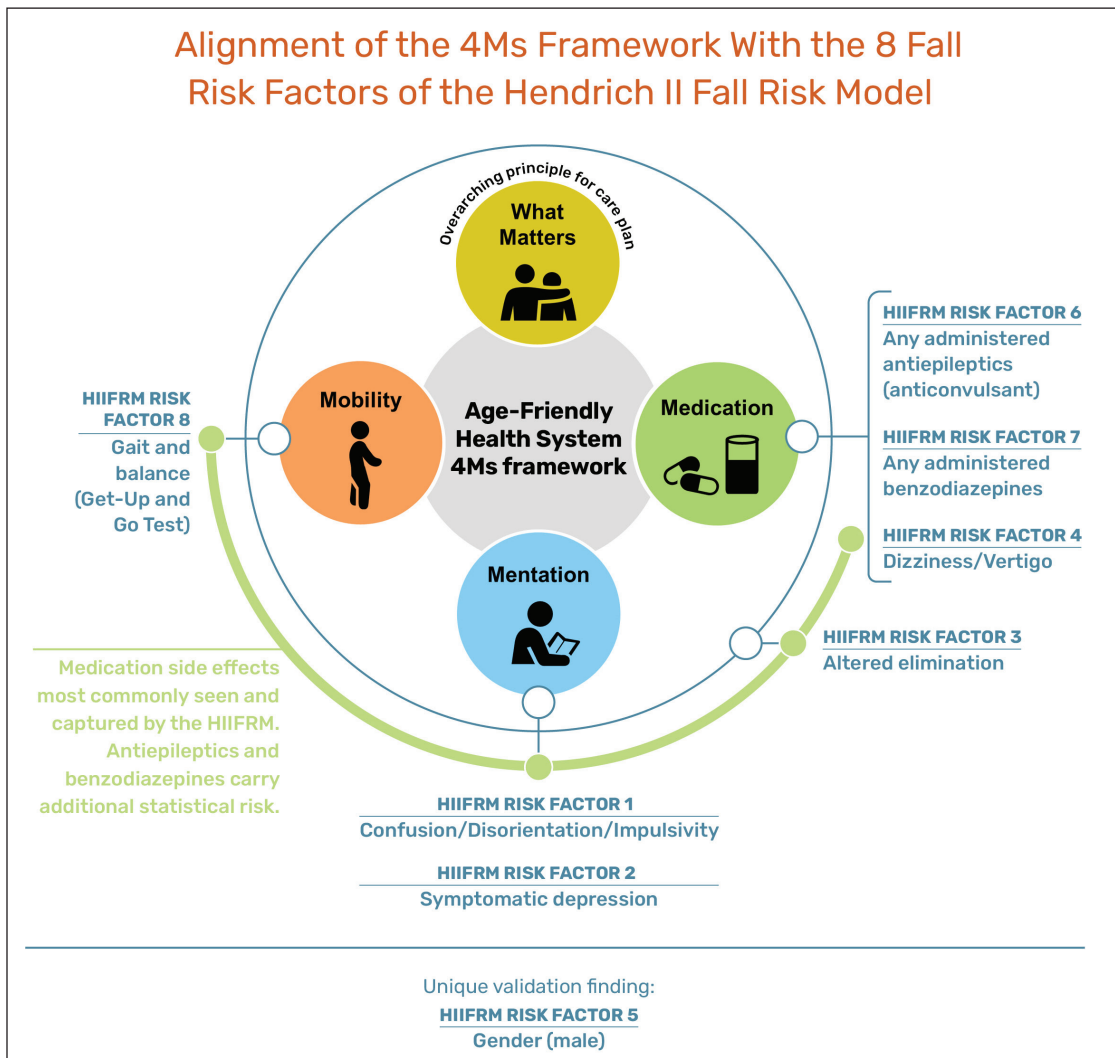


Figure 1. This graphic shows how the 4Ms framework of Age-Friendly Health Systems can organize specific evidence-based interventions to prevent injurious falls and promote healthy aging. HIIFRM = Hendrich II Fall Risk Model. Image courtesy of Ann L. Hendrich. Used with permission.

to patient care can optimize nursing expertise and enhance the effectiveness and efficiency of interprofessional teamwork.

BACKGROUND

This call to action is motivated by concern that progress in reducing falls in hospitalized patients in the United States has been slow.¹ Furthermore, falls in the hospital—227,000 occurred in 2017, according to the Agency for Healthcare Research and Quality²—represent only the tip of the iceberg, with falls in community and home settings also ubiquitous. In 2018, falls were the leading cause of injury in adults ages 65 and older, with 27.5% reporting

at least one fall within the past year and 10.2% reporting a fall that resulted in injury.³ The same year, fall-related injuries among older adults led to some 3 million ED visits, 950,000 hospitalizations or transfers to another facility, and 32,000 deaths.³ Total U.S. health care costs in 2015 attributable to falls in older adults were estimated at \$50 billion.⁴

