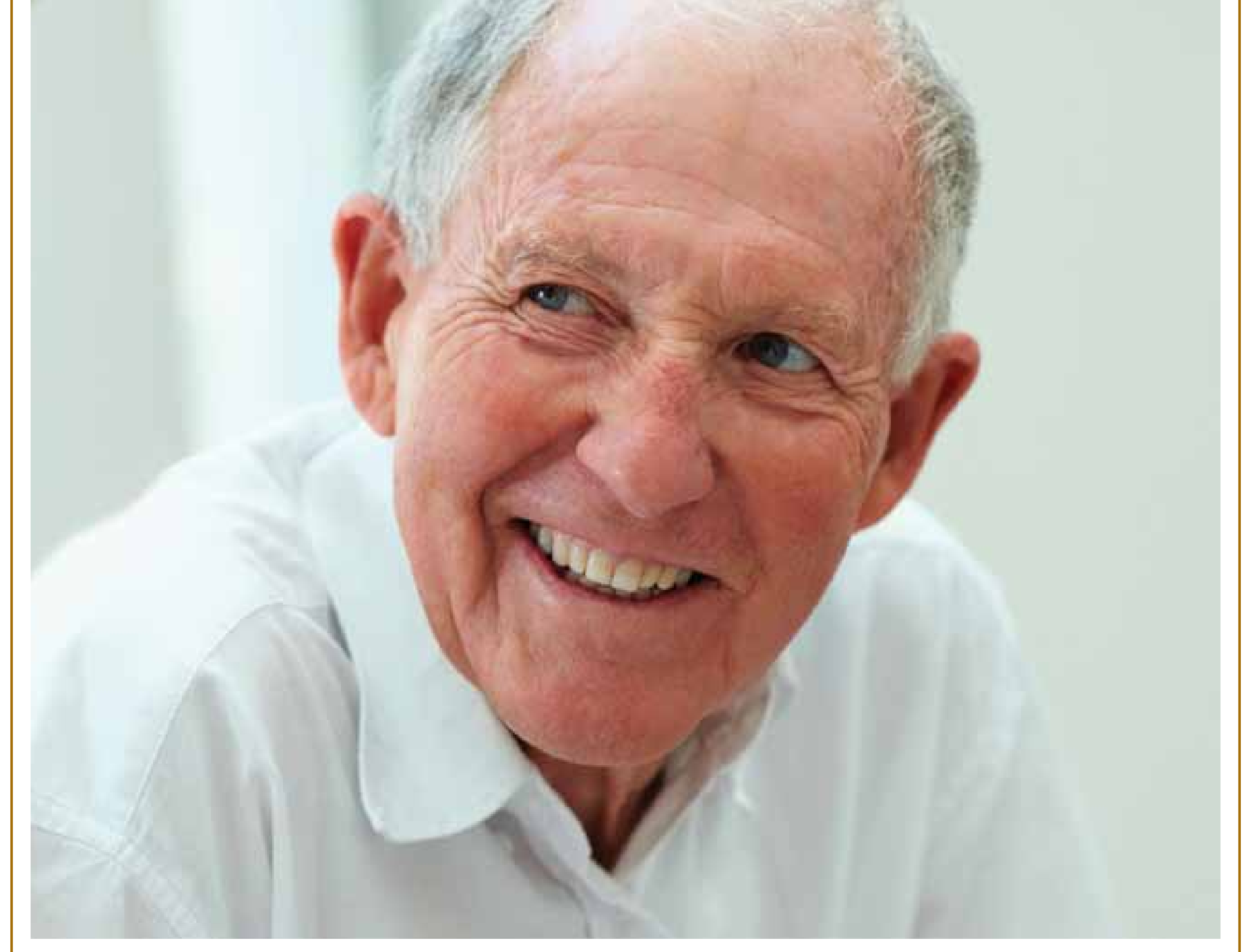
An Open Letter to Dennis:

We Can Do More to Educate Our Patients About Falls Risk

BY JEFFREY L. DANHAUER, CAROLE E. JOHNSON, CRAIG W. NEWMAN, VICTORIA A. WILLIAMS, AND DENNIS VAN VLIET



Dear Dennis,

In this country, more money is spent on health care in the last few weeks and days of one's life than during an entire lifetime. Often this results from falls, many of which might have been prevented. Physicians alone cannot be expected to do it all. As audiologists who treat at-risk seniors, we too need to take a patient-centered approach and act as advocates for falls prevention.

