Falls prevention in hospitalised older adults with cognitive impairment: strategies and ethical implications

Abstract

Falls are the most commonly reported patient safety incident in hospitals in the UK, and a major cause of patient harm. Older adults with cognitive impairment, such as dementia or delirium, are at particular risk of falls in acute settings due, for example, to attempting to mobilise without support, inability to communicate their needs or misjudging danger. Nurses have a central role in falls prevention, balancing patient safety with preserving individuals' dignity and autonomy to ensure that practice is consistent, compassionate and ethically sound. This article explores strategies for reducing the risk of falls in older adults with cognitive impairment in acute settings. The authors discuss patient safety interventions, including the use of enhanced observation and technological devices such as pressure-sensitive mats and bed-exit alarms, and consider the ethical implications of using such interventions. The authors also discuss the importance of multidisciplinary assessment and rehabilitation, as well as education for staff, patients and families, in effective falls prevention practice.

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Why you should read this article

• To understand why older adults with cognitive impairment are at particular risk of falls in acute settings

• To learn about the ethical implications of using patient safety interventions such as enhanced observation

• To consider how repeated, simple explanations and consistent messaging can enhance older adults' engagement with falls prevention strategies

Falls are one of the most common causes of harm in older people. Around one in three adults aged 65 years and over will experience a fall each year, which rises to one in two for those aged over 80 years. Falls in older adults frequently result in fragility fractures, head injury, loss of independence and higher mortality. In the UK, the total annual cost of fragility fractures for health and social care services is estimated to be £4.4 billion (Office for Health Improvement and Disparities 2022). Moreover, falls are the most reported patient safety incident in acute hospitals and mental health trusts in England and Wales (Office for Health Improvement and Disparities 2022), despite the availability of falls prevention guidelines (Montero-Odasso et al 2022, Office for Health Improvement and Disparities 2022, National Institute for Health and Care Excellence (NICE) 2025a).

Cognitive impairment is a major risk factor for falls. In people with dementia, for example, falls risk is increased because of associated symptoms, such as difficulties with judgement, sensory perception, mobility and coordination, and communicating needs (Dementia UK 2023). Reducing the risk of falls in older adults with cognitive impairment in acute settings presents challenges for nurses, particularly where individuals have limited awareness of risk, or difficulties in engaging with safety advice. Nurses need to be able to apply evidence-based, ethically sound approaches to falls prevention to enhance patients' safety while maintaining their dignity and autonomy.

Technological approaches, such as bed and chair alarms or sensor-based monitoring, are commonly used in hospitals, but their effectiveness is variable and influenced by how these are implemented in practice. Evidence suggests that use of such interventions can create tension between the implementation of standard safety measures and the delivery of person-centred care, particularly regarding patients' autonomy and dignity (Considine et al 2023). International guidance emphasises that falls prevention strategies are most effective when they are tailored to the individual and developed through shared decision-making with patients and carers (Montero-Odasso et al 2022). Recent UK national policy reinforces the importance of person-centred falls prevention practice, with publication of the updated NICE (2025a) guidelines on falls assessment and prevention in older people. The NICE (2025a) guidelines, which include community and hospital inpatient settings, emphasise the importance of multifactorial assessment, use of person-centred safety interventions and regular review of any interventions used.

In this article, the authors explore strategies for reducing the risk of falls in hospitalised older adults with cognitive impairment, including the use of patient safety interventions, multidisciplinary assessment and rehabilitation, and education for staff, patients and families.

The authors also discuss the ethical implications of falls reduction interventions and provide some implications for practice for nurses, organisations and the wider healthcare system.

Patient safety interventions

Interventions commonly used in acute settings to reduce the risk of falls in older adults include enhanced observation and technological devices, such as pressure-sensitive mats and bed-exit alarms. However, it is important that nurses consider the ethical implications of the use of these interventions.

