Older Adult Fall Risk Screening Tool for Clinicians

All adults 65+ should be screened annually for fall risk (or anytime they have a fall) by a community based-program, primary care provider, or allied health professional. The tool below highlights the recommended actions to address fall risk screening, assessment, and interventions for community-dwelling adults 65+.

Fall definition: A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level, with or without injury.

Start by having client complete the Fall Risk Self-Assessment Tool.

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York Region

FALL RISK SELF-ASSESSMENT TOOL

Complete the Fall Risk Self-Assessment Tool to determine your risk and risk factors for falling.

CIRCLE "YES" or "NO" to the following statements - Note the first two questions count for 2 points each if 'yes':

CIRCLE "YES" or "NO"			HELPFUL TIPS
I have fallen in the past year.	YES (2)	NO (0)	Learn more about reducing your risk; people who have fallen are more likely to fall again.
I use or have been advised to use a cane or walker to get around safely.	YES (2)	NO (0)	Talk with a physiotherapist about the most appropriate walking aid for your needs.
Sometimes I feel unsteady when I am walking.	YES (1)	NO (0)	Exercising to build strength and to improve your balance can reduce your risk of a fall.
I steady myself by holding onto furniture when walking at home.	YES (1)	NO (0)	Do balance exercises every day. Consider having a home safety assessment. Remove hazards at home that might cause a trip or slip.
I am worried about falling.	YES (1)	NO (0)	Learning how to prevent a fall can reduce fear and promote active living.
I push with my hands to stand up from a chair.	YES (1)	NO (0)	Strengthening your muscles can reduce your risk of falling and being injured.
I have some trouble stepping up onto a curb.	YES (1)	NO (0)	Daily exercise can help improve your strength and balance.
I often have to rush to the toilet.	YES (1)	NO (0)	Rushing increases your risk of falling. Make sure the pathway to the bathroom is well lit and free of clutter. Talk with your doctor about potential treatment options.
I have lost some feeling in my feet.	YES (1)	NO (0)	Talk with your doctor or health care provider as numbness in your feet can cause falls.
I take medication that sometimes makes me feel light-headed or more tired than usual.	YES (1)	NO (0)	Talk with your doctor or pharmacist about medication side effects that may increase your risk of a fall.
I take medication to help me sleep or improve my mood.	YES (1)	NO (0)	Talk with your doctor or pharmacist about other ways to get a good night's sleep or improve your mood.
I often feel sad or depressed.	YES (1)	NO (0)	Talk with your doctor or health care provider about symptoms of depression and finding help with positive solutions.
Add up the number of points for each "YES" answer and enter your total score.	**TOTAL SCORE:** _____		**If you scored 4 POINTS or more, you may be at risk. Talk to your doctor or health care provider about any questions you may have.**

* **This resource was adapted** from the Centers for Disease Control and Prevention's "Stay Independent" brochure with permission from:
Waterloo Wellington Local Health Integration Network, Wellington-Dufferin-Guelph Public Health and the Region of Waterloo Public Health.

Once the self-assessment tool is complete, clinicians ask these KEY questions:

- Have you had one or more falls in the last year?
- Are you concerned (worried) about falling?
- Do you have difficulty with walking or balance?
- Did you score 4 ≥ on the Fall Risk Self-Assessment Tool?

If client answered YES to any KEY question they are AT RISK. Complete the MULTIFACTORIAL RISK ASSESSMENT below to identify fall risk factors.

If client answered NO to all KEY questions they are NOT AT RISK OF FALLING - see the Not at risk of falling interventions.

NO - Not at risk of falling interventions

- ☐ Educate client of fall prevention strategies (refer to the **Fall Prevention Resource for Adults 65+ and Caregivers** resource for a list of strategies)
- ☐ Refer client to activities to build strength and balance, visit **falls.centralhealthline.ca**
- ☐ Discuss Vitamin D with client
- ☐ Reassess fall risk annually (or with a fall) and inquire about falls with every visit

YES - At risk of falling - MULTIFACTORIAL RISK ASSESSMENT

Identify fall risk factors:

- ☐ Evaluate gait, strength, and balance (Timed up & Go)
- ☐ Review the results of the **Fall Risk Self-Assessment Tool**
- ☐ Concerned (worried) about falling? (fear about falling- Falls Efficacy Scale I, Short FES-I)
- ☐ Physical exam, including:
  - ☐ Measure orthostatic blood pressure (lying and standing positions) and cardiovascular assessment
  - ☐ Medication review (Beers Criteria, Vitamin D)
  - ☐ Cognitive screening (Dementia Quick Screen)
  - ☐ Feet and footwear check
  - ☐ Use of mobility aids
  - ☐ Check visual acuity (Snellen eye test)
  - ☐ Ask about potential hazards in the home (e.g. slippery floors, loose rugs, poor lighting, etc. See home safety checklist in **Your Guide to Fall Prevention)**
  - ☐ Bone mineral density test
  - ☐ Fracture risk assessment (FRAX©, CAROC©)
  - ☐ Check for co-morbidities (depression, osteoporosis, etc.)
  - ☐ Asses for adequate social supports and consider social prescribing

NEXT - FOR THOSE AT RISK, DISCUSS INTERVENTIONS TO REDUCE FALL RISK

- ☐ Educate client on fall prevention strategies (refer to the **Fall Prevention Resource for Adults 65+ and Caregivers** resource for a list of strategies)
- ☐ Create an individualized care plan (including physical activities and social activities)
- ☐ Refer to physiotherapist to improve gait, strength and balance
- ☐ Refer to activities to build strength and balance, visit **www.falls.centralhealthline.ca** for a list of community fall prevention programs or refer to **Which exercise program is best for me?** resource
- ☐ Manage and monitor blood pressure; all modifiable cardiac risk factors should be treated
- ☐ Manage medication (optimize medication to reduce fall risk)
- ☐ Discuss Vitamin D with health care professional or pharmacist
- ☐ Review cognitive screen and monitor for changes in cognition
- ☐ Address foot problems (educate on shoe fit, traction, insoles, heel height; refer to podiatrist)
- ☐ Optimize vision (refer to optometrist/ophthalmologist)
- ☐ Refer to Home and Community Care Support Services as needed
- ☐ Refer to occupational therapist for home safety assessment
- ☐ Review fracture risk assessment and monitor bone health
- ☐ Optimize treatment of identified co-morbidities
- ☐ Refer to **Ontario.ca/seniors** or **A Guide for Programs and Services for Seniors** for health, social and financial supports
- ☐ Refer to exercise, occupational therapy and cognitive behavioural therapy for concerns of falling

FOLLOW-UP WITH AT-RISK CLIENT in 30 to 90 days

- ☐ Review the care plan
- ☐ Assess and encourage fall risk reduction behaviours
- ☐ Discuss and address barriers to adherence
- ☐ Transition to maintenance exercise program when client is ready
- ☐ Reassess fall risk annually (or with each subsequent fall) and inquire about falls every visit

Resources in bold are available online

Sources:

- AGS Geriatric Health Professionals: Algorithm based on AGS and BGS Geriatric algorithm
- CDC Algorithm for Fall Risk Screening, Assessment, and Intervention

Created by the Fall Prevention Committee

York Region