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Nursing interventions for hospitalized elderly at risk of falling

ABSTRACT | Objective: to compare the nursing interventions related to the risk of falling in the hospitalized elderly recorded in the medical records, with the interventions and activities proposed by the Nursing Intervention Classification. Method: cross-sectional, descriptive study using the cross-mapping tool, carried out in a university hospital. Data collection was performed in its own form and filled out from the evolutions recorded by nurses in 67 medical records of elderly classified as at risk of falling. The term phrases were written manually on the form and then summarized in Excel 2011 spreadsheet. Simple descriptive statistics were applied with the aid of the Statistical Package for Social Sciences- SPSS 22.0 program to portray and analyze the data. Results: when comparing the interventions recorded by nurses with nursing interventions and activities of the Nursing Intervention Classification, 10 interventions were evidenced. Conclusion: The study enabled the qualification and optimization of care in relation to the prevention of falls, guiding and improving the therapeutic plans of nursing. Through the articulation of the data and knowledge generated with the execution of the study, one can know and learn about the diversity of activities suggested by NIC interventions/activities, which can increase the nurse's record in relation to preventive actions in the event of falls.

Keywords: Elderly; Accidents Due to Falls; Nursing Care.

RESUMEN | Objetivo: comparar las intervenciones de enfermería relacionadas con el riesgo de caer en los ancianos hospitalizados registrados en los registros médicos, con las intervenciones y actividades propuestas por la Clasificación de Intervención de Enfermería. Método: estudio transversal y descriptivo utilizando la herramienta de mapeo cruzado, realizado en un hospital universitario. La recopilación de datos se realizó en su propia forma y se rellenó de las evoluciones registradas por las enfermeras en 67 registros médicos de ancianos clasificados como en riesgo de caída. Las frases del término se escribieron manualmente en el formulario y luego se resumieron en la hoja de cálculo de Excel 2011. Se aplicaron estadísticas descriptivas simples con la ayuda del programa paquete estadístico para ciencias sociales- SPSS 22.0 para representar y analizar los datos. Resultados: al comparar las intervenciones registradas por las enfermeras con las intervenciones de enfermería y las actividades de la Clasificación de Intervención de Enfermería, se evidenciaron 10 intervenciones. Conclusión: El estudio permitió la calificación y optimización de la atención en relación con la prevención de caídas, orientando y mejorando los planes terapéuticos de la enfermería. A través de la articulación de los datos y conocimientos generados con la ejecución del estudio, se puede conocer y conocer la diversidad de actividades sugeridas por las intervenciones/actividades NIC, que pueden aumentar el historial del enfermero en relación con las acciones preventivas en caso de caídas.

Palabras claves: Ancianos; Accidentes Debidos a Caídas; Cuidados de Enfermería.

RESUMO | Objetivo: comparar as intervenções de enfermagem referentes ao risco de queda no idoso hospitalizado registradas nos prontuários, com as intervenções e atividades propostas pela Nursing Intervention Classification. Método: estudo transversal, descritivo, com utilização da ferramenta mapeamento cruzado, realizado em um hospital universitário. Coleta de dados realizada em formulário próprio e preenchido a partir das evoluções registradas pelos enfermeiros em 67 prontuários de idosos classificados com risco de queda. As frases-termo foram escritas manualmente no formulário e depois sumarizados em planilha de Excel 2011. Aplicou-se estatística descritiva simples com o auxílio do programa Statistical Package for Social Sciences- SPSS 22.0 para retratar e analisar os dados. Resultados: ao se comparar as intervenções registradas pelos enfermeiros com as Intervenções e Atividades de Enfermagem da Nursing Intervention Classification, evidenciaram-se 10 intervenções. Conclusão: O estudo possibilitou a qualificação e otimização do cuidado em relação à prevenção de quedas, norteando e aperfeiçoando os planos terapêuticos de enfermagem. Através da articulação dos dados e conhecimentos gerados com o executar do estudo, pode-se conhecer e aprender acerca da diversidade de atividades sugeridas pelas intervenções/atividades NIC, as quais podem incrementar o registro de enfermeiro em relação às ações preventivas no evento de quedas.

Palavras-chaves: Idoso; Acidentes por Quedas; Cuidados de Enfermagem.