I got your message and was so sorry to hear that your dad passed away yesterday after a recent fall. Lately, I have been hearing a lot of similar stories from colleagues, family, friends, and patients. This caused me to do some research on the topic of falls risk. I discovered that each year in the United States, nearly 20,000 elderly persons die as a result of falls (Centers for Disease Control and Prevention, 2011a). Of course we know that many falls go unreported and more than a third of the people 65 years of age and older will fall this year, and the prevalence increases with age (Centers for Disease Control and Prevention, 2011a). As you recall, my dad was one of those statistics a couple years ago. He had fallen several times before, but the last one finally took his life too. He was only one month shy of 95 and lived alone. Dad was in reasonably good health, aside from a severe hearing loss for which he refused to use hearing aids, despite the fact that my wife, son, and I provided him with the best devices on the market on several occasions. His falls history included a broken leg when he fell on his front porch a few years earlier. For years, we tried to get dad to use the ambulatory devices (e.g., canes and walkers) we bought for him, but his excuse was always the same—he did not need them and would not use them

because they made him look old! He had driven his car right up until his last fall—very scary! But he, like so many seniors, refused to give up that hallmark of freedom and independence. My dad lasted about one week in the hospital after his last fall, during which time a parade of physicians and physical, speech, and occupational therapists among others ran every test imaginable on him. He was in a coma, and all these specialists were able to get about as much response from him as they could have from the chair in his hospital room! All that finally came to a halt when I told them they could keep testing, probing, and billing him, but only if they could assure me that he would someday get up and walk out of the hospital and have a good quality of life. Of course they could not do that and seemed embarrassed for their efforts.

Unfortunately, in this country, more money is spent on health care in the last few weeks and days of one's life than during an entire lifetime (Centers for Disease Control and Prevention, 2011b). Often this results from falls, many of which might have been prevented. This is an anthem that I hear families voice almost daily. I believe that all those professionals could have done so much more for my dad if they had simply counseled him enthusiastically and forcefully years earlier about falls prevention and ways to avoid checking out of this world in the fashion that he did and that so many other seniors will do. On the other hand, I cannot lay all the blame on physicians, because I know that our entire family enthusiastically and forcefully counseled dad over the years, as you did your father. We continually asked him to use his walker, and brought his physician into the discussion. He either forgot or made conscious decisions to ignore that advice, depending on when and where he was. The fact is that our counseling is ineffective much of the time when we have patients who are rightfully allowed some degree of autonomy. All of this was not news to our family since my wife's grandmother endured multiple falls, broken bones, and convalescent center stays until she too took a final fall that proved to be her demise.

In falls prevention, as with hearing problems and hearing aids, we audiologists know that many seniors will fail to take steps to deal with their balance problems until their family physicians finally provide concrete recommendations and guidance about falls prevention.

Appendix A

WEBSITES, ITEMS TO INCLUDE IN A CASE HISTORY, AND FACTORS TO MONITOR ON A REGULAR BASIS

Web Sites

Centers for Disease Control and Prevention, Injury Prevention & Control, Home and Recreational Safety: www.cdc.gov/homeandrecreationalsafety/falls/index.html

Fall Prevention Center of Excellence: www.stopfalls.org

NIH Senior Health, Falls and Older Adults: http://nihseniorhealth.gov/falls/toc.html

Medline Plus, Falls: www.nlm.nih.gov/medlineplus/falls.html

Items to Monitor on a Regular Basis

1. Grooming and personal hygiene
2. Cognitive ability and short-term or working memory
3. Gait and mobility
4. General health and any changes since last visit
5. Living arrangements
6. Medications taken
7. Ability to keep scheduled appointments
8. Ability to wear hearing aids regularly (if needed), change hearing aid batteries, and care for, clean, and know when hearing aids are functioning properly

