Reframing the View of Falls and Care of the Older Adult: The Role of the Nurse Leader in Combatting Ageism Stereotypes and Promoting Equity

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When an older adult falls, the fall is often a proxy for underlying conditions, such as gait and balance issues or changes in cognitive or functional status. The ageist bias that "old people just fall" can hinder a holistic evaluation and management of the root causes of the fall, many of which are modifiable. Ageism has a profound impact on the health outcomes and experiences of older adults, and should not be overlooked as a social determinant of health. Nurse leaders can advance health equity for older adults by integrating evidence-based care planning using a nurse-driven, technology-enabled approach.

"Older adults suffer from confusion and falls because they're old, right? It's just a part of aging." These bias and other stereotypes, such as assumptions that hearing, mental status, and mobility will decline as an inevitable part of aging, all too often influence how we think about and care for older adults (OAs). The evidence, however, tells a different story. It is true that the prevalence of fall injuries among OAs is a pressing concern: Falls are the leading cause of injury in adults age 65 years and older, with 27.5% reporting at least 1 fall within the past year and 10.2% reporting a fall with injury.[1] In 2019, fall-related injuries among OAs resulted in more than 3 million emergency department visits, 982,000 hospitalizations or transfers to another facility, and more than 34,000 deaths.[2] But, as eloquently explained in a recent commentary in *The Lancet Healthy Longevity*, old age itself is not a disease and "chronological age per se is phenotypically very heterogeneous with enormous inter-individual variability."[3(p.610)] The authors point out that if we assume that age alone is the cause of a disease or health condition, we may not thoroughly evaluate and manage other factors that may be the actual root causes.

Seminal research on fall risk factors bears this out: Even when age appears to predict falls in a univariate analysis, adjusting for age reveals a number of risk factors that predict falls more reliably, such as depression, gait and balance issues, and cognitive and functional status; the science indicates that age is not an independent risk factor.[4-6] For example, the validation study for the Hendrich II Fall Risk Model (HIIFRM) found that, after adjusting for other risk factors, a younger and an older person with the same HIIFRM score have the same risk of falling.[4] If evidence-based interventions are aligned to address the modifiable risk factors at the root of most falls, the downward spiral that follows a fall for many individuals, no matter their age, can be prevented.[7,8] Ideally, targeted interventions are done consistently and proactively for the older adult, with ongoing self- or practitioner-monitoring and intensively during an acute phase of illness.

THE TIP OF THE ICEBERG

Using falls as an example related to ageism, a fall is frequently a proxy for underlying conditions that are hindering healthy aging and causing frailty or mobility

KEY POINTS

- **Age is not a disease, yet ageism biases too often impede the comprehensive assessment and management of health conditions of older adults.**
- **Nurse leaders can engage their teams in a review of their knowledge and practices in caring for older adults and in the design of evidence-based approaches to promote healthy aging, in collaboration with technology partners.**

challenges; the fall may be the tip of the iceberg that signals the need for a holistic assessment of the person's condition and situation (*Figure 1*). A large validation study of the Hendrich II Fall Risk Model published in 2020, with a diverse study population of more than 214,000 patients, identified more than 77,000 patients with multiple fall risk factors that were not actively managed during hospitalization, indicating a significant risk for the person returning home.[7]

For example, imagine an OA who is admitted to the hospital for a heart or pulmonary condition. The nurse administers a standard fall risk assessment and implements environmental precautions, but the underlying fall risk factors that are identified by the assessment—depression, polypharmacy, and poor gait and balance—are not addressed; they don't become part of the medical problem list or the post-discharge care plan. This may be the result of unintended bias—"old people just fall"—or a lack of knowledge among many new or experienced nurses who maintain a standard of care for fall prevention that entails limiting the person's movement, often with the use of bed alarms, an intervention that is not supported by the evidence.[9] Limiting the person's mobility can result in further functional decline, exacerbating underlying issues rather than putting the person on a path to healthier aging.[10]

What's needed is a transformative new lens for nursing practice and interprofessional team-based care, looking at the relationship between fall risk factors and the medical diagnoses to create an individualized care plan within the electronic health record (EHR). Although this may sound unrealistic in the current environment, which has been strained by COVID-19, it can be done and will create efficiencies while improving care, but this transformation does require a systematic review of the organization's practice and culture. Building age-friendly health care systems must include a review of how practices related to care of the OA can and do affect quality of life and human suffering. Fall risk factors, such as polypharmacy and gait and mobility issues, are often a barometer for the OA's overall health, and comprehensive assessment of these risk factors, with appropriate selection of evidence-based interventions, should be integral to a holistic, cross-continuum care plan, supported by an interoperable EHR and designed to help OAs live their best life.[8]

