

The Inpatient Fall: Not just an Incident Report

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You have doubtless received the RN call stating that Mr. Nameless fell while escaping from his posey vest, and that -you need to examine him and fill out the incident report. Importantly, the workup for the fall does not end here. Falls are a symptom, not a diagnosis. Understanding why someone fell is the first step to prevention.

Falls are common in the elderly:

- 1/3 of community dwelling elders fall yearly
- 50% of nursing home elderly fall yearly
- Falls account for 89% of inpatient incident reports
- Rate of falls in inpatient elders: 1.5 falls per bed annually
- 50% of inpatient fallers fall repeatedly

Falls increase the length of hospital stay. Elders who have fallen once are 3-20 times more likely to require a skilled nursing facility admission. Fifty percent of elders hospitalized for a fall will be dead within one year.

Falls occur when environmental demands exceed a person's ability to compensate. Therefore, both intrinsic and extrinsic risk factors need to be addressed. Interventions can occur as early as the admission assessment by identifying high-risk patients. Risk factors for falls include:

- age 65 yrs or older
- past falls history
- cognitive impairment (i.e. dementia, delirium)
- urinary/fecal incontinence
- balance problems, lower extremity weakness, arthritis
- psychotropic drug use
- ETOH

PT/OT evaluation of all high-risk patients on admission allows early identification of modifiable risks, gait retraining, or balance training.

Review medication lists to remove unnecessary medications or choose less dangerous alternatives. Medications known to increase falls risk are:

- Diuretics
- Antihypertensives
- Tricyclic antidepressants
- Sedatives
- Hypoglycemics

Orthostatic hypotension is a common cause of falls. Hospital rooms are quite risky, therefore identify and remove environmental hazards for the visually, hearing, physically, or cognitively

impaired patient. Restraints worsen the risk of delirium and falls. Participating in a restraint-free care plan reduces the risk of falls.

Despite excellent fall prevention efforts, falls do occur. Always obtain a history of the fall. Examination needs to evaluate both causes and outcomes of the fall (if serious injury, consult trauma surgery):

- Vitals (orthostatics too)
- ABCs
- Neurologic exam
- Neck exam: if direct trauma to neck or if point tenderness over cervical spine or new neurologic findings then place cervical collar to immobilize neck and consider imaging via the Canadian c-spine rule
- Search for soft tissue injury and fractures
- Reexamine in 1 hour (very important for picking up concussive symptoms, slow bleeds, etc)

A fall in an inpatient facility is an incident and by law has to be reported to a physician. The incident report is available online at <http://www.internal.bmc.org/incidents/incidentreport.html> and will need to be filled out immediately after your acute exam. If the patient allows, notify the patient's health care proxy or family. Be honest about the nature and probable etiology of the fall. Share with the patient and family the identified fall prevention plan. If a complicated or serious injury occurs, discuss the case ASAP with the primary medical team, nurse manager, and legal (8-RISK).

The primary team needs to reevaluate the patient the day after and intervene as appropriate:

- Why did the patient fall?
- What were the outcomes of the fall?
- Consult or recontact PT/OT
- Repeat Neuro exam (subdurals may be missed initially)
- The entire health care team (medicine, nursing, rehab, social work, care management) needs to participate in implementing a fall prevention plan

Inpatient falls are deadly. Identifying high-risk patients and developing an intervention plan can prevent falls. When a fall occurs, use it as an opportunity to intensify risk factor amelioration.

References

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