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INTRODUCTION

In Brazil, the elderly population is the fastest growing population segment in recent times⁽¹⁾. Such growth can be justified by birth control and increased life expectancy, the result of a greater offer of quality of life. There are predictions that in the period from 1950 to 2025, the group of elderly people in the country must have increased by fifteen times, while the total population by five. Thus, the

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nation should occupy the sixth place in terms of the contingent of elderly people, reaching, in 2025, about 32 million people aged 60 or over⁽²⁾.

One aspect of concern in relation to the accelerated aging process is the repercussions on health services, hospitalization is an important resource in the care of the elderly, being part of the health care network. Hospitalizations, especially if repeated and prolonged, can produce negative consequences for the health of the elderly, such as decreased functional capacity, quality of life and increased frailty⁽³⁾.

Hospitalization is understood by society as an important period for the patient's recovery, however, it is not so welcome because it is linked to illness and can, consequently, potentiate the worsening of certain physical conditions, especially in the elderly population, and predispose the occurrence of adverse events, such as falls.

Falls are commonly defined as "inadvertently falling to the ground or another lower level, excluding intentional changes in position to rest on furniture, walls or other objects"⁽⁴⁾. Falls in the hospital environment are the third most reported adverse event by the National Health Surveillance Agency (ANVISA) Notivisa System. The data from this system indicate that from March 2014 to March 2017, more than 12 thousand falls were reported and, mostly, due to lack of balance⁽⁵⁾.

The falls suffered by patients during the hospitalization period are relevant complications that demonstrate the deficiency of safety in care, in addition to constituting health services as a priority concern when discussing care quality control systems⁽⁶⁾.

The nursing diagnosis (ND) Risk of Falls, proposed by NANDA-I, largely meets the need to identify the elderly at risk to propose and add measures that guarantee their integrity. The NANDA-I taxonomy describes for the first time the ND Risk of Falls in the year 2000,

inserted in the Safety / Protection domain, in the Physical Injury class. It is defined as the increased susceptibility to falls that can cause physical damage, its risk factors are diverse⁽⁷⁾.

According to the Nursing Interventions Classification (NIC), in the Fall Prevention intervention, ten activities related to patient/family guidance and education are included. In the nursing prescriptions for patients with ND Risk for Falls, the orientation of the patient/family regarding the risks and prevention of falls is generally identified. The care prescribed by nurses is frequent⁽⁸⁾.

Linked to this issue of aging, the hospitalization process of the elderly and the adverse events that can happen in this environment, especially falls, there is an awakening to the issue of patient safety. Brazil is one of the countries that make up the World Alliance for Patient Safety and, in 2013, the Ministry of Health (MS) developed and released Ordinance No. 529, which instituted the National Patient Safety Program (PNSP), which defines the relevant concepts in the area and the main strategies for the implementation of the program. Among the strategies to reduce safety incidents established by the PNSP, there is the fall prevention protocol aimed at the hospital environment⁽⁹⁾.

With a focus on Goal 6 of the PNSP, which aims to prevent falls and pressure ulcers, it is emphasized that hospitalization is identified as one of the factors that increase the risk of falling⁽¹⁰⁾. This risk is more accentuated in the elderly, due to the unknown environment, the presence of several systemic diseases, submission to therapeutic procedures, use of various medications, in addition to the fragility resulting from the morbidity that triggered hospitalization⁽¹¹⁾.

The nurse, being aware of the changes that the aging process entails, needs to be attentive to identify them, as well as perceive the needs expres-

sed or not, and determine the actions for a better quality of life for the elderly, performing individualized care, trying to maintain independence and autonomy⁽¹²⁾.

Thus, the prevention of falls is linked to the issue of the implementation and application of effective interventions by the nurse and his team, maintaining safe and quality care.

In this context, the study aimed to compare the nursing interventions related to the risk of falling in the hospitalized elderly registered in the medical records, with the interventions and activities proposed by the Nursing Intervention Classification (NIC).

METHODOLOGY

This is a cross-sectional, documentary study and adopted the use of the cross-mapping tool, carried out in a public university hospital in Niterói/RJ. We chose to perform the collection in the Medical and Surgical Clinic, female and male, the data collection started in May 2017 and ended at the end of July 2017. We worked with a convenience sample, which consisted of 67 medical records for people aged 60 and over.