For several decades, nurses have held the primary responsibility for preventing falls, with the fall risk assessment typically “sitting aside” the overall care plan. Standard practice has focused mainly on adding up and documenting a patient’s fall risk score, with less nursing time spent on interventions aimed at reducing modifiable risk factors. Recently,

regulatory and payment bodies have incentivized “zero falls,” with the Centers for Medicare and Medicaid Services no longer reimbursing hospitals for injuries related to inpatient falls.⁵ This has had the unintended consequence of further institutionalizing practices aimed at keeping patients immobile. And while the use of physical restraints to prevent falls is no longer considered safe or ethical in most cases, the use of bed alarms remains widespread, despite the lack of evidence of their efficacy in reducing falls.⁶ Indeed, limiting mobility during hospitalization raises patients’ risk of many preventable, hospital-acquired conditions as well as functional decline,⁷—thus potentially increasing their risk of falling in the future. A recent meta-analysis found that adult inpatients spent 87% to 100% of their time sitting or lying in bed.⁸ A study of the functional impact of 10 days of bed rest on healthy older adults found they experienced a 12% decline in aerobic capacity and a 15.6% decline in knee extensor strength.^{9,10}

in geriatrics, community health, and public health. Furthermore, as the COVID-19 pandemic has revealed all too vividly, health care inequalities associated with age, race and ethnicity, socioeconomic status, and sexual orientation persist.

Environmental safety precautions to address extrinsic fall risk factors continue to be essential. But implementing only these precautions will not have the desired impact on reducing falls. Instead, we must shift our perspective, and assess for and recognize intrinsic fall risk factors as we do for disease states and any complications. This means making a patient’s fall risk factors part of the relational care plan and addressing them with an interprofessional care team throughout the care continuum. The fact that fall-related injuries remain a leading cause of 30-day readmissions points to a lack of adequate follow-up and coordination across the care continuum.¹⁵ In a small study among older adults at high risk for future falls who were seen in a primary care clinic, 48% received less than

We must create a ‘next era’ of practice, reimagining fall prevention through the lens of what matters to the person.

In 2007, I wrote an article on predicting patient falls using the Hendrich II Fall Risk Model (HIIFRM), which appeared in this journal as part of its “How to Try This” series.¹¹ The health care landscape has changed considerably since then. Care delivery has largely shifted to outpatient, ambulatory, and for-profit clinics, as well as the home. The acute care environment is now reserved for the most vulnerable and critically ill patients, with acute care delivery becoming ever more complex and technology dense. At present, and for the foreseeable future, nearly all hospitalized patients will likely be at some risk for an injurious fall. Yet nursing practices aimed at reducing falls in the hospital setting have changed little.

The aging of the U.S. population constitutes another seismic shift affecting the health care industry. An estimated 50 million Americans are 65 years of age or older,¹² and more than half are living with multiple chronic conditions.¹³ Although older adults appear to be at greater risk for falling, neither age nor a history of falls are the root causes. Rather, older adults are more likely to have intrinsic fall risk factors, many of which can be addressed with appropriate interventions.¹⁴ But hospital and institutional standards of care haven’t yet evolved sufficiently to reflect known best practices identified by experts

half of the recommended assessments and interventions within 12 months of their index fall.¹⁶ This underscores the need to recognize fall risk as a continuum-of-care issue and not just a hospital problem. That said, a hospital stay provides an opportunity to assess and address the patient’s intrinsic fall risk factors in order to prevent falls both during hospitalization and after discharge, and to incorporate modifiable risk factors into a transition plan.

THE NEXT ERA IN FALL REDUCTION PRACTICES

A “next era” can be described as one in which a series of new events begins and segues in phases or stages, while being continually informed by the past and the present. So what should the next era of injurious fall reduction practices look like, and how can our care standards reflect this? We should sustain the use of environmental safety precautions aimed at reducing extrinsic fall risk factors for all patients. But we must also push our global standards of care to the next level by fully embracing the use of a valid, reliable fall risk assessment tool that focuses on intrinsic fall risk factors, taking an interdisciplinary approach. Advancing the next era of care will demand much more critical thinking—but not necessarily more time¹⁷—by nurses and other providers.

I propose that we start with an approach built on three pillars—**E**lectronic health record integration, **R**isk factors that matter, and **A**ssessment and care plans—to advance new and broader evidence-based protocols. This ERA approach is currently in beta testing as part of a system-wide research project in Hackensack Meridian *Health*, a large, integrated health care system in New Jersey.