HEALTH EQUITY FOR THE OLDER ADULT

Health equity is defined as the "attainment of the highest level of health for all people."[11] This is different from health equality. Health equality means that everyone is offered the same standard of care; health equity means that everyone has the opportunity to achieve their full health potential. Equitable health care is not one-size-fits-all; rather, care is tailored to the

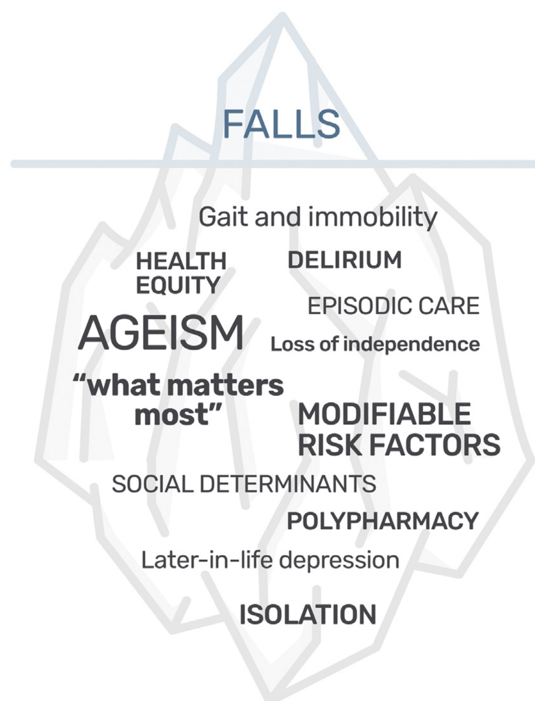

Figure 1. Falls as a proxy for underlying conditions ©Ann L. Hendrich. Used with permission.

specific needs of the individual, which includes addressing barriers tied to social determinants of health (SDOH)—the economic and social conditions that influence the health of people and communities.[12]

Most health care systems have already begun a comprehensive assessment of how SDOH are impacting clinical outcomes and access to care. The central role of nursing in this effort is highlighted by the recent report from the National Academy of Medicine on *The Future of Nursing 2020-2030: Charting a Path to Achieve Health* Equity.[13] COVID-19 has demonstrated just how vulnerable OAs, especially those from communities of color, are to inequities in the care provided.[14] It is surprising to see how often age is *not* included in assessments of SDOH and health equity when it is clear that age and ageism play a major role is shaping how OAs experience the health care system, across the continuum. The World Health Organization (WHO) defines ageism as "the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) directed towards others or oneself based on age."[15(p.2)]

So, what would it mean to provide equitable care for the older adult? The World Health Organization commissioned a global systematic review of studies on the impacts of ageism on health.[15,16] The findings are stark—95.5% of the studies on ageism and health outcomes conducted over the last 25 years reported worse health outcomes for OAs tied to ageism across

11 health domains. These domains include being denied access to health care and treatments, reduced longevity, poor quality-of-life and well-being, physical illness, and mental illness, among others. For example, the analysis found that there were 6.33 million cases of OAs experiencing depression globally linked to ageism. A study of OAs in the United States found that as many as 1 in 10 reports experiencing emotional, physical, or sexual mistreatment or neglect.[17] Achieving health equity for OAs requires care providers to learn how ageism affects OAs in their communities and in their health care encounters and how ageism, rather than age itself, impedes the OA from achieving their full health potential. This education should be an essential element of nursing curricula as we prepare nurses to meet the needs of a population living longer lives.

THREE RECOMMENDATIONS FOR NURSING PRACTICE AND THE NURSE LEADER

Recommendation One: "Look Inward"

The first step to reducing ageism in practice is to know one's own understanding and beliefs about equity and ageism. The literature review conducted as part of the WHO's *Global Report on Ageism* found that educational interventions focusing on knowledge, skills, and competencies aimed at reducing ageist stereotypes, prejudice, and discrimination are effective.[15] One dimension of this education is to look at how we talk about age and aging, learning to use person-centered language that rejects negative stereotypes, while being racially and culturally sensitive.[18,19] As a nurse leader, make it a priority to connect with your department responsible for teaching associates and providers about SDOH to assess whether age and ageism are included in your organization's curricula. This may entail reaching out to departments such as organizational development, human resources, or community benefits.