Questions That Audiologists Need to Ask on a Case History

1. Do you have a hearing problem? When was the last time you had your hearing checked?
2. Do you routinely use hearing aids? If so, do you have them cleaned and checked regularly?
3. Can you hear smoke detectors, alarms, door bells, and phone rings?
4. What medications are you currently taking? What is your daily alcohol consumption, and do you use it with medications?
5. Have you had any change in hearing, ringing in the ears (tinnitus), or dizziness that might be related to new prescriptions or changes in dosages of previous medications?
6. Do you have a vision problem? When was the last time you had your vision checked?
7. Do you need and use eyeglasses for any vision problems?
8. Have you fallen recently? If yes, when was the last fall?
9. How many times have you fallen in the past year?
10. Have you ever been injured, broken bones (e.g., hips, arms, legs), or lost consciousness as a result of a fall?
11. Do you have osteoporosis, weak bones, or back, leg, or hip problems?
12. Do you have any difficulty walking and getting around? If so, do you need assistance? Do you routinely use a cane, walker, wheelchair, or other assistive device?
13. Do you have peripheral neuropathy or numbness in your feet or legs?
14. Do you live alone? If so, do you have a support network of family, friends, and neighbors that looks in on you regularly?
15. Do you have a phone or cell phone located within easy reach of the chair you usually sit in to view television?
16. Do you have a television remote control located within easy reach of the chair you usually sit in to view television?
17. If you have a hearing loss and use hearing aids, are they equipped with t-coils? Is your home looped for television and telephone use with your hearing aids?
18. Do you routinely use a First Alert or similar system for emergencies?

Other questions should be added as appropriate.

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All audiologists should check to see that questions about falls are included in their case history forms and that they include discussions about fall risk in their counseling with patients.

Physicians have enormous power here, much more than families and loved ones who can nag for years to get the individual to seek help or comply with recommendations. Unfortunately, physicians have less and less power when patients have to take steps to pay for and follow their recommendations. I realize that physicians alone cannot be expected to do it all. The phrase "It takes a village" really applies in reducing falls risk. As audiologists who treat these often "hard-headed," at-risk seniors, we too need to take a patient-centered approach and act as advocates for falls prevention. We need to remind our physician colleagues who treat the elderly that they should recognize and exercise their power to influence older persons' lives sooner. If so, then many years of frustration with inadequate communication skills and potentially fatal falls could be avoided or delayed, and a better quality of life could be maintained.

In over 35 years of working with patients, I have witnessed an increasing number of them fall, break a hip, and end up in a convalescent hospital for the rest of their lives. This seems to happen more and more frequently—or maybe it is because I am just getting older and am more sensitive to this issue. The thing that my dad dreaded most was ever having to be moved to a nursing home; his fall took his life, and he never had to experience that fate, but many seniors find themselves in unfamiliar and undesirable places as a result of their falls, especially if they have no family that can or will take care of them in their homes. Even elderly persons living in nursing homes where full-time care is available are not exempt from falls. Annually, about half of the nation's 1.7 million nursing home residents will fall at least once, and one out of 10 of these falls will end in serious injury. Dad's death happened at a time when Carole Johnson, Craig Newman, Victoria Williams, and I were preparing an article on the topic of falls risk. The article has since been published in the *Journal of Family Practice* (Johnson et al, 2009). We wrote the article for a medical journal to help remind physicians about the need for them to screen for hearing loss and falls risk in their elderly patients. Along with other information on the topic, the article provided physicians with a convenient checklist of items that they should cover in their visits with the elderly and their families. The need to assess patients' hearing was at the top of the list, because if patients cannot hear what physicians are saying, then questions and information covered in the rest of the visit may be rendered useless. Physicians should be sure that their elderly patients have their hearing aids on and working, and consider having a PockeTalker or similar device available in their offices for those who do not use but need amplification. Similar checklists and Web sites are provided here for audiologists to use with their patients (see APPENDIX A) and other stakeholders (see APPENDICES B and C) to remind them of the important roles they need to play in this area as well.

Just after completing the *Journal of Family Practice* article, Carole Johnson's father also began suffering from a series of falls that have ultimately forced him to leave his comfortable home of over 40 years and take occupancy in an assisted-living facility where he can easily migrate to more continuous care and convalescence as they become necessary. This same scenario played out with Carole's aunt who recently passed away in a similar manner.