Electronic health record integration. One ideal we should all be working toward is a practice environment that incorporates a valid and reliable fall risk assessment tool (such as the HIIIFRM) into the electronic health record (EHR). The EHR can routinely update a patient's fall risk factors, along with concurrent data gathered during comprehensive assessments, in- and outpatient visits, laboratory and diagnostic tests, and other hospital records, and sum the total fall risk score in real time as the patient's condition changes. This global integration saves nursing and medical time and avoids unnecessary duplication by interprofessional care team members.¹⁸ Moreover, the EHR should support integration of the patient's modifiable fall risk factors into the nursing and medical problem lists, thus facilitating the selection and implementation of appropriate interventions by providers collaborating along the care continuum. The EHR could also be configured to identify and flag patients at high fall risk as their condition changes. On units where most or all patients have some degree of fall risk, health care teams could consider eliminating visual identifiers (such as colored armbands) since each patient's fall risk is quantified within the EHR. Whenever possible, the patient's EHR should be integrated across all care environments and accessible to the patient. Environmental safety and safe mobility measures are thus made a minimum standard, and help eliminate needless nursing tasks.

Practicing nurses can ask for changes in the EHR that enhance their workflow, conserve nursing time, and maximize their role on the care team. These might include configuring the EHR to be auto-populated with updated fall risk scores and to make evidence-based interventions for each risk factor readily available in the electronic care plan. Nursing leaders can prioritize upgrades to EHR functionality as they set their change agendas.

Risk factors that matter. As most falls are multifactorial in nature, it's important to avoid oversimplification. This “reluctance to simplify” is a central tenet of high reliability science¹⁹ and a driver of progress in patient safety work. It's important to assess fall risk using a tool that includes risk factors that have been scientifically validated across large, diverse populations.

One such tool is the HIIIFRM, which has been validated in studies among such populations^{14,20} and is widely used both in the United States and internationally. The HIIIFRM assesses eight fall risk factors that have been scientifically identified as essential to predicting falls^{11,14}:

- altered mental status (confusion, disorientation, impulsivity)
- symptomatic depression
- altered elimination
- dizziness or vertigo
- two medication categories (antiepileptics and benzodiazepines)
- gender (male)
- decreased ability to rise from a chair (from the Get-Up-and-Go Test).

Regarding medications, it should be noted that only the two named drug categories have been shown to increase fall risk within the model. The most common side effects of other medications (such as effects on orthostatic hypotension, mobility, gait, cognition, mood, and elimination) are already assessed as part of other HIIIFRM risk factors.

The ERA approach can help nurses use their time more effectively by focusing on targeted actions that improve patient outcomes.

Scoring is based on both the presence of a factor and the degree to which that factor increases risk, with higher total scores reflecting higher overall risk. Possible total scores range from 0 to 16; scores of 5 and above indicate that the patient is at higher risk for falling.²⁰ Once a specific risk factor has been identified, it can be addressed with targeted care pathways and plans.

Assessment and care plans. As Resnick recently stated, much of what should and can be done to reduce falls has been known for 40 years.²¹ There is evidence pointing to both the efficacy of multifactorial interventions, customized to the individual's fall risk assessment,²² and the complexity of implementing such interventions, which can adversely affect their efficacy if not addressed.²³

A useful tool for aligning interventions with a person's fall risk factors is the evidence-based

framework anchored by the 4Ms: What Matters, Mentation, Medication, and Mobility.²⁴ This framework was developed by an advisory group of multidisciplinary experts at the behest of Age-Friendly Health Systems, an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement in partnership with the American Hospital Association and the Catholic Health Association of the United States. The 4Ms framework represents the next-era approach to healthy aging and constitutes part of an emerging “age-friendly ecosystem.”²⁵

Figure 1 illustrates how each of the 4Ms is strongly connected to known fall risk factors. By establishing corresponding care pathways and plans, we can incorporate fall prevention strategies into the promotion of healthy aging and individual independence.

What matters. The overarching concept guiding any patient’s care plan should be what matters to that patient. Configuring the EHR to capture this information in the patient’s own words must be seen as a basic standard of care, regardless of care setting. Viewing fall risk reduction through the lens of the individual’s values and goals will help clarify how to best weigh risk versus reward in decision-making. For instance, if an individual places high value on maintaining personal independence, they might choose to accept certain risks in order to stay mobile. This suggests that all falls may not be preventable, nor should they be. True person-centered care is achieved when the individual (or their care proxy) can make such decisions in consultation with their family members and care providers.

are available to help diagnose and support interventions for delirium.^{26, 29}

When a patient presents with delirium (often labeled as confusion) upon or during hospitalization, this constitutes a medical emergency. The care team should identify delirium as a fall risk factor and evaluate it as such during the comprehensive assessment. The team should then select diagnostic processes to determine its etiology—for example, by considering sepsis, which is highly prevalent in hospitalized older adults and often fatal.³⁰ The EHR can be configured to give clinicians easy access to diagnostic tools with basic algorithms that enable them to ask probing questions, such as “Why is this risk factor present?” “Is it associated with something internal or external to this person?” and “How long has it been present?” The EHR should support the rapid integration of this information with other diagnoses in the care plan.