Enhanced observation

Enhanced or one-to-one observation is one of the most used prevention approaches for older adult inpatients who are at high risk of falls (McVey et al 2024, Randell et al 2024). Nurses may view this as a reliable strategy, particularly for patients with cognitive impairment who may be unable to follow safety instructions consistently. However, evidence suggests that those undertaking the enhanced observation are frequently healthcare support workers who may not have received effective preparation and may lack knowledge of enhanced observation protocols, including when to escalate concerns, or of communication strategies when working with distressed patients (Wood et al 2018).

Best practice in enhanced observation includes the use of clear, locally agreed protocols that set out roles, responsibilities and escalation pathways. Such protocols typically specify (Ayton et al 2017):

• The level of observation required, for example constant one-to-one observation, intermittent checks at defined intervals or cohort observation (that is, where a small group of patients at

similar risk are observed together within the same clinical area by a designated member of staff).

• Criteria for initiating and discontinuing enhanced observation.

• Communication and documentation requirements, including how observation levels, risk status and care plans are recorded in patient notes and observation charts, communicated within the multidisciplinary team, and clearly handed over between staff at shift changes to ensure continuity and safe escalation when needed.

• Thresholds for escalation, for example to the nurse or medical team, in response to observed changes in behaviour, cognition or physiological status.

Enhanced observation protocols may also include guidance on purposeful engagement strategies, such as regular orientation to the environment, assisted mobility and toileting, management of distress or agitation, and the handover relevant information to ensure continuity of care. Enhanced observation is most effective when framed as active, therapeutic engagement rather than as passive surveillance, and when supported by brief, focused training for staff undertaking the observation and high-quality handovers that clearly communicate the patient's current risk level, care plan and escalation steps (Ayton et al 2017).

Effective enhanced observation involves anticipating, and increased supervision of, patients' needs through, for example, proactive toileting, regular pain and comfort assessments, hydration support and timely assistance with mobilisation. These key nursing activities can reduce the risk of unplanned movement and subsequent falls. Enhanced observation should therefore be integrated into holistic nursing care rather than viewed as a standalone safety measure (Cameron et al 2018).

Technological devices

Findings from a recent systematic review (Campollo-Duquela et al 2025) and from a clinical study (Wen et al 2024) have indicated that while pressure-sensitive mats, bed-exit alarms and similar sensor technologies are widely used to alert staff when patients are mobilising without assistance, the evidence for their effectiveness in reducing falls is limited and inconclusive. Moreover, nurses have reported frustration with such devices, such as the noise of alarms, frequent false positives and unclear policies on when alarms should be applied, while patients have described alarms as confusing or stigmatising, particularly when no explanation for their use is provided (Considine et al 2023).

These issues reinforce that such devices should not be regarded as a universal solution and suggest that their efficacy depends on use with appropriate patients, staff responsiveness and integration with fundamental nursing care, including observation, effective communication and ensuring a safe environment. Importantly, not all acute settings have access to technological falls prevention devices; furthermore, reliance on such equipment alone risks overlooking fundamental nursing interventions. Environmental modification – for example, ensuring adequate lighting, clutter-free walkways, appropriate footwear and easy access to walking aids – is central to falls prevention (NICE 2025a).

Nurses must exercise their clinical judgement when considering the use of falls prevention devices and ensure that technology complements rather than replaces skilled nursing assessment and presence. Regular review of the use of any device is essential, and the device should be removed when the risk of falls reduces or if it causes the patient distress or is restrictive (Considine et al 2023).

Ethical considerations

Falls prevention interventions should not become a form of disguised restraint. Patients have described feeling restrained, confused or stigmatised when alarms or enhanced observation are used without explanation or choice (Hill et al 2024). Nurses must therefore balance patients' safety with respect for their independence. NICE (2018, 2025a) guidelines emphasise that falls prevention strategies should be tailored to the assessed risk and regularly reviewed, and that the least restrictive option appropriate for the individual should be selected. Ethical practice requires that falls prevention interventions are proportionate, time-limited and clearly linked to an identified clinical risk rather than applied as routine practice (Haley et al 2025).