Dennis, these stories are not unique to us; it is shocking how many people have their own similar experiences to share. I was relaying the story of your father's fall and passing to one of my patients and his wife this morning, and they both nodded and smiled. Their eyes welled up with tears as they informed me that both of their fathers had passed away just last month as a result of falls they suffered, even though they had been in reasonably good health. More and more, we find that social discussions with family and friends turn to some tragedy or another relating to an elderly person falling. The problem is

Appendix B

PATIENT HANDOUT ON FALL PREVENTION

One-third of all seniors fall every year. The following are things you can do to prevent falls.

HEARING: Get your hearing checked regularly!

- If you use hearing aids, wear them and have them cleaned and checked regularly
- Consider use of hearing aids with t-coils and looping your home, or hearing aid technologies that provide connectivity to telephones, televisions, and other devices via Bluetooth or cimilar circuitry

VISION: Get your vision checked regularly!

- If you need glasses, wear them regularly!
- Ensure adequate lighting when walking, both inside and outside of the home. If you go out and will be returning after dark, be sure to leave a light on. Do not try to save on electricity by not using good lighting. Remember, the costs of injuries due to falls from inadequate lighting far outweigh the savings on electricity that might be had from not using lights! Carry a small flashlight or keychain light so you can see to unlock doors.

BONES: Keep your bones strong!

- Have your bone density monitored
- Take calcium supplements if your physician recommends them
- Exercise regularly
- Avoid getting up too quickly to answer the door or telephone, especially after sitting for long periods when leg muscles can go to sleep or cramp

HAZARDS: Safeguard your home!

- Remove throw rugs, clutter, and other obstacles from your floors
- Ensure adequate lighting both inside and outside, especially on porches and walkways
- Install handles and railings, especially in bathrooms and on porches
- Be sure to check for pets or children under foot
- Avoid wet spots both inside and outside, especially rain and ice
- Make sure to wear shoes with a sturdy, flat soles that make good contact with floors and other surfaces; avoid use of slippers and flip-flops
- Always use a walker or wheelchair if appropriate; canes may help, but be aware that they mainly only prevent falls in one direction—walkers are superior
- Get and use a First Alert or similar system for use in emergencies
- Make sure your neighbors, physicians, and audiologists have a list of family or other contact persons in case of emergencies

MEDICATIONS: Ask your physician or pharmacist about drugs causing dizziness!

- Know which of your medications (singularly or in combination) cause dizziness or vertigo, ringing in the ears (tinnitus), hearing loss, and/or cognitive impairment
- Investigate alternative medications with your healthcare professional(s)
- Avoid using alcohol with medications
- Keep an updated list of your medications with you
- Do not self-medicate

SEDENTARY LIFESTYLES: Stay active!

- Join an exercise or swim class

- Walk every day
- Discuss any peripheral neuropathies (e.g., numbness and tingling in feet, legs, or arms) with your physician and audiologist
- Maintain a good sense of humor, be with other people, laugh a lot, and have fun
- Take extra care driving, avoid driving at night or in inclement weather, and know when it is time to pass over the keys and give up driving

Be sure to contact your primary care physician if you have any sudden onset of dizziness, unsteadiness, or lack of mobility.

If you should have an accident, be sure to report it and any injuries immediately to your family, your physician, and your audiologist.

Do not get in the habit of falling and not telling anyone!

ubiquitous. You and I have been seeing patients and conducting research on elderly persons for many years now. I am always taken aback to realize that we are now them! Although our minds lead us to believe that we are still as young and vibrant as ever, we are now over 60! Like it or not, this puts us in the elderly category in spite of catchy phrases like "the 60s are the new 40s" or "we are only as young as we feel." In case our hips, knees, backs, skin, and hair fail to remind us, one look in the mirror is an instant wake-up call that we too need to be careful. While I like to think that I am as capable as ever and am actively pursuing my P90X workouts, I must admit to having noticed some unsteadiness when I jump on and off of my tractor on Saturdays. I have even fallen off a ladder in the past couple of years. I have a few close friends that have fallen off the roofs of their houses recently; these once vital, accomplished athletes, while still young in their minds, are now well over 60 and need to be reminded about the risks of falling by their health-care providers (i.e., physicians and audiologists)!