The inclusion criteria were the medical records of: elderly people who had a hospital stay longer than 48 hours; that the bed was visually identified for Fall Risk; that in the therapeutic plan, referring to the day of hospitalization, the Risk of Fall was scored; and that, at least, there were two evolutions written by the nurse.

The exclusion criteria considered were: medical records not located at the place of custody; and those who, even with visual identification in the bed and identified in the therapeutic plan for risk of falling, were not written in the evolution the nursing interventions related to the risk of falling.

The independent sociodemographic variables identified were age,

sex, income, education level and marital status.

The medical records of the elderly hospitalized in the elected clinics that met the study criteria were surveyed. From the separate medical records, the nursing interventions related to the risk of falling described by nurses for the elderly classified with such risk were identified in the evolutions, these interventions were manually transcribed for an instrument created.

From the manual record performed on the collection instrument, a database was created with the aid of the Office Excel for Windows® 2011 spreadsheet, to map the registered interventionist actions. Due to the similar interventions recorded in the first and second evolutions and the verbal approach, it was considered pertinent to make a grouping by similarity, shown in Table 3 of the mapped interventionist actions.

Cross-mapping was performed by comparing the actions written in the medical records, and the interventions/activities proposed by the NIC. To carry out this mapping procedure, it was necessary to consider the following rules⁽¹³⁾: map using the context of the nursing diagnosis; maintain consistency between the intervention being mapped and the definition of the NIC intervention; map the intervention from the NIC intervention label to the activity; use the "keyword" in the intervention, to map to the NIC intervention; and use verbs as the "keywords" in the intervention.

From the data collected, a database was built in an Excel Microsoft® 2011 spreadsheet. The statistical analyzes were processed using the IBM SPSS program (Statistical Package for the Social Science), version 22.0. For characterization of the sample and descriptive analysis of the variables, the sociodemographic data were synthesized in distributions of absolute (n) and relative (%) frequencies. Still

in the descriptive analysis, a percentage comparison (%) of the total NIC activities related to the fall identified in the mapped interventions with the interventions found in the researched records was performed.

In line with Resolution 466/12/2012, of the National Health Council (CNS), this research was sent and approved by the Research Ethics Committee (CEP) of University Hospital Antônio Pe-

dro (HUAP), under the number CAAE Protocol 64103616.1.0000.5243 and Opinion 2,004,425.

RESULTS

Regarding the synthesized socio-demographic data, based on the information obtained from the 67 medical records included in the study, the frequency expressed in Table 1 is obser-

Table 1. Frequency distribution of the variables of the socio-demographic profile UFF / EEAAC / MACCS. Niterói, RJ, Brazil, 2017.

| Variável | Frequência (%) |
|-------------------------------|----------------|
| Sexo | |
| Feminino | 22 (32,8%) |
| Masculino | 45 (67,2%) |
| Estado Civil | |
| Solteiro | 22 (32,8%) |
| Casado | 31 (46,3%) |
| União Estável | 01 (1,5%) |
| Divorciado | 02 (3,5%) |
| Viúvo | 11 (6,4%) |
| Escolaridade | |
| Não Informada | 23 (34,3%) |
| Analfabeto | 01 (1,5%) |
| Ensino Fundamental Incompleto | 13 (19,4%) |
| Ensino Fundamental Completo | 16 (23,9%) |
| Ensino Médio Completo | 10 (14,9%) |
| Ensino Superior | 04 (6,0%) |
| Renda Mensal | |
| Não Informada | 24 (35,8%) |
| 1 a 3 salários mínimos | 34 (50,7%) |
| 3 a 6 salários mínimos | 09 (13,4%) |
| Idade | |
| 60 a 64 anos | 16 (24,6%) |
| 65 a 68 anos | 14 (21,5%) |
| 69 a 72 anos | 07 (10,8%) |
| 73 a 76 anos | 11 (16,9%) |
| 77 a 80 anos | 06 (9,2%) |
| 81 a 84 anos | 05 (7,7%) |
| 85 a 89 anos | 06 (9,2%) |

Source: Pereira ES, 2018⁽¹⁴⁾.

ved, where the predominance of married, male elderly, with an age range of 60 to 64 years.