Informed patient consent should be sought and gained before implementation of any healthcare intervention, including enhanced observation, alarms or sensors, with clear explanations given about the purpose of the intervention. In patients who have been assessed as lacking capacity, any intervention must be considered in their best interest and must be the least restrictive option, in accordance with the Mental Capacity Act 2005 (Department for Constitutional Affairs 2007). Families and carers should be involved in best interest discussions wherever possible to support transparent and person-centred decision-making (Department for Constitutional Affairs 2007). The Nursing and Midwifery Council (NMC) The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates reinforces these legal duties, requiring nurses to ensure that 'the rights and best interests of those who lack capacity are still at the centre of the decision-making process' (NMC 2018). The NMC (2018) Code also requires that nurses preserve patients' dignity and practise in a way that is evidence-based, proportionate and centred on the individual.

There is also an ethical responsibility to staff. A study undertaken in the US found that strong organisational pressure to prevent falls contributed to nurses' fear of such safety incidents, as well as concerns about being blamed and about the organisation's response following a patient fall (King et al 2018). This pressure led to unintended consequences in nursing practice, including restriction of patients' mobility to avoid them falling. The study suggested that learning-focused, rather than punitive, approaches to patient falls may better support both staff well-being and patient safety (King et al 2018). In the UK, this approach could be supported through the Patient Safety Incident Response Framework (NHS England 2025), which focuses on a systems-based rather than individual-based approach to responding to, and learning from, such incidents.

Key points

• Falls are one of the most common causes of harm in older people

• Reducing the risk of falls in older adults with cognitive impairment in acute settings presents challenges for nurses, particularly where individuals have limited awareness of risk

• Environmental modification – for example, ensuring adequate lighting, clutter-free walkways, appropriate footwear and easy access to walking aids – is central to falls prevention

• Nurse-led falls prevention practice includes identifying individual risk factors, documenting mobility plans, supervising patients during ambulation and toileting, and communicating relevant information to healthcare support workers

Multidisciplinary assessment and rehabilitation

Preventing falls in older patients with cognitive impairment requires contributions from across the healthcare team. While nurses are often central to assessment and observation, collaboration with physiotherapists, occupational therapists, doctors and healthcare support workers can enhance patient outcomes.

Comprehensive falls assessment

NICE (2025a) recommends that all patients in hospital aged 65 years and over (and those aged 50-64 years who are at increased risk due to factors such as frailty or a history of falls) should be considered at risk of falls and routinely receive a comprehensive falls assessment and tailored interventions. Healthcare professionals, such as medical consultants, nurses, physiotherapists and occupational therapists, should work collaboratively on these assessments, which should be undertaken by staff with skills and experience in falls prevention (NICE 2025b).

A comprehensive falls assessment aims to identify a patient's risk of falling and should incorporate the components shown in Box 1.

Box 1. Components of a comprehensive falls assessment

The following assessments and examinations (where appropriate) should be undertaken in a comprehensive falls assessment:

- Alcohol misuse
- Cardiovascular examination (including a lying and standing blood pressure test)

• Cognition and mood

• Delirium (in hospital inpatient and residential care settings only)

• Diet, fluid intake and weight loss

• Dizziness

• Footwear and foot condition

• Functional ability

• Gait, balance and mobility, and muscle strength

• Hearing impairments

• Long-term conditions that affect the person's daily life, for example arthritis, dementia, diabetes mellitus or Parkinson's disease

• Medication review

• Neurological examination

• Osteoporosis risk assessment

• Urinary continence

• Visual impairment

(National Institute for Health and Care Excellence 2025a)

Nursing assessments form the foundation of a comprehensive falls assessment, but input from physiotherapists and occupational therapists, for example, can ensure that identified risks associated with mobility, balance, transfer and the environment are addressed (Reis da Silva

2023). NICE (2025a) recommends that such assessments are reviewed regularly and adapted as the patient's condition changes. This is particularly important for patients with dementia or delirium, where their risk of falling can fluctuate rapidly.

Mobility support and rehabilitation

Following a comprehensive falls assessment, nurses have a central role in setting practical, achievable mobility and activity goals with patients. Nurse-led falls prevention practice also includes identifying individual risk factors, documenting mobility plans, supervising patients during ambulation and toileting, and communicating relevant information to healthcare support workers (Ojo and Thiamwong 2022, NICE 2025a).