Medication. Medication overuse is a growing problem. Almost 40% of older adults take five or more drugs daily,³¹ leaving them vulnerable to potential side effects such as altered cognition, dehydration, gait and other mobility disturbances, mood changes, hypotension, and altered elimination. To address this, the first evidence-based Beers Criteria for Potentially Inappropriate Medication Use in Older Adults was created in 1991; since 2011, it’s been periodically updated and published by the American Geriatrics Society, most recently in 2019.³² The stated goal is to improve the care of older adults “by reducing their exposure to [potentially inappropriate medications] that have an unfavorable balance of benefits and harms” in com-

Adopt a mindset that encourages an appropriate level of risk-taking to maintain mobility, with close monitoring.

Mentation. Delirium serves to exemplify a well-known fall risk factor that is both prevalent and amenable to intervention.²⁶ Delirium could be assessed and addressed more effectively with a next-era approach. In general medical and geriatric units, delirium occurs in 29% to 64% of older adults.²⁷ In the ED, 8% to 17% of older adults present with delirium,²⁷ with studies reporting that the diagnosis is missed in 57% to 83% of cases.²⁸ Evidence-based resources with proven efficacy, such as those developed and compiled by the American Geriatrics Society CoCare: HELP program (formerly the Hospital Elder Life Program),

comparison with other treatment options.³² A Beers Criteria pocketcard is available online at <https://geriatricscareonline.org/ProductAbstract/2019-ags-beers-criteria/PC007>. The Beers Criteria point to several categories of drugs, including antiepileptics and benzodiazepines, that increase fall risk in older adults. During a hospital admission, it’s important to link the patient’s fall risk assessment with a medication evaluation. For patients at high fall risk, reducing or stopping such medications should warrant careful consideration.

Mobility. The EHR can also be configured to prompt the care team to treat the mobility plan

A Continuum of Care Model: Using Fall Risk Factors to Promote Safe Mobility and Healthy Aging

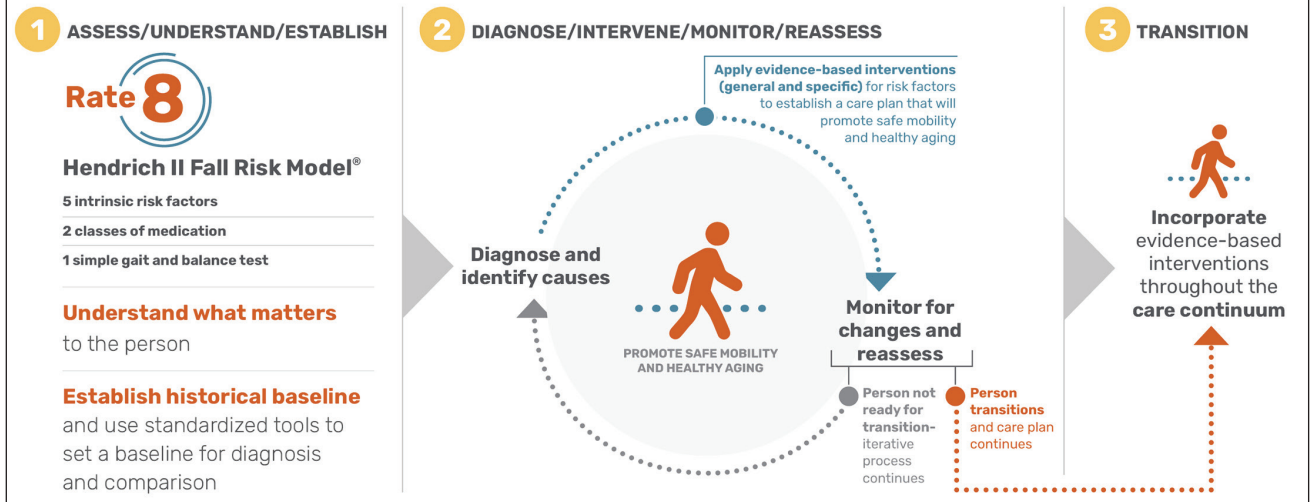


Figure 2. This flow chart maps how fall risk factors can be integrated into the care plan with evidence-based interventions that follow the patient across care transitions. Copyright © Ann L. Hendrich. Used with permission.

with the same focused attention as any other written order. For any hospitalized patient, a bed rest order should be weighed and justified or eliminated. Some innovative critical care units are now using early mobilization even with ventilated patients and seeing reduced complications and lengths of stay.³³ EHR systems should be capable of interfacing with wearable trackers that can measure an individual’s ambulation (in steps or distances) against designated weekly, daily, or even by-the-shift goals. Conversations with the patient about what matters most provides a way to link mobility goals to their other life goals and values. Documenting a patient’s desires and risk tolerance might also ease the hospital risk manager’s fear of litigation and help move the industry toward a less risk-averse position.

To be clear, injurious fall risk should always be minimized to the extent possible. But supporting a patient’s goals with a realistic mobility plan may be more important to their health and well-being than striving to avoid all falls—an effort that in itself could have unintended consequences and costs. Family members and caregivers might need to accept that, for some patients, preserving mobility and independence will necessitate some fall risk.