In the first record, 176 term-phrases

were identified that expressed nursing interventions related to the prevention of the risk of falling. The second record, in turn, had a total of 112 phra-

se-terms. Two consecutive evolutions written by the post-admission nurses of the patients were analyzed, from 67 records read, a total of 134 evolutions were read, culminating in 288 mapped phrases-terms.

In the first record, the highest frequencies of the terms identified were: bed maintained with elevated bars (45 cases, 67.2%) and assessed level of consciousness (44 cases, 65.7%). In the second record, the highest frequencies of mapped terms were: level of consciousness (35 cases, 52.2%) and bed rest with elevated bars (27 records, 40.3%). Other terms were also mapped, as shown in the records in Table 2.

With the interventions mapped in the 1st and 2nd evolutions, we proceeded to a grouping by similarity of the interventions, shown in Table 3, so that it was possible to compare what was found in the records with what the literature, the NIC, presents.

According to the data presented in Tables 2 and 3, 10 Interventions and 37 mapped activities related to the Nursing Intervention Classification (NIC) were listed, as follows: Environmental Control; Self-care assistance: bath/hygiene; Self-care assistance: transfer; Assistance in SELF-CARE: use of toilet; Shower; Physical CONTENTION; POSITIONING: wheelchair; FALL prevention; Care with the REST in the Bed and TRANSFER. Of the mapped NIC interventions, 40% are linked to the Physiological Domain: Basic and the Level: Facilitating Self-Care.

Table 2. Frequency distribution of mapped phrases from the records. UFF / EEAAC / MACCS. Niterói, RJ, Brazil, 2017.

| Registros | N | Frequência (%) |
|---|----|----------------|
| Primeiro Registro | | |
| Leito mantido com grades elevadas | 45 | 67,2% |
| Avaliado nível de consciência | 44 | 65,7% |
| Encaminhado ao banho de aspersão com auxílio | 23 | 34,3% |
| Deambula com auxílio | 19 | 28,4% |
| Auxílio de cadeira higiênica e de rodas | 14 | 20,9% |
| Paciente restrito ao leito | 13 | 19,4% |
| Orientado a família sobre auxiliar o paciente | 13 | 19,4% |
| Movimentação em bloco e posicionamento no leito | 05 | 7,5% |
| Segundo Registro | | |
| Avaliado nível de consciência | 35 | 52,2% |
| Repouso no leito com grades elevadas | 27 | 40,3% |
| Auxílio para deambular em pequenas distâncias | 10 | 14,9% |
| Orientação do familiar para mobilização no leito | 09 | 13,4% |
| Encaminhado ao banho de cadeira higiênica | 07 | 10,4% |
| Identificação no leito de risco de queda | 07 | 10,4% |
| Paciente restrito ao leito | 06 | 9,0% |
| Contido no leito | 05 | 7,5% |
| Banho no leito | 03 | 4,5% |
| Orientado o paciente como movimentar-se com auxílio do andador/muleta | 02 | 3,0% |
| Avaliar equilíbrio | 01 | 1,5% |

Source: Pereira ES, 2018⁽¹⁴⁾.

Table 3. Frequency distribution of Similar Groups. UFF / EEAAC / MACCS. Niterói, RJ, Brazil, 2017.

| Grupos de Similares | N | Frequência (%) |
|---|----|----------------|
| Nível de Consciência | 80 | 59,7% |
| Leito Gradeado | 72 | 53,7% |
| Auxílio na locomoção e/ou transferência | 55 | 41,0% |
| Orientação ao familiar e/ou paciente | 24 | 17,9% |
| Condição do paciente | 24 | 17,9% |
| Risco de Queda informado | 07 | 5,2% |

Source: Pereira ES, 2018⁽¹⁴⁾.

Chart 1. Nursing Interventions and Activities according to the NIC, mapped in the records interconnected with the Similar Groups formed. UFF / EEAAC / MACCS. Niterói, RJ, Brazil, 2017

| Intervenção NIC | Atividade NIC | Intervenção Registrada |
|---|---|---|
| Controle do AMBIENTE: segurança | Identificar as necessidades de segurança do paciente, com base no nível de capacidade física e cognitiva e no histórico comportamental anterior. Usar dispositivos protetores para limitar fisicamente, a mobilidade ou o acesso a situações prejudiciais. | Avaliar nível de consciência. Conter paciente. |
| Assistência no AUTOCUIDADO: banho/higiene | Determinar quantidade e tipo de assistência necessária. Facilitar que o paciente tome o banho sozinho, conforme apropriado. | Encaminhar ao banho de aspersão. Realizar banho no leito |

