

Guest Editorial

Research agenda on risk and prevention of falls: 2002–2007

Decades of research have been conducted on the risk, prevention, and management of falls. Although extensive research addresses the issue of assessing fall risk, the link between risk assessment and the effectiveness of interventions remains weak. We have learned that the apparently simple phenomenon of falling is extremely complex and therefore demands a multivariate approach and coordination among many research disciplines to test clinical interventions across populations and settings. Unfortunately, individual research interests, or those of individual organizations, have driven much of the research in this area to date. Therefore, the Veterans Integrated Service Network 8 Patient Safety Center of Inquiry issued a call across professions and experts to identify knowledge gaps that could and should be investigated through scientific rigor and to build a program of research in fall prevention and management.

Patient falls are a high-frequency, high-risk problem within the Veterans Health Administration (VHA), and staff practices related to preventing and managing falls are highly variable. The estimated prevalence of falls is 1,000 to 1,500 a year in acute care settings and 1,000 to 1,700 a year in long-term care [1]. Seven thousand to twelve thousand people 65 years and older have lost their lives because of falls in the past few years. Nearly one-third of older Americans fall, costing more than \$20 billion in direct healthcare costs, according to the U.S. Department of Health and Human Services [2]. Within the VHA, patient falls are the leading cause of reported adverse events [3]. The most serious consequences of falls are hip fractures. In most cases, the immediate cause of hip fracture is a sideways fall with direct impact on the greater trochanter of the proximal femur. However, adverse outcomes go beyond the injuries sustained as a result of a fall. An injurious fall increases estimated costs (relative to nonfallers, in 1996 dollars) by \$1,042 in hospitals, by \$5,325 in nursing homes, by \$253 in emergency rooms, and by \$2,820 in home health settings [4]. Although an injury may



Pat Quigley, PhD, ARNP, CRRN

Deputy Director

*Veterans Integrated Service Network 8 Patient Safety Center
Tampa, FL*

not result from a fall, a patient who has fallen may harbor a fear of a repeat fall with consequent restriction of activity and loss of confidence, mobility, and independence [5]. This, in turn, contributes to further increased risk for falls as well as social isolation [6]. Many of the fall intervention programs have been limited in scope, facility type, geographic location, or intervention method.

Traditional fall prevention and fall management programs have been less than fully effective in preventing falls in part because they have focused on environmental safety and physical restoration after a patient has fallen and sustained negative consequences [7]. Traditional programs focus on physical