Many modifiable fall risk factors (such as gait, balance, or strength problems, as well as side effects of medications) will not be immediately responsive to interventions during an acute care hospi-

talization, whether because of patient acuity or a short length of stay. This underscores the importance of longitudinal fall risk assessment and monitoring well beyond the initial assessment. During a patient’s hospitalization, providers and others on the care team (which might include nurses, physicians, pharmacists, occupational and physical therapists, social workers, and clergy) must collaborate to create a long-term care plan that addresses the patient’s modifiable risk factors and contributes to better care transitions.³⁴ Figure 2 presents a flow-chart showing how fall risk factors and interventions can be integrated into a care plan that follows the patient across care transitions.

For patients who return home after a hospitalization, minimum care standards should include using environmental safety checklists along with addressing identified intrinsic risk factors. We must help people understand the importance of knowing their risk factors and how to either self-monitor or engage support if they can’t do so alone. This is vital to sustaining or improving their mobility and independence. Safety measures for home monitoring can include wearable devices, automated pill dispensers, observation cameras, home health visits, televisits, social media check-ins, and phone calls. Most of these options are currently available, and many are inexpensive; some patients and their families might need help in exploring how best to access and use them. Such assistance can be included in

transition planning and offered after discharge by home health or outpatient providers. All of these measures can mitigate the fears of patients and their families, and can make a big difference in preserving independence.

A PATIENT'S STORY

The following story illustrates how integrating a fall risk assessment into the care plan using the ERA approach points to the optimal interventions for reducing modifiable risk factors. (This case is a composite based on my experience.)

Jack Huron, age 74 years, presents to the ED with confusion, dizziness, dehydration, and weight loss, and is admitted to the hospital. This hospitalization occurs less than 30 days after his previous admission. Mr. Huron has a history of mild heart failure, hyponatremia, hypokalemia, and falls at home. He is accompanied by his daughter.

The previous admission. Documentation from Mr. Huron's last admission showed that while in the hospital he developed delirium, which cleared with hydration but added three days to his stay. A provider prescribed a benzodiazepine to treat the delirium, although drugs in this class are not shown to have efficacy for delirium and often increase its severity. Mr. Huron's mental state worsened until the drug was discontinued. He was not screened for depression; the care plan at that time focused primarily on the medi-

cal diagnosis of heart failure. A nutrition consult was ordered to address his poor nutritional status and weight loss, but failed to identify a specific cause for his loss of appetite. Eventually his confusion and delirium cleared, but his mood was low. Although Mr. Huron lived alone, there was family support available, and he was discharged to home after five days. A follow-up clinic visit was scheduled for a week after discharge, but there was no record of this in the EHR because his primary care physician isn't in that system. His daughter later stated that she was unaware of this appointment, and that no one called the home when he missed it.

The HIIFRM assessment performed on admission identified several fall risk factors: confusion, dizziness, male gender, and difficulty rising from a chair (see Figure 3). He was placed on a high fall risk protocol that included timed toileting and bed rest.

What are the gaps in care? The gaps in care during this earlier hospitalization and at discharge include the following:

- The root cause of Mr. Huron's declining health and high fall risk was missed because the primary focus was on the medical diagnosis of heart disease.
- He was prescribed a benzodiazepine for delirium, although drugs in this class are not shown to have efficacy for delirium and often increase its severity.

At Mr. Huron's earlier hospitalization, the HIIFRM was administered to determine his fall risk factors. His total score of 9 indicated that he was at risk for injurious falls. But as this illustrates, depression wasn't identified until his second hospitalization, when the care team engaged the patient and his daughter in conversation and asked him what matters most in his life.

Risk Factor	Initial Score (partial assessment)	Score Using ERA Approach
Confusion	4	4
Depression	0	2
Dizziness/vertigo	1	1
Altered elimination	0	0
Gender	1	1
Medication: antiepileptics	0	0
Medication: benzodiazepines	0	0
Get-Up-and-Go Test: rise from a chair	3	3
Total score	9	11

Figure 3. This table shows the results of Mr. Huron's two HIIFRM screenings. ERA = electronic health record integration, risk factors that matter, assessment and care plans; HIIFRM = Hendrich II Fall Risk Model. Total score ≥ 5 = at risk for falls. For a guide to scoring, see "Quick Guide for Scoring the Hendrich II Fall Risk Model" at <https://hendrichfallriskmodel.com/model-quick-scoring-guide>. Copyright © Ann L. Hendrich. Used with permission.

Key Practice Recommendations for Nurses

- Focus on identifying the root causes of a patient's past falls and current risk factors. Implement individualized interventions to address these root causes.
- Advocate an interprofessional approach wherein fall risk factors are fully integrated into the medical and nursing care plans.
- Perform baseline fall risk assessment and frequent reassessments to detect subtle changes in the patient's condition and prevent falls that might result from such changes.
- Recognize that "zero falls" thinking promotes inpatient immobility and deconditioning. Adopt a mindset that encourages an appropriate level of risk-taking to maintain mobility, with close monitoring.
- Question the ageist bias that assumes falls by older people are inevitable and "the hospital's problem." Increase your knowledge of age-friendly care and the nature and impact of later-in-life changes.
- Learn how to apply standardized tools that help establish useful baselines with regard to mental status, polypharmacy, and gait and balance. Ask your organization to make these tools readily available in the electronic health record. The Institute for Healthcare Improvement offers an extensive list of standardized tools in *Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults*, Appendix D (www.ihl.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf).
- Whenever possible, engage and educate your patients about fall risk factors and their individual fall risk. Emphasize the possibility of reducing modifiable risk factors through continuous self-monitoring and practices to sustain or improve their mobility.