As audiologists, we can and need to play a greater role in helping our patients, friends, and families be more aware of and prepared for falls risk. It seems that our elderly female patients are even more likely to sustain falls than males. Whether we choose to practice vestibular testing and/or rehabilitation like some of our colleagues who excel in that area (e.g., Jacobson, Kileny, Shepard, Worthington, Gans, Akins, and others), we at least need to know when to make referrals to them. We especially need to keep an eye on our elderly patients who are frail and live alone. In addition to their primary care physicians, we audiologists might be the only ones who see these patients on a consistent basis. How many patients have we seen transition in a very short time from being able-bodied, active seniors enjoying their retirement to stooped-over, fragile individuals who are more and more unsteady with each and every visit to our offices? The checklists and Web sites in Appendix A can be used by audiologists to help them with this process.

All audiologists should check to see that questions about falls are included in their case history forms and that they include discussions about falls risk in their counseling with patients. However, because case histories may only be updated every few years, we should pay more attention to the general well-being of our patients as they come in for hearing aid repairs, batteries, or checkups. We audiologists need to be observant and have prevention discussions with our once-bouncy and energetic patients who now shuffle their feet and touch the walls of the hallway on the way to our exam rooms and attempt

compensation via increased proprioceptive input. We and our office personnel should be alert for sudden changes in our patients' personal grooming, weight, and ability to get around that might signify that they are becoming unable to manage their own lives. For example, if once punctual patients fail to show up for appointments, we should call them or family members to make sure that they are okay because many seniors who live alone fall at home, cannot get up, and may go for days before being discovered. It is important for our offices to maintain a list of names and telephone numbers of family members who can be contacted in these situations. We should also encourage families to obtain First Alert or similar devices for their elderly loved ones. We had just purchased a First Alert contract for my dad the day he fell, but we were too late, and he never got a chance to use it. Families should be advised that they need to get these devices and have elderly loved ones begin using them well ahead of an emergency. We all remember seeing and joking about the elderly lady in the television ad a few years ago where she was seen shrieking, "Help! I've fallen and can't get up." Although the ad was somewhat humorous, it did make the point and seems to be more on target with every passing year. Carole Johnson recently related to me how her aunt had fallen and failed to answer the phone for a few days until it was discovered that she had fallen and could not reach the phone. This scenario might be avoided with the First Alert type systems that I see more and more patients using. These devices allow the elderly to maintain some degree of independence while proving assurance to family members. Routine checking for changes in vision, loss of weight and/or bone density, decrease in physical activity, and side effects of medications can often uncover potential problems that could lead to falls, as well as tinnitus and hearing loss.

When I see that there might be a problem in this area, I find that it is helpful to introduce the topic of falls risk by giving patients and their families the handout in Appendix A and telling them about my dad and others who have succumbed to untimely accidents. Such mishaps could often easily be prevented by use of ambulatory assistive devices like walkers; making sure that shoe

Appendix C

HANDOUT FOR STARTING A FALLS PREVENTION PROGRAM

What are some statistics on senior citizens falling?

- One-third fall every year
- 20,000 per year will die as a result of falls
- Falls risk can be reduced
- Falls prevention programs work

Who is at risk for falling? Everyone, but especially those who are ...

- Over 80 years of age
- Female
- Prone to osteoporosis or other physical problems
- Dependent on ambulatory assistive devices (e.g., wheelchairs, canes, etc.)
- Taking certain prescriptive medications, especially when used with alcohol
- Known to have a history of falling

What are components of a falls prevention program?