| | | |
|---|--|--|
| Assistência no AUTOCUIDADO: transferência | Determinar a capacidade atual do paciente para transferir-se. Selecionar a técnica de transferência adequada ao paciente. Orientar o indivíduo sobre técnicas de transferência de uma área a outra. Orientar o indivíduo quanto ao uso de auxiliares da deambulação. Auxiliar o paciente no recebimento de todo o atendimento necessário antes de realizar a transferência, conforme apropriado. Auxiliar o paciente a deambular usando o corpo como muleta humana, conforme apropriado. Avaliar o paciente ao término da transferência quanto a laterais da cama levantadas. | Auxiliar na deambulação. Orientar o paciente quanto à movimentação. |
| Assistência no AUTOCUIDADO: uso de vaso sanitário | Ajudar o paciente a chegar ao vaso sanitário/ cadeira higiênica/ comadre/ urinol partido/ urinol comum, a intervalos específicos. | Auxiliar paciente na cadeira higiênica. |
| CONTENÇÃO Física | Auxiliar nas mudanças periódicas de decúbito. Auxiliar nas necessidades relativas à nutrição, eliminação, hidratação e higiene pessoal. Documentar os motivos do uso da intervenção restritiva, a resposta do paciente à intervenção, sua condição física, os cuidados de enfermagem oferecidos durante a intervenção e a justificativa para suspender a contenção. | Conter paciente. Auxiliar o paciente quanto à movimentação. |
| Banho | Auxiliar banho da paciente em cadeira de banho, na banheira, no leito, de pé no chuveiro ou em banho de assento, conforme apropriado ou desejado. | Encaminhar ao banho de aspersão. Realizar banho no leito. Auxiliar banho na cadeira. |
| POSICIONAMENTO: cadeira de rodas | Orientar o paciente sobre as formas de transferir-se da cama para a cadeira de rodas, com base em seu estado de saúde. Orientar o paciente sobre as formas de funcionamento de cadeira de rodas, conforme apropriado. | Auxiliar o paciente na cadeira de rodas. |
| Prevenção contra QUEDAS | Identificar déficits cognitivos ou físicos do paciente, capazes de aumentar de aumentar o potencial de quedas em determinado ambiente. Monitorar o modo de andar, o equilíbrio e o nível de fadiga como deambulação. Orientar e acompanhar o paciente para adaptar-se às mudanças sugeridas no modo de andar. Auxiliar a pessoa sem firmeza na deambulação. Providenciar dispositivos auxiliares. Encorajar o paciente a usar bengala ou andador, conforme apropriado. Usar laterais da cama para evitar quedas. Educar os familiares sobre fatores de risco que contribuam para quedas e a forma de reduzir esses riscos. Colocar avisos de alerta aos funcionários de que se trata de paciente com risco de queda. | Avaliar nível de consciência. Avaliar equilíbrio. Avaliar na deambulação. Orientar a família sobre o auxílio ao paciente. Orientar o paciente quanto à movimentação com auxílio andador/ muleta. Identificar paciente com Risco de Queda. |
| Cuidados com o REPOUSO no Leito | Elevar as laterais de cama, conforme apropriado. | Manter grades elevadas. |
| TRANSFERÊNCIA | Determinar o nível de consciência e a capacidade de colaborar. Ajudar o paciente a receber todos os cuidados necessários. Elevar a lateral da cama no lado oposto ao do enfermeiro, evitando queda do paciente. Usar cadeira de rodas para movimentar o paciente que não consegue funcionar. Auxiliar o paciente a deambular, usando o seu corpo como muleta humana, conforme apropriado. Avaliar o paciente ao término da transferência quanto a laterais da cama levantadas. Planejar o tipo e o método da mudança. Determinar quantidade e tipo de assistência necessária. | Avaliar nível de consciência. Manter grades elevadas. Auxiliar paciente na cadeira de rodas. |

Source: Pereira ES, 2018(14).