- He was placed on bed rest during his stay as a precaution against falls. Upon discharge he was weak and showed unsteady balance and gait.
- Prior to discharge, no interprofessional team member performed a home assessment to identify environmental adjustments that could improve his safety there.
- At discharge, the care plan consisted of providing a printout of the discharge diagnosis and scheduling him for a follow-up visit a week later with his primary care physician. It did not include a home health care referral or other transition-to-home follow-up measures.
- The EHR wasn't integrated across all care settings along the care continuum.
- Neither Mr. Huron nor his daughter received education on fall risk factors or how to monitor his status at home.
- Although Mr. Huron lives alone, his social isolation wasn't addressed.
- There was no home monitoring other than family checks.

As a result of these gaps, the care provided during this hospitalization failed to prevent a relatively healthy person from presenting again to the ED and requiring readmission less than a month later.

The present admission: a different approach.

Consider how this patient's outcomes might improve with the implementation of next-era principles and practices.

During this admission assessment, the nurse sits down with Mr. Huron and his daughter for a few minutes. Listening for understanding, the

nurse learns that after a 50-year marriage, Mr. Huron has become a recent widower. He says his wife was the joy of his life; they raised five children together and have seven grandchildren. They lived in the same house during the entire marriage. His wife kept the household organized and loved to cook for the family. To stay active, the couple took long walks together. They attended church every Sunday. But the neighborhood has changed over the years; several friends and family members have moved or passed away, and now his wife is gone. Mr. Huron's daughter explains that all these losses and grief have deeply affected him. He stays in the house for days, neglecting his walks and forgetting appointments. He's even stopped attending church, where his social network was strong. He is alone for days at a time, and has trouble sleeping. The nurse recognizes that he might be depressed, and adds possible depression as a risk factor on his HIIIFRM screening. In closing, the nurse asks Mr. Huron and his daughter to say what matters most to him. He answers readily, "I just want to go back home and live where we've always lived! I don't want to go to a nursing home."

This patient's multiple fall risk factors—confusion, dizziness, male gender, difficulty rising from a chair, other gait and balance issues, and now depression—serve to inform the potential for his safe discharge to home *if* the much-needed social, community, and medical supports are in place. His low mood and mental status are understood to be causal factors in his presenting dehydration. His disturbed sleep and poor nutritional status

are recognized as secondary to grief and depression, which are not uncommon in later life after repeated losses. His physical inactivity, also associated with these conditions, is compounding his general weakness and gait and balance issues, resulting in falls.

This second hospitalization comes with further risks, including recurrence of delirium, further deconditioning, infections, worsening depression, and in-hospital falls. The multidisciplinary ERA approach, applying the best practices highlighted in this article, can support more rapid recovery and a stronger care transition for this patient, as follows:

We must reimagine how a patient's risk factors can help to guide care and promote optimal health using virtual and direct means.

- The EHR is configured to automatically incorporate environmental safety precautions (regarding room lighting, toileting, bed height, chairs, nonslip footwear, and so on) for this patient's general safety. The nurse need only approve such precautions, and no longer has to spend time entering them into the record.
- Mr. Huron's stated goal of going "back home" and not into a nursing home becomes central to his transition plan from the time of admission.
- His dehydration and weight loss prompt immediate actions to improve fluid and dietary intake. For example, fluids are offered in easy-to-use containers, and he's asked which foods he might be willing to eat.
- His daughter brings a few familiar items (such as photos, calendars) from his home to the hospital room. These can help orient him, lower stress, and reduce the risk of delirium. The team also strives to minimize potential environmental triggers (such as loud noises) that can agitate patients.
- Since the nurse's talk with Mr. Huron and his daughter revealed that he might have undiagnosed depression, further assessment is warranted. When Mr. Huron screens positive for depression on the two-item Patient Health Questionnaire (PHQ), the team adminis-

ters the nine-item PHQ (www.phqscreeners.com) to help establish a diagnosis and baseline. Because the patient has a history of delirium, the EHR automatically adds the 2-Item Ultra-Brief Delirium Screen (www.nursing.psu.edu/wp-content/uploads/2019/03/UB-2-with-disclaimer-fick_Delirium-Pocket-Card_052118.pdf).³⁵

- Based on this patient's readmission within 30 days of his last hospitalization, screening for dementia is also prompted in the EHR. He will be monitored, since delirium can be superimposed on dementia and is difficult to assess.
- The formulary prevents the prescribing of a benzodiazepine, should delirium develop, by alerting the team's physicians to the risks.
- Daily mobility goals are defined immediately, and in-bed stretching and bedside stretching, standing, and strengthening exercises are prescribed. By the third morning, the team sees measurable progress.
- The transition form automatically imports data from the EHR and provides this information to Mr. Huron's primary care, home health care, and specialist providers to facilitate his follow-up care at home and in the community.