Staff Involvement and Education

- Ongoing in-services providing knowledge and skills
- Participation
  - Taking special precautions for at-risk residents
  - Reporting and documenting all falls, especially noting any injuries
  - Enacting precautions for falls prevention
    - Eliminating environmental hazards
    - Reminding residents of potential hazards

Safety Audit of the Environment: Patient Rooms and Public Spaces

- Removing potential obstacles (e.g., electrical cords, throw rugs)
- Installing skid- and slip-proof surfaces (e.g., avoiding floor polish, wax, or puddles; securing carpeting, non-skids mats/appliqués in bathrooms, etc.)
- Ensuring adequate lighting
  - Avoiding glare
  - Using contrasting colors (tape on steps/ furniture and carpeting)
- Installing handles and railings (stairways, hallways, bathroom showers and tubes, etc.)
- Installing emergency alerting systems

Resident and Family Programs

- Provide lectures on falls risk and prevention that emphasize
  - Role of vision
  - Threat of osteoporosis and other physical problems
  - Dangers of environmental hazards
  - Role of medications in dizziness
  - Importance of exercise
- Target at-risk residents and their families for falls risk prevention programs
- Offer exercise classes (e.g., Tai Chi , Zumba, Sit 'n Be Fit)
- Inspect residents' living quarters for hazards
- Provide reminders to:
  - Ask for help, if needed
  - Use:
    - Ambulatory assistive devices
    - Handles, rails, and grab bars
    - Lights at night
  - Avoid unnecessary risks
  - Report:
    - Hazards in room or common areas
    - Peers at risk for falling
  - Avoid getting up or standing too quickly
  - Report sensations of dizziness
  - Make sure shoes fit properly

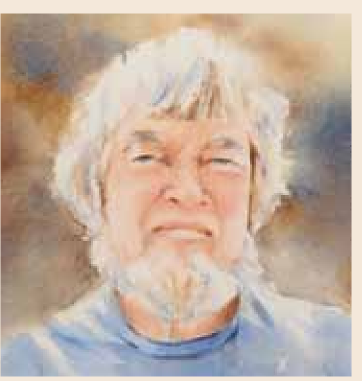
Program Stakeholders and Partners

- Residents
- Families
- Staff
- Health-care providers
  - Primary care physicians
  - Audiologists
  - Physical therapists

We audiologists are all in a unique position to offer more than hearing tests and hearing aids to our patients—we can and need to do more.

soles are sturdy and that they make firm and level contact with surfaces; removal of throw rugs, loose carpeting, and clutter in the home; assuring adequate lighting; checking that pets and toddlers are not underfoot; taking special care on wet, icy, or slippery surfaces; making sure that eyeglasses and hearing aids are on and functioning properly; and having portable telephones and television remote controls located within arm's reach of the favorite viewing chairs. One of the take-home messages that I received from the recent AudiologyNOW! was how important it is for audiologists to counsel patients about loops and the use of t-coils in their hearing aids. In this case, looping the living areas of elderly persons might keep them from having to get up and move around quickly, particularly after sitting for long periods, to adjust televisions or answer phones, which is exactly how my dad fell. Many of these suggestions are simple, common sense things that everyone already knows to do, but attending to any one of them might prevent a catastrophic fall. Adding these items to audiologists' counseling of elderly (or even younger when appropriate) patients and their families and warning about the importance of warding off osteoporosis and neuropathy, keeping active, and investigating how medications (especially if taken along with alcohol) may contribute to falls does not require much additional time during an office visit but can show them that you care about all aspects of the patients' well-being. It also offers an opportunity for audiologists to make the inner ear connections between the hearing and balance mechanisms clear to patients and why it is sometimes necessary to evaluate both vestibular and auditory systems and to consider how vision and proprioceptive sensory integration may contribute to both. These aspects are clearly within the audiology scope of practice and should not be left to our primary care physician colleagues alone.

If audiologists will take the time to include a discussion of falls risk for their patients when appropriate, then perhaps they may be able to help families avoid the consequences of untimely accidents like the ones we have all had to deal with in our own families. We audiologists are all in a unique position to offer more than hearing tests and hearing aids to our patients—we can and need to do more. We can also extend our influence into the community by speaking on the need for decreasing falls risk when addressing civic organizations or providing in-services to staff at long-term residential care facilities who may wish to establish falls prevention programs. Appendix C is an example of an outline for a



EDWARD W. VAN VLIET 1918–2011

Edward Van Vliet died in February 2011 as a result of complications resulting from a fall in his home. A carpenter by trade, he was very physically active throughout his life in work and play. He enjoyed hiking and appreciated nature, and especially loved fishing. Parkinson's disease progressed over the last 10 years of his life, limiting his mobility and balance, but not his sense of humor or dignity. In spite of the Parkinson's, he did what he could with patience and a smile.

talk to encourage administrators and staff to set up a falls prevention program.