DISCUSSION

First, it is extremely important to understand that it is through the record that everything that was done in the care process by the nurse and his team is supported. The debates around

the records written by nursing point to its presentation as one of the main communication tools for the exchange of information between the teams involved in the care, whose objective is to clearly present the patient's needs, the clinical conduct of care that have

been implemented and the continuous evaluation of the care provided. In this respect, registering is an ethical and social responsibility⁽¹⁴⁾.

There are publications that explain the importance and what are the preventive measures written in relation to

falls in the hospital environment, such as those presented in a study regarding preventive measures in relation to falls in the elderly, infer that in articles published from 2002 to 2012: fall prevention programs; risk assessment tools; guidelines; interventions; presence of companion/volunteer; decreased nursing work; scales for assessing functionality and motor; call light; nursing care; fall risk identification; Exercises; restriction; walking aid; presence of bed side rails; alarm; low bed and adequate footwear, were interventionist actions written in order to maintain patient safety in relation to falls⁽¹⁵⁾.

In clinical nursing practice, it is essential to assess the risk of falling, based on the multifactorial nature of this event. It is desirable to use standardized classifications and languages, which represent current knowledge. Nurses with relevant information for an accurate diagnosis can intervene, write necessary care appropriately, aiming at positive results in the health of the elderly⁽¹⁶⁾.

In this present study, a grouping represented in Table 3, presented in the results, of Similar Groups, of the actions described by the nurses and mapped was performed, promoting a facilitation in the process of comparison between what was evidenced in the registry and what the NIC presents, making it possible to detect the most outstanding interventions in a general evaluation of the records.

Regarding the mapping of the question of assessing the level of consciousness, it was observed that this term was clearly described in 59.7% of the medical records analyzed for the study. By linking/comparing the question of assessing the level of awareness with the interventions proposed in the NIC, in line with the activities, the interventions identified were: ENVIRONMENTAL CONTROL: safety, FALL PREVENTION and TRANSFER.

In a study on the analysis of the

risk of falling in a hospitalized adult patient, the patient's cognitive condition was highlighted as an important factor to be considered for the issue of risk of falling, showing the relevance of evaluating and monitoring the sensory, cognitive, and also the assessment and communication to the entire team of any changes at these levels⁽¹⁷⁾.

The greater number of falls among elderly people with cognitive impairment can be explained by the decline in specific cognitive domains, such as executive function, attention and memory⁽¹⁸⁾.

The maintenance record of the meshed bed was prescribed in 53.7% in the medical records studied. When crossing this intervention prescribed by nurses with those traced by the NIC, the connection with the interventions was obtained: control of the ENVIRONMENT: safety, care with the REST in bed and TRANSFER. This connection was established according to the very essence of the intervention and the activities presented by them.

Research refers that all beds in the environment, in which the study was carried out, have bars that open only from the outside, inducing the patient to ask for help from the nursing team or the companion to open the bars when leaving the bed and emphasizes that the maintenance of elevated bars is an extremely important factor for the protection of the elderly in the hospital environment⁽¹⁹⁾.

Regarding the registered interventions linked to the issue of assistance in locomotion and/or transfer, the similar interventions identified with the NIC were: Assistance in SELF-CARE: bathing/hygiene; Assistance in SELF-CARE: transfer; Assistance in SELF-CARE: use of toilet, bath; POSITIONING: wheelchair and TRANSFER.

It is of utmost importance to identify and record the need for assistance in walking/transferring to the hospitalized elderly, with a view to reducing the possibility of falls, since this el-

derly person, in addition to presenting a change in the general level of their health, also is in a new physical space that, in isolation, already becomes a risky environment to perform certain activities alone.

It is noteworthy that actions such as "Assisting the person without ambulation during walking" and "Providing auxiliary devices (eg, cane and walker) to make the floor more firm" are interventions that show 100% agreement between actions outlines for the prevention of falls in the applicability of NIC nursing intervention in hospitalized adults and elderly⁽²⁰⁾.

Regarding guidance to family members and/or patients, the description of such action was identified in 17.9% of the studied records, and the associated NIC interventions were: Assistance in SELF-CARE: transfer and Fall prevention. These had activities linked to the issue of orientation to the family and the patient.

In addition, it is essential that health professionals get involved and write health education actions, together with the relatives of the elderly with a potential risk of falling, thus favoring an exchange of information in order to facilitate the identification of risk factors and the selection of strategies to reduce falls⁽⁴⁾.