The transition to home. While many older adults are hesitant to allow visits by home health aides and even family members, Mr. Huron understands that, without help, he may suffer injurious falls that will impede his ability to live on his own. The team uses a multidisciplinary approach to plan his transition and follow-up care, and close any gaps in care continuity. Mr. Huron and his daughter are consulted as well, and he approves the plan. His daughter agrees to serve as a supportive partner and liaison. Before Mr. Huron leaves the hospital, an initial follow-up appointment with his primary care provider is scheduled, with transportation. (This is now possible because EHR integration has been achieved.) Mr. Huron is coached regarding his risk factors and how to monitor himself, and receives instruction on a simple daily stretching and exercise routine. A room-by-room home safety check is completed by the social worker remotely, using a video application and with the daughter's on-site assistance, before discharge.

Once home, Mr. Huron and his daughter continue to have access to his health record, and can attend televisits between in-person visits to providers. She will continue to check on him daily by phone or in person. A physical therapist will make periodic home visits to assess his progress with activity goals. His daughter reaches out to

his church to arrange weekly visits from church members and to set up grief counseling. This patient is likely to have a better life course because his health care team went beyond determining his fall risk score; rather, they sought to learn the underlying causes of his falls and to address all of the modifiable risk factors.

Not every older adult has an adequate family support system. But there are local resources and federal funding programs designed to help older adults stay in their homes and communities. A variety of services are often available, although interagency coordination may be lacking. At the community health level, then, an essential next step is to replace siloed services with partnerships and collaborations, with special attention to underserved and vulnerable populations. Insurers and the federal government have begun to make changes to better support preventive and cross-continuum care. But we can act right now. Nurses, social workers, and other outpatient providers can collaborate and share information about available services in their communities. Local resources can also be quickly found online by visiting the free database known as Aunt Bertha's Find Help at www.findhelp.org and entering a zip code.

CONCLUSIONS

New models are needed to raise the standard of care for older adults and pave the way for the next era in healthy aging and injurious fall prevention. Innovative thinking about care design that includes input from providers, older adults, and family members will allow us to build better care models and workflows. The ERA approach, which incorporates the 4Ms framework, is one such example. We must reimagine how a patient's risk factors— intrinsic as well as extrinsic—can help to guide care and promote optimal health using virtual and direct means. There is strong evidence to support such projects, but disruption of the status quo and openness to innovation will be required. We will face significant challenges.

In the acute care environment, disrupting the status quo demands change and action on many levels. With regard to older adults, disruption means

- shifting our perceptions of and biases about aging.
- being willing to adopt evidence-based practices from the content experts.
- giving up non-value-added nursing tasks.
- making age-friendly care a competency across care settings.
- obtaining leadership support for increased organizational fall risk tolerance, in order to promote inpatient mobility and minimize deconditioning.

- committing to gaining the knowledge and skills needed to provide care that goes beyond the basics.

Nurses at all levels—practicing nurses, specialists, and leaders—can be influential in introducing, advocating, and spreading innovations that improve care while focusing on what matters most to each patient. (For more, see *Key Practice Recommendations for Nurses*.) At any care site, change usually begins with a small group of people who are dedicated to reducing or eliminating problems and can build momentum by identifying small, practical action steps. Consider this article a call to action: the next era of practice is urgently needed. Each of us must heed the call and step up. ▼

For 19 additional nursing continuing professional development activities on the topic of falls, go to www.nursingcenter.com.

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REFERENCES

1. Shorr RI, et al. Impact of the hospital-acquired conditions initiative on falls and physical restraints: a longitudinal study. *J Hosp Med* 2019;14:E31-E36.
2. Agency for Healthcare Research and Quality. *AHRQ national scorecard on hospital-acquired conditions: updated baseline rates and preliminary results 2014–2017*. Rockville, MD; 2019. National scorecard reports; <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/hacreport-2019.pdf>.
3. Moreland B, et al. Trends in nonfatal falls and fall-related injuries among adults aged ≥ 65 Years—United States, 2012–2018. *MMWR Morb Mortal Wkly Rep* 2020;69(27):875–81.
4. Florence CS, et al. Medical costs of fatal and nonfatal falls in older adults. *J Am Geriatr Soc* 2018;66(4):693–8.
5. Fehlberg EA, et al. Impact of the CMS no-pay policy on hospital-acquired fall prevention related practice patterns. *Innov Aging* 2017;1(3).
6. Shorr RI, et al. Effects of an intervention to increase bed alarm use to prevent falls in hospitalized patients: a cluster randomized trial. *Ann Intern Med* 2012;157(10):692–9.
7. Wald HL, et al. The case for mobility assessment in hospitalized older adults: American Geriatrics Society white paper executive summary. *J Am Geriatr Soc* 2019;67(1):11–6.
8. Fazio S, et al. How much do hospitalized adults move? A systematic review and meta-analysis. *Appl Nurs Res* 2020;51:151189.
9. Kortebein P, et al. Effect of 10 days of bed rest on skeletal muscle in healthy older adults. *JAMA* 2007;297(16):1772–4.
10. Kortebein P, et al. Functional impact of 10 days of bed rest in healthy older adults. *J Gerontol A Biol Sci Med Sci* 2008;63(10):1076–81.