Recommendation Two: "Change the Story About Aging"

Assess and evaluate care of the older adult by engaging practicing nurses in a review of their practices, self-knowledge, and your organization's current standards of care for OAs. Are these standards of care the same for all adults, or do they enable health equity by tailoring care for common conditions of the OA such as polypharmacy, later-in-life depression, isolation, body image changes, and fears of losing independence? Does a fall risk assessment simply become a check box and a score, or does the presence of fall risk factors signal an opportunity for critical thinking and interprofessional practice that could reduce the potential harm of these risk factors? A simple gap analysis begins with reviewing the current state of practice of your organization's quality improvement approach (such as "plan, do, check, act") and then adopting a framework for care that deflects ageism in how we practice. Nurses have a crucial role to play in achieving health equity,[13,20] and this role should include ensuring health equity around age.

Ageist assumptions lead to practice biases that can actually harm OAs; our care will miss opportunities to detect and observe diagnoses that, if addressed, could improve the quality of life of the OA. Excellent programs to draw from include Age-Friendly Health Systems,[21] 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. Age-Friendly Health Systems is a practice- and evidence-based framework for care of the older adult, anchored by the 4Ms: What Matters, Mentation, Medication, and Mobility. Use of the 4Ms framework disrupts ageism by facilitating the use of evidence that transcends bias by clinicians caring for OAs. Nurses Improving Care for Healthsystem Elders (NICHE) is another established program that promotes principles and evidence-based tools to achieve patient-centered nursing care for OAs.[22]

Recommendation Three: "Connect the Dots and Reduce Human Suffering"

The medical problem list, the nursing care plan, and the EHR still run parallel in many organizations. This results in separate and distinct patient goals, disparate interventions, and the lack of interprofessional solutions that can limit the contribution of nursing. We should never forget that every gap in care caused by this fragmentation has the potential to create human suffering and reduce longevity.

Care of the older adult is multifaceted and as unique as the care of pediatric patients. One of the challenges is that the nursing work environment and practice tools lag the evidence, and high standards of care for OAs have not been uniformly implemented across the continuum of care. For example, mobility is life-giving for OAs; its impact on clinical outcomes, morbidity and mortality risks, and hospital-acquired complications is well-established yet still poorly adopted as a universal standard for many.[10] A functional mobility assessment and daily mobility goals must be prioritized with the person on admission and daily in acute care facilities.

Our vision should be of a nursing practice that is nurse-driven, technology-enabled, supported by an interoperable EHR with clinical decision support, and with care planning organized by a framework such as the 4Ms framework of Age-Friendly Health Systems. Such a nursing practice could:

1. Positively affect the nursing work environment and workflow, as clinicians collaborate with technology partners to reduce or eliminate non-value-added

tasks and redundancy and instead create a nurse-driven, global care plan that is generalizable and scalable for nursing.
2. Increase utilization of evidence-based content for OA care, allowing the novice and experienced nurse to focus on solution-based care of the OA.
3. Reduce prevalence of hospital-acquired conditions for high-risk, hospitalized OAs and improve organizational performance in reducing hospital complications, mortality, and cost of care (sepsis, delirium, depression, readmissions, deep vein thrombosis, catheter-associated urinary tract infections, central line-associated bloodstream infections) when workload complexity is decreased and nursing knowledge of OA care is increased.
4. Facilitate the transformative care model and operational changes needed to address the density and complexity of care delivery in today's environment. This will require leaders to engage nurses and the health care team in the design and approaches of these innovations while also using basic and practical aspects of leading change with management tools (Rogers' theory of change; Kotter's 8-Step Process for Leading Change; continuous quality improvement—plan, do, check, act; etc.).

Hackensack Meridian Health and Centura are 2 large health care systems that are intentionally guided by this vision of nursing practice. These systems are actively working to change practices and educate nurses and teams to reframe falls and care of the older adult.

SUMMARY

The complexity of the work environment and the current nursing workforce challenges from COVID-19 must serve as reminders of how inadequately prepared our health care systems are to care for OAs and why our knowledge and practice must be broadened and modernized. Assumptions about the needs of OAs are entangled with the challenges of managing chronic conditions, frequent emergency department visits, readmission to the hospital, lack of access to preventative care and nursing assessments—all of which are bound up with social determinants of health, of which age is one. Disparities associated with race, ethnicity, and socioeconomic status can further affect the older adult with indignity and personal losses.[23] One sudden acute illness can tip even a previously healthy older adult's life from one of independence or assisted independence to one of total dependence, isolation, and depression. This leaves the person with an inability to live their best life. The nurse leader can explore these concepts to leverage equitable nursing care for OAs and to promote nursing research and evidence from an expanded perspective of equity and respect for OAs and rejection of ageism bias.[24]

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