Physiotherapy-led rehabilitation strategies, involving strength and balance training, have been shown to improve lower limb strength, balance and mobility, and to reduce fall-related injuries, in community dwelling older adults (Sadaqa et al 2023). However, patients with significant cognitive impairment may struggle to remember or apply new techniques. In such circumstances, rehabilitation can be more effective when embedded within everyday nursing care. Assisted mobilisation, consistent routines, such as regular toileting schedules and planned supported walks, alongside repetition and simple verbal or physical cues to initiate safe transfers, standing, stepping and correct use of mobility aids, can be more effective than providing complex instructions. Nurses can reinforce rehabilitation goals during routine activities, such as washing, dressing and transfers, ensuring that principles are applied throughout the day rather than confined to formal therapy sessions (Cameron et al 2018).

Communication and coordination

Communication between various members of the multidisciplinary team is essential in effective falls prevention practice. Suboptimal communication between different professionals can undermine falls prevention care plans, particularly when it is unclear who is responsible for the patient's mobilisation, use of equipment or enhanced observation (Ayton et al 2017). Structured interdisciplinary bedside rounds (SIBRs) – a person-centred, team-based intervention where professionals such as doctors, nurses, occupational therapists and physiotherapists meet at the patient's bedside to discuss care planning – have been shown to reduce inpatient falls by promoting shared understanding of risk, agreed goals and consistent messaging across professions (Basic et al 2021, Schwartz et al 2024).

Nurses are well placed to coordinate care by communicating any changes in the patient's cognition, mobility or falls risk to the wider team, ensuring that rehabilitation therapy recommendations are followed, and that families and carers are kept informed. This coordinating of care is particularly important for patients with cognitive impairment, where consistency and familiarity can help to reduce confusion and distress (Almeida et al 2024).

Education for staff, patients and families

Education is consistently identified in the literature as a key component of effective falls prevention; however, its provision and quality are variable across hospital settings (Heng et al 2022). Randell et al (2024) identified that nurses generally have good awareness of fall risks, but that healthcare support workers who undertake enhanced observation may lack structured training in this activity. This gap in knowledge can lead to uncertainty among healthcare support workers about how to respond to patients who are displaying agitation or attempting to mobilise unassisted.

Short, focused training on falls prevention, dementia awareness, communication skills and escalation protocols should be mandatory for all staff involved in enhanced observation. Ward-based teaching sessions, simulation and use of near-miss case studies can help to reinforce practical skills and build staff's confidence. Where training is integrated into organisational induction programmes and refreshed regularly, staff have been found to be more consistent in applying protocols (Cameron et al 2018).

Education for patients with cognitive impairment requires adaptation. For individuals with dementia who may have limited ability to retain information, providing repeated, simple explanations and consistent messaging can enhance their engagement in, and adherence to, falls prevention strategies. The use of visual prompts, brief verbal reminders and provision of reassurance during routine care delivery can reinforce safety behaviours, such as waiting for assistance or using call bells (Lambert et al 2024).

Dementia-informed care is particularly important in falls prevention, since hospital environments can increase distress, confusion and loss of orientation in patients with the condition, thereby increasing their risk of falling. The Royal College of Nursing (RCN) (2026) emphasises the importance of person-centred dementia care grounded in understanding the individual, through the use of, for example, personal profiles, life history information and knowledge of the individual's usual routines. The RCN (2025, 2026) also highlights the role of dementia-friendly environments in supporting patients' independence, minimising unnecessary transfers between wards or care settings, and promoting well-being through continuity of staffing, clear and consistent communication, and opportunities to maintain physical and cognitive function, such as regular supported mobility, engagement in daily activities and support with self-care.

Older patients who experience a fall often develop fear of falling, reduced confidence and activity avoidance, which can increase the risk of subsequent falls. Nurses have an important role in mitigating this fear through providing reassurance, supporting graded mobilisation and offering encouragement following a fall. Therefore, education should also focus on rebuilding an individual's confidence and promoting safe independence (Almeida et al 2024).