11. Hendrich A. How to try this: predicting patient falls. Using the Hendrich II Fall Risk Model in clinical practice. *Am J Nurs* 2007;107(11):50-8.
12. Roberts AW, et al. *The population 65 years and older in the United States: 2016*. Washington, DC: U.S. Census Bureau; 2018 Oct. ACS-38. American community survey reports; <https://www.census.gov/content/dam/Census/library/publications/2018/acs/ACS-38.pdf>.
13. Centers for Medicare and Medicaid Services. *Chronic conditions among Medicare beneficiaries chartbook and charts: 2018 edition*. Baltimore, MD; 2019. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.
14. Hendrich AL, et al. Validation of the Hendrich II Fall Risk Model: the imperative to reduce modifiable risk factors. *Appl Nurs Res* 2020;53:151243.
15. Hoffman GJ, et al. Posthospital fall injuries and 30-day readmissions in adults 65 years and older. *JAMA Netw Open* 2019;2(5):e194276.
16. Phelan EA, et al. Adoption of evidence-based fall prevention practices in primary care for older adults with a history of falls. *Front Public Health* 2016;4:190.
17. Hendrich A, et al. A 36-hospital time and motion study: how do medical-surgical nurses spend their time? *Perm J* 2008;12(3):25-34.
18. Moskowitz G, et al. Using electronic health records to enhance predictions of fall risk in inpatient settings. *Jt Comm J Qual Patient Saf* 2020;46(4):199-206.
19. Weick KE, Sutcliffe KM. *Managing the unexpected: sustained performance in a complex world*. 3rd ed. Hoboken, NJ: John Wiley and Sons; 2015.
20. Hendrich AL, et al. Validation of the Hendrich II Fall Risk Model: a large concurrent case/control study of hospitalized patients. *Appl Nurs Res* 2003;16(1):9-21.
21. Resnick B. Falls: do we know anything more than we did 40 years ago? *Geriatr Nurs* 2020;41(2):67-8.
22. Guirguis-Blake JM, et al. Interventions to prevent falls in older adults: updated evidence report and systematic review for the US Preventive Services Task Force. *JAMA* 2018;319(16):1705-16.
23. Bhasin S, et al. A randomized trial of a multifactorial strategy to prevent serious fall injuries. *N Engl J Med* 2020;383(2):129-40.
24. Institute for Healthcare Improvement. *Age-friendly health systems: guide to using the 4Ms in the care of older adults*. Boston; 2020 Jul. Age-friendly health systems; http://www.ihio.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf.
25. Fulmer T, et al. Moving toward a global age-friendly ecosystem. *J Am Geriatr Soc* 2020;68(9):1936-40.
26. Hshieh TT, et al. Hospital elder life program: systematic review and meta-analysis of effectiveness. *Am J Geriatr Psychiatry* 2018;26(10):1015-33.
27. Inouye SK, et al. Delirium in elderly people. *Lancet* 2014;383(9920):911-22.
28. Rosen T, et al. Assessment and management of delirium in older adults in the emergency department: literature review to inform development of a novel clinical protocol. *Adv Emerg Nurs J* 2015;37(3):183-96.
29. American Geriatrics Society. *AGS CoCare: HELP*. 2019. <https://www.americangeriatrics.org/programs/ags-cocarer-help>.
30. Rhee C, et al. Prevalence, underlying causes, and preventability of sepsis-associated mortality in US acute care hospitals. *JAMA Netw Open* 2019;2(2):e187571.
31. National Center for Health Statistics. *Health, United States, 2018*. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2019. <https://www.cdc.gov/nchs/data/abus/abus18.pdf>.
32. American Geriatrics Society Beers Criteria Update Expert Panel. American Geriatrics Society 2019 updated AGS Beers Criteria for potentially inappropriate medication use in older adults. *J Am Geriatr Soc* 2019;67(4):674-94.
33. Escalon MX, et al. The effects of early mobilization on patients requiring extended mechanical ventilation across multiple ICUs. *Crit Care Explor* 2020;2(6):e0119.
34. Hendrich A, et al. A proclamation for change: transforming the hospital patient care environment. *J Nurs Adm* 2009;39(6):266-75.
35. Fick DM, et al. Preliminary development of an ultra-brief two-item bedside test for delirium. *J Hosp Med* 2015;10(10):645-50.



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