CLIENT SAFETY: PREVENTING FALLS AND THE USE OF RESTRAINTS

INTRODUCTION

Certified nursing assistants (CNAs) often care for clients who are elderly, and CNAs may also care for clients who are confused or disoriented. The elderly client and the client who is confused may be at risk for falling and client falls are a big source of injury.

Client safety should always be one of your top priorities when you are working as a CNA, so you will need to know how to prevent elderly and confused clients from falling. Most of the information and techniques you can use for preventing falls that are presented here are simple, but they require a lot of careful and consistent effort in order for them to be used successfully. In addition, you must be sure to carefully document what you have done to keep clients safe and prevent falls, and this is especially true if restraints must be used.

OBJECTIVES

When the student has finished this module, she/he will be able to:

1. Identify the first goal concerning client falls.
2. Identify the three basic causes of client falls.
3. Identify a very effective environmental method of preventing falls.
4. Identify one way to make sure that the environment doesn't contribute to falls.
5. Identify the two basic client issues that can contribute to falls.
6. Identify the staff issue that contributes to client falls.
7. Identify the four issues that are included in a risk of falling assessment.
8. Identify four actions you should take if a client falls.
9. Identify three important concepts regarding the use of restraints.
10. Identify three important concepts of caring for a client who is in restraints.

CLIENT FALLS: FREQUENCY AND SERIOUSNESS

Client falls in hospitals and health care facilities are common occurrences. Some studies have noted that up to 17% of all clients in a hospital will suffer a fall, and a large number of the people admitted to long-term care facilities are admitted because they need care for injuries caused by a fall. Many clients will fall more than once (more on this later). Client falls are also very serious. Although the majority of clients who fall will not sustain an injury, approximately 5% of clients who fall will break a bone, will sustain a laceration that needs stitches, will dislocate a joint, or will even suffer a fractured skull. In addition, hospitals may not be reimbursed by insurance companies or the government for medical costs associated with a fall (and these can be up to $25,000 and occasionally much more for one fall) and falls in a hospital or health care facility may result in long and expensive litigation. Client falls are a serious matter.

WHY DO FALLS HAPPEN?

There are many factors that can lead to a fall. Some of these involve the clients, some involve the staff, and some involve the environment.

Learning Break: Preventing client falls should be your first goal. Part of preventing falls involves knowing *why* falls occur so you can identify clients who are likely to fall, you can identify situations in which a fall is likely to occur, and you an identify staff issues that might contribute to a fall.

- Staff issues: Health care professionals do not *directly* cause clients to fall. However, the CNA, RN, etc. can act to *prevent* falls, and failure to do so is the where the issue of staff enters the equation. As a CNA one of your top priorities is client safety, and preventing falls is a big part of that priority. In order to fulfill this responsibility, you must have knowledge and you must be proactive. You must know why falls occur, you must be able to assess how likely it is a client might fall, you must know which clients are most likely to all, and you must actively work to prevent falls. *Failure of the staff to be proactive is a big reason why falls occur.*

- Environmental issues: The environment can contribute to client falls. The hospital/healthcare facility environment is generally safe but for an elderly client or a client who is confused or disoriented, even these very safe surroundings can be hazardous. Make sure there is **adequate lighting**. If the lighting is dim or a client's room is very dark, elderly or confused clients may not be able to identify where they are. They may not notice objects such as electrical cords, IV poles rugs, etc. and walk into them or trip over them. **Unneeded clutter** such stools, wheelchairs left in halls or near bathroom entrances can be a hazard. If the client is ambulatory, the entire environment must be evaluated to make sure it is safe. This is the responsibility of administration, but if you see an unsafe situation, you must let someone know. Many of the environmental hazards that may cause a client to fall can be eliminated by a simple sense assessment. Look around and use common sense: is there is anything in the environment that would be dangerous to someone who has difficulty with walking or balance, someone with diminished eyesight and decreased muscle strength, or someone who is confused or disoriented?

Learning Break: One of the most effective ways you can make sure the environment doesn't contribute to client falls is **orientation of the client to the environment.** Someone who is elderly or confused may not be able to adjust quickly and easily to new surroundings. When a client arrives on the unit for the first time, show them where the bathroom is, where the light switches are, where the call light is, where the nursing station is, etc. This orientation should be repeated if the client is moved to a new room or if the client's condition changes and makes him/her less likely to remember the surroundings. **You may also need to repeat the orientation from time to time: this is a very important concept that is often neglected.**

- **Client issues:** Client issues are the most complicated aspect of falls. Many client falls happen to people who are elderly, and there are a multitude of reasons for this. The elderly may have problems with hearing, depth perception, and vision. The elderly lose muscle mass, coordination, and strength, and their sense of balance is often diminished. The incidence of psychiatric and/or physical conditions such as Alzheimer's disease and dementia that affect consciousness, perception, and orientation (being aware of who and where you are and accurately knowing and understanding what is happening around you) is higher in the elderly population. People who are elderly take medications that affect muscular strength, coordination, or balance. They take medications that cause drowsiness or confusion. Of course, these problems are not inevitable because of age. Falls can happen to anyone, and certain diseases and conditions that affect someone's mental functioning (and increase the risk of a fall) can occur in young people, as well.

Learning Break: Client falls can be caused by anything **physical or mental** that affects strength, sensory perception, balance, or orientation to the environment. This includes advanced age, certain medications, and certain medical conditions such as a stroke, Parkinson's disease, Alzheimer's disease, etc.

ASSESSING THE RISK OF FALLS

Keeping the environment safe is relatively simple and is often a matter of common sense. The administration and the staff should have plans in place for monitoring the clients – the preventative action.
. But although maintaining a safe environment and having a monitoring plan are important, being able to recognize who is most likely to suffer a fall is vital. Performing **a risk of falling assessment** – when appropriate – will help you and the other staff to determine if a client is at risk for a fall. The assessment should focus on these four areas.

