

# Adult Inpatients' Perceptions of Their Fall Risk

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Patient falls continue to be a high priority for healthcare organisations due to the detrimental physical, psychological, social and financial consequences that can occur. A large number of falls in hospitals are unwitnessed and mostly occur due to patient behaviours and not seeking assistance. Understanding these patient behaviours may help to direct fall prevention strategies, with evidence suggesting the need to integrate patients' perspectives into fall management. The qualitative and quantitative findings are organised into five domains: Fall Risk Perception Measures, Patients' Perceptions of Fall Risk, Patients' Perceptions of Falling in Hospital, Patients' Fear of Falling and Barriers to Fall Prevention in Hospital.

Keywords: falls ; patient ; perception ; hospital ; fall prevention ; falls risk assessment

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## 1. Description of Fall Risk Perception Measures

There were variations in the constructs used to describe patients' fall perceptions, with a total of 25 validated tools utilised to quantify fall perception. The single-item question "*are you afraid of falling?*" was the most frequently used fall perception measure [1][2][3][4][5][6][7], followed by the 16-item Fall Efficacy Scale-International (FES-I) [1][5][8][9][10][11] and the 7-item shortened version of the Fall Efficacy Scale-International [4][11][12][13][14]. The Falls Efficacy Scale (FES) also featured in five studies [10][11][15][16][17], with one study utilising the shortened FES [18]. Physiological fall risk tools were incorporated into some studies ( $n = 8$ ) to compare patients' perceptions with their actual fall risk. The Self-Awareness of Falls Risk Measure (SAFRM) was noted to be the only validated measurement tool that incorporated both the patients' and clinicians' perceptions of fall risk using the same measure [19][20].

Many studies utilised fall perception measures such as the FES and FES-I to measure fear of falling; however, it has been established that fear of falling and fall self-efficacy are different constructs [4]. In one study, participants' self-efficacy improved after a fall question-and-answer education intervention [21], whereas there was a lack of significant findings on fall self-efficacy with the implementation of a multimedia fall prevention program [16]. Further, there were reports of an association between high medication use and lower fall self-efficacy and engagement in fall prevention strategies [16]. A low fall self-efficacy rating was also related to poor physical performance [4].

## 2. Description of Patients' Perceptions of Fall Risk

A prominent emergent theme was the disparity between patients' perceived fall risk and their clinical risk of falling. Patients did not consider themselves to be at risk of falling [7][22][23][24][25][26][27][28][29], and in three studies, approximately one-third of participants accurately identified their fall risk [5][12][19]. These statistics contrast with Radecki, Reynolds [30], as more than half of participants accepted that they were at risk of falling. Similarly, the findings of Greenberg, Moore [18] demonstrate alignment between participants' perceived and actual risk. However, the tool used was not a validated fall risk assessment (Vulnerable Elders Survey). The importance of conducting comprehensive assessments was highlighted in Byrd [31]. In this study, clinicians were unaware of the presence of anosognosia in stroke participants, suggesting that these participants may have had inadequate fall prevention management. Despite fall prevention education, some patients overestimated their own ability in a hospital setting and were unaware that their fall risk could change with their medical condition [29]. A falls expert who recounted their own personal patient experience affirmed, "*Despite all the cues that nursing staff were giving me, I could not grasp that I was at high falls risk*" [32]. Evaluating both patients' perceived and actual fall risk is essential to inform fall prevention education and strategies [5][27][33].

## 3. Description of Patients' Perceptions of Falling in Hospital

The perception of the loss of independence and autonomy was highlighted in Gettens, Fulbrook [34] and Radecki, Reynolds [30], in which participants described their desire to be perceived as physically competent by others. Feelings of

disappointment and disempowerment were expressed over their loss of independence after a hospital fall; however, this produced a behavioural change in which patients were more receptive to assistance [34]. These changes were also noticed in Turner, Jones [35], where participants reported increased reliance on nursing staff and a subtle shift in the locus of control after their falls. Self-blame with admissions of guilt over risk-taking behaviour was identified in Lim, Ang [29], with one person disclosing, *"It was because I refused to listen to other people's advice. I wanted to take the risk to try (walking) by myself."* An older adult's motivation for maintaining independence and assuming risk-taking behaviours can be attributed to a desire to go home [36].

An emerging theme was patients' lack of awareness over the causes of their hospital falls. Differing opinions were observed between patients and nurses in the work by Hoke and Zekany [26], in which patients attributed their falls to environmental factors, whereas nursing staff attributed their falls to *"not calling for assistance."* Patients were more likely to blame extrinsic factors for their falls and did not understand the multifactorial basis behind falls [22]. Similarly, falls were perceived to be mechanical in nature and were referred to as a "loss of balance", rather than to medication use or pre-existing conditions [35]. Patients were more receptive to interventions from health professionals following their hospital falls [22][34].

## 4. Description of Patients' Fear of Falling

There were varied emotions and beliefs around the possibility of falling in hospital. Emotions ranged from apathy or no concern to extremely worried [22][37]. Falls were not considered to be a medical or life-threatening issue for some patients [29]; thus, some participants failed to see the consequences of a fall. The term "fear of falling" was frequently used in studies to determine patients' fall perceptions and is associated with a range of adverse health and psychosocial outcomes [39]. A fear of falling was associated with higher levels of anxiety and reduced social support [2], reduced self-related quality of life scores and higher risk of falling [15] and higher dependency in activities of daily living (ADLs) [15]. There was also a higher association between fear of falling in women and those without a spouse [2][9][17]. Fear of falling increased after a hospital fall, with a reduction in confidence and reduced self-efficacy [35]. Self-perceived factors for increased fear of falling included balance difficulties, dyspnoea, muscle weakness and a history of falling [1][38].

## 5. Description of Barriers to Fall Prevention in Hospital

Patients' thoughts and feelings about their own recovery were identified as the main barrier to engaging with fall prevention strategies [39]. Participants were more likely to engage in fall prevention if they viewed their fall risk as temporary rather than permanent [33]. In Twibell, Siela [28], 10% of participants acknowledged that they had no intention of using the call bell to request assistance when mobilising. Self-identity was important for participants, especially if they considered themselves to be strong and independent. Some participants had difficulty accepting fall prevention strategies that threatened their perceived self-identity, such as the use of a walking frame to ambulate [33].

Participants reported high confidence in the ability of the nursing staff to keep them safe. In Sonnad, Mascioli [7], 40% of patients did not consider themselves to be a fall risk because of high-quality nursing. Despite fall education delivered by nurses, the reduced use of the hospital call bell for requesting assistance was noted in some studies [14][26][37]. A common reason identified for this was that participants considered the nurses to be busy and did not want to impose on them [29][36] [39]. Negative experiences or attitudes towards "unfriendly" nursing staff were also recognised as a factor in noncompliance with call bell use [29][36][37]. Some participants identified that delayed assistance from nurses instigated their risk-taking behaviour, leading to a risk of falling [30][36][37][39]. Valuing one's dignity was considered a priority over potential falls. Avoiding incontinence and subsequent feelings of embarrassment took precedence over the risk of falling, as expressed by some participants [29][30][36][37][39].

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