Audiologists, physicians, care givers, and families need to give elderly persons their due respect and acknowledge their desires to maintain their independence. We need to remember that just because people reach a certain age and become more frail, it does not necessarily mean that they all are incompetent, demented, or incapable of making proper decisions. Dennis, I am reminded of how you told me that your dad had looked a bit demented with blueberry jelly on his face when the paramedics arrived at his house after one of his earlier falls but that his appearance was due to his Parkinson's disease interfering with his grooming habits rather than incompetence as he was quite capable of interacting and reasoning with and assuring them that he was okay. Similarly, Carole Johnson relayed how her dad could not sleep recently and allowed a piece of toast to burn and set off alarms while he was in the shower at 5:00 am, which prompted a visit from the assisted-living facility staff. He told Carole how strange it must have looked to see an old man standing naked with the kitchen on fire as the firemen broke down his door. Unfortunately, he lost his toaster oven and was put on close watch after the incident, but that he was able to acknowledge the humor in the situation and was able to discuss and joke about the event with Carole showed that he was neither senile nor incompetent. These stories remind us that age, how someone looks, and the situation should cause us to respect and not prejudge and jump to conclusions about a person's cognitive status. Nevertheless, these events can be a precursor of things to come. Your dad fell and passed away only a few days after his incident with the paramedics, and Carole just informed me that her dad hit a bicyclist while driving his car today. Although it was a relatively minor accident, not his fault, and no one was hurt, Carole's dad freely admitted that his driving days were over. I saw my dad dent his car and knock off his rearview mirrors on people's mailboxes on multiple occasions yet deny that he had problems driving and refused to give up the keys. Take a look at your elderly patients' cars and observe them pulling in and out of the parking lot, and you will quickly notice which ones are likely to be at risk for falls and other issues.

In reality, in spite of our efforts it will often be difficult to get all patients to follow our recommendations. We all know of examples like the couple who was in their 80s, lived alone, had no help in the house, and were clueless about what to do, even about how to get a housecleaner. During an extensive counseling session in which it was stressed how important it was for them to plan for help and for emergencies, it was determined that their nearest family member was a daughter about 90 minutes away, who was busy and rarely visited. Although the schedule was jammed as a result of a lengthy counseling session, they were given a simple "to do" list for them to take home, which hopefully had a small impact on a huge and growing problem for them. Several important questions arise as busy clinicians begin addressing issues of falls risk with their patients. How much time can we exert on this type of counseling? Where do we draw the line on helping these people with whom we have had long-standing relationships and who are not being fully served by their family and physicians? How effective can we be in counseling patients when they do not or cannot see how serious the topic is? I recall you telling me how your father insisted on keeping his old wobbly swivel rocker that threatened to toss him through the window every

time he sat in it and how he steadfastly refused the power lift chair you bought for him. We audiologists need to include anything that helps us counsel this stubborn, independent, and proud population. Things will likely get worse as Medicare is gutted and patients have to start paying more and more for treatment. We must remember that even if we are effective with our counseling, patients may still look at the cost and refuse to follow the plan.

Again, Dennis, I am very sorry to hear about your loss. Unfortunately, we will probably hear about similar accidents from a lot more of our friends, both inside and outside of the audiology community over the coming years, especially as we baby boomers embrace the challenges of joining that "chronologically gifted" group known as the elderly. Hopefully, this article can serve as a heartfelt wake-up call for clinicians that will encourage them to help look after the global needs of their patients. At the risk of information overload, the attached counseling checklists include critical safety and convenience factors that should be valuable to assure that patients are doing all that can be done to ensure their safety, including having a support network. If audiologists use these checklists as handouts for their patients, then they can at least highlight the critical points in the office and patients can go over the rest (hopefully with families) at home at their own convenience. If we are lucky and take our own advice, then maybe the best we can hope for is that we and our immediate loved ones are not the next to fall.

Sincerely,
Jeff

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ALSO OF INTEREST

"Dizziness and Fall Prevention: Interview with Lynn S. Alvord, PhD." Scan the QR code to view this article on your mobile device.

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