- Medications: Is the client receiving medications that might make him/her more likely to fall? Any medication that can cause dizziness, confusion, drowsiness, or affect blood pressure can increase the risk of falling. Examples of such drugs are sleeping medications (e.g., Ambien®), pain medications (e.g., morphine), sedatives (e.g., Ativan®) or antihypertensives (e.g., verapamil).

- History of falls: This is somewhat controversial. Some authorities believe that someone who falls once is not at risk for falling again, while other experts believe that a client who falls once *is* much more likely to fall again. There is no definite answer to the question, but it is sensible, safe, and doesn't have a negative impact on the client to assume that one fall may lead to another and to plan accordingly.

- Ambulatory status: Can the client walk without assistance? Does he/she need help? Does the client use a cane or a walker? What is the client's gait like? Is it normal, weak, or definitely unsteady?

- Mental status: Does the client know his/her limits in terms of ambulation and orientation and accept them? Or do they forget or refuse to acknowledge these limits? Does the client have a medical or psychiatric diagnosis that might make him/her more likely to be confused, forgetful, or disoriented? Does the client have a medical diagnosis that would interfere with his/her ability to ambulate or make them more likely to fall? Some conditions such as Alzheimer's, dementia, recent surgery, anemia, depression, weakness, stroke, etc. should be considered.

PREVENTING FALLS

Learning Break: Most falls are predictable and preventable.

Preventing falls is relatively easy. You need to know why falls occur, you need to know who is likely to fall, and then using that knowledge take some simple to make sue a fall doesn't happen. The following are some simple steps you can take to prevent falls.

- Side rails down, bed in low position: Traditionally, side rails were considered to be a safety device. This has been shown to be false. If clients are confused or disoriented, they will not recognize side rails as a safety measure, they will simply see them as obstacles to overcome. When they try and climb over them, a fall will almost certainly happen. The bed should always be in the lowest position, as well. If a fall occurs from bed, better it happens when the bed is closest to the floor. The wheels of the bed should also be locked

- Call light: The call light should be operating and it should be where the client can see it and reach it. The use of the call light should be reinforced frequently. Make sure the client understands what it is used for. Make sure that the client understands that using the call light is not a sign of weakness or an inconvenience to the staff.

- Know your clients: Know who has fallen before, who does not seem to have a good sense of his/her physical limits, who takes medications that may cause drowsiness or dizziness, etc. These issues were covered earlier in the module, but they are important to remember.

- Be proactive: Check on clients frequently and document this. Realize that falls happen when clients need to use the bathroom or are trying to reach objects that are not close at hand. A toileting program that provides regular and reliable times for the clients to eliminate can help decrease the incidence of falls.

WHAT SHOULD YOU DO IF A CLIENT FALLS?

If a client falls, follow these steps:

- Look for injuries such as bleeding, obvious breaks, dislocations, mental confusion, etc.

- Call for help immediately.

- Notify the supervisor as soon as possible. The physician should be notified as soon as possible, as well.

- Document very carefully. Make careful observations about the client's condition and the surrounding area. Be objective.

USING RESTRAINTS

A restraint is any device that limits a client's ability to move or manipulate the environment. Restraints can be very simple. A mitten can be applied that limits someone's ability to use his/her hands and fingers, preventing the client from disturbing IV lines, surgical dressings, etc. Restraints can also be complex and very restrictive: cuffs can be applied to hands and feet and a vest can be applied to the chest, and the client will not be able to move at all.

For many years, restraints were used to prevent clients from falling. However, it has clearly been proven that there are safer and more effective ways to prevent falls, and that restraints cause more harm than good. If they are not used in the proper way and in the right circumstances, restraints increase the chances a client will be injured. There are very, very few circumstances in which it is appropriate to use restraints to prevent falls.

However, there are instances in which restraints *are* needed. But they must be used very carefully and the decision to do so is an important one. Follow these guidelines.

- Restraints must be used only as the last resort. Look for less intrusive solutions. Make sure that the situation that is causing you to consider using restraints can't be solved by simpler methods. If the client who is weak and confused is always trying to climb out of bed, risking a fall, try to re-orient them to the surrounding, institute a program of consistent toileting program, make sure the client doesn't have some medical issue such as a fever or low blood pressure that may be causing the confusion.

- Use restraints only if the client is a danger to others or to themselves and there is no other way to keep everyone safe.

- Restraints are only used if a physician has ordered their use.

- The specific type of restraints will be ordered by the physician; do not use anything else.
- Apply the restraints with the supervision of a nurse.
- There should be a policy in place for using restraints. This policy should cover how the restraint is put on, how and where it is secured, how long it can be left on, how to check if it has been applied safely, and how often the client and the restraint should be checked.

For example, in order to use wrist restraints, they should be applied snugly enough so the client cannot remove them, but not so tight that they cause pain or interrupt circulation. The wrist restraint must be secured to something that cannot be moved. Make sure the knot (wrist restraints have attached straps that are tied to the frame of the bed, stretcher, etc.) is secure but can be easily released. Check the patient and the restraint according to policy; this may be every 15 minutes, but it should be at least every 60 minutes. Check the color, pulse, and temperature of the restrained limb. The restraints should be carefully removed every so often according to the physician's order or the restraint policy. Removing the restraints allows the client to exercise the limb and allows the staff to examine the skin that was covered by the restraining device. Finally, **document, document, document.** Document why the restraints were needed, when they were applied, how often the client and the restraints were checked, and what you noticed during these checks.