The similar group, identified as the patient's condition, was composed of the information found on how the patients presented themselves, for example, "contained patient" and "patient restricted to bed". These conditions were found and described in 17.9% of the medical records included in the study and, when articulated with the NIC interventions, were mapped: ENVIRONMENTAL CONTROL: safety and Physical CONTENTION.

When analyzing the issue of physical restraint to prevent the occurrence of falls in hospitalized elderly, it is observed that the prevalence of the record of such conduct is not

high. Similar data were found in another study⁽¹⁷⁾, in which it is understood that the implementation of this type of care is widely used in semi-conscious, unconscious and demented elderly patients, and should always preserve the patient's humanitarian issue, following institutional protocols and legal parameters.

The use of physical restraint, in most cases, is implemented for safety reasons, the biggest reason being the prevention of falls. Also ratifying the need for a clear description of the implementation of this security measure⁽²¹⁾.

Regarding the description of the identification of the risk of falling, that is, the risk of falling informed as it was named in the Similar Group, it was observed in the study that, even though the nurse and his team detecting this risk in the beds, after previous evaluation of the patient, this intervention was little described in the medical records, only 5.2% had such action written.

When comparing the similar group of reported fall risk with the NIC intervention and the activities presented, it can be seen that such action is directly related to the FALL PREVENTION intervention, which highlights the importance of placing warning notices to employees that it is a patient at risk of falling and also the effective registration in the medical record of this identification.

It is understood that the prevention of falls and the correct identification of patients who are susceptible to such an occurrence are elements that underpin the promotion of patient safety; thus, knowledge of the risk of falling can be an indicator for monitoring patient safety in this regard⁽²²⁾.

It is pertinent to clarify that, in relation to the NIC domain prevalent in the study in relation to the mapped NIC interventions, the following stand out: The Physiological Domain: Basic



It is understood that the prevention of falls and the correct identification of patients who are susceptible to such an occurrence are elements that underpin the promotion of patient safety; thus, knowledge of the risk of falling can be an indicator for monitoring patient safety in this regard



and the Level: Self-Care Facilitation. This information presents an inference, as seen during the study, that, despite the prevention of falls is an issue that presents care linked to other domains and levels such as Safety: risk control and Basic Physiological: control of immobility, which also emerged in the study, however, the issue of facilitation, assistance and help in performing the activities of the hospitalized elderly are more emergent when researching the actions taken and recorded, with a view to preventing the hospital fall event.

In the development of this documentary and mapping study focusing on interventional actions to prevent falls, some limitations emerged, among them the difficulty of data collection, using the patient's record and the nurse's evolution as a source. It is believed that the present study can serve as a basis for the increment of new preventive actions related to the fall event in the nursing therapeutic plan. It is also hoped that further studies using cross-mapping will be developed, enabling expansion in the standardized record.

CONCLUSION

This study mapped the nursing interventions registered by nurses for the elderly at risk of falling registered in the medical records, with the interventions/activities proposed by the Classification of Nursing Interventions (NIC), using the methodological tool of cross-mapping and found that similar interventions to the NIC were presented by the nurses.

When comparing the nursing interventions recorded in the medical records with those proposed by the NIC, the complexity of care for hospitalized elderly people was recognized and interrelated with the prevention of falls.

Of all the 288 mapped interventionist phrases, linked to the prevention

of falls, in the 67 records analyzed, a grouping of similar interventions could be made, which culminated in 06 groups identified during the study as Groups of Similar.

It is of great value to point out that the FALL PREVENTION intervention, which is directly linked to the diagnosis of Fall Risk, was the one that obtained the greatest number of mapped and compared activities found in the nurses' registry.

With the completion of the study,

there was the possibility of knowing and learning about the diversity of activities suggested by the NIC interventions/activities, which can increase the nurse's record in relation to preventive actions in the event of falls. It is of utmost importance to develop studies that can awaken the creation of standardized instruments, protocols, bundles, among others, that provide a greater number of relevant and effective interventions in preventing falls in the hospital environment. Instruments

that can, in addition to adding more interventionist actions, contribute to a more agile registration process and that contemplate the important factors to be highlighted.

Thus, the study reaffirms the need to carry out research that supports the practice of care associated with the issue of maintaining patient safety, especially the issue of preventive actions in order to avoid the occurrence of falls in the hospitalized elderly population. 🌱

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