Families and carers are often overlooked in fall prevention strategies, yet their involvement is vital. The Triangle of Care – a quality improvement scheme for health and social care providers that promotes safety, recovery and well-being by including and supporting unpaid carers – stresses the central role of family carers as partners in care, recommending their active involvement in assessment, decision-making and review processes to improve safety and outcomes for patients (Carers Trust 2026). This is particularly important in patients with cognitive impairment. Carers can provide valuable insights into patients' routines, behavioural cues and preferences. Explaining ward-based safety strategies to carers can support them to reinforce consistent messages when visiting the patient in hospital. Where patients lack capacity, involving families in education and decision-making supports best interest processes and can enhance patients' acceptance of interventions (Bunn et al 2018).

Communication is at the heart of effective education. Education approaches must be adapted to individuals' needs, using clear language, repetition, reassurance and non-verbal cues where appropriate. Knowing the patient, involving carers and tailoring explanations to their level of comprehension can help to reduce distress and enhance cooperation. A person-centred education approach is also more likely to preserve patients' dignity, even when safety interventions such as alarms or enhanced observation are required (McVey et al 2024).

Implications for practice

Falls in cognitively impaired older adult inpatients present unique challenges for nurses, who may often have to balance competing pressures of staffing issues, patient safety and preserving patient dignity.

Box 2. Implications for practice

• Nurses have a central role in ensuring falls prevention strategies are applied safely, consistently and ethically, and have a legal, ethical and professional responsibility to use the least restrictive intervention, review the use of safety interventions frequently and withdraw these when the risk of falls reduces

• Nurses should encourage patient engagement in falls prevention strategies by offering clear, simple explanations of any interventions used and repeating these as necessary, and by tailoring information to individuals' cognitive ability to maximise their understanding and cooperation

• Multidisciplinary teamwork should be embedded into routine ward falls prevention practice. Nurses can coordinate discussions between team members, such as physiotherapists, occupational therapists, doctors, the patient and their family or carers to ensure a shared understanding of fall risks, agreed interventions and review plans, in line with the National Institute for Health and Care Excellence (2025a) guidelines on falls prevention

• Inpatient settings must ensure there are clear protocols for the use of patient safety interventions, such as bed and chair alarms or enhanced observation. These interventions should only be applied when there is a well-defined clinical rationale. Where possible,

informed consent should be obtained from the patient, the rationale documented and ongoing need reviewed daily

• Hospitals should prioritise structured falls prevention education for all staff, particularly healthcare support workers who often provide enhanced observation. Short, practical training sessions in falls prevention, dementia awareness and escalation procedures can help to ensure that these staff deliver enhanced observation safely and consistently

• Organisations should align post-fall reviews with the Patient Safety Incident Response Framework (NHS England 2025), approaching such incidents as opportunities for learning and improvement rather than occasions for blame. Nurses should be supported to reflect on patient safety incidents, contribute to service improvement and share learning across teams, strengthening patient safety and staff well-being (King et al 2018)

Conclusion

Effective falls prevention in hospital settings is vital to ensure the safety of older adults with cognitive impairment. While patient safety interventions such as bed and chair alarms or enhanced observation may be widely used in inpatient settings, their efficacy depends on appropriate implementation. Furthermore, nurses should consider the ethical implications of the use of such interventions, particularly in patients who may lack capacity. Reducing the risk of falls requires a comprehensive falls assessment, with input from the multidisciplinary team, coordinated care and effective communication, including with patients and their family or carers.

In addition, education for staff, patients and families, alongside consistent communication and provision of dementia-informed care, is essential to ensuring safe and compassionate care. By embedding evidence-based interventions, aligning practice with national guidelines such as NICE (2025a), and fostering a learning culture supported by frameworks such as the Patient Safety Incident Response Framework (NHS England 2025), nurses can reduce the risk of harm to hospitalised older adults with cognitive impairment while preserving their dignity and autonomy.

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