Falls Risk Screening and Assessment

Frances Batchelor

As a professional carer.....

Hazard identification
Risk assessment
Risk control

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

_____________________________________________________________________________________________

_________________________________________________________________________
Falls risk factors

Age
Health problems
Medications
Environment

Stable vs changing
Modifiable vs non-modifiable

Intrinsic vs extrinsic

New medical condition e.g. UTI
Falls
Falls Risk Screening

- Indicates how likely someone is to fall
- Quick and brief
- Identifies the need to do further falls-risk assessment
- Can be completed routinely for all individuals
Falls Risk Assessment

• ............... conduct a **systematic** and **comprehensive**, multidisciplinary fall-risk assessment .................

• to inform the development of an individualised plan of care to prevent falls

Ref: Safety and Quality Council, Best practice guidelines for Australian hospitals and residential aged care facilities, 2005

In your workplace.....

• What falls risk screens are used?
• What falls risk assessment tools are used?
• Who does screening/assessment?
• When is screening/assessment done?
• What is your role?
Screening
1. Recurrent falls in last year?
2. Acute fall?
3. Gait/balance problems?

Assessment
1. History of falls
2. Medications
3. Gait, balance, mobility
4. Vision
5. Neurological exam
6. Muscle strength
7. Heart rate/rhythm
8. Postural hypotension
9. Feet/footwear
10. Environmental hazards

Multifactorial management
1. Minimise medications
2. Exercise – individually tailored
3. Vision, including cataracts
4. Manage postural hypotension
5. Heart rate and rhythm management
6. Vitamin D supplement
7. Foot and footwear problems
8. Home modifications
9. Education/information

Recommendations
• Older people should be asked about falls at least once per year
• Those presenting with recurrent falls/acute fall need assessment and multifactorial management
• Older people with a history of one or more falls in the past year should be assessed using a simple, validated balance test or falls risk screening
• Older people who perform poorly on the above should undergo a detailed assessment

American Geriatrics Society / British Geriatrics Society guidelines:
JAGS 2011, 59: 148-157
# Falls Risk for Older People

## in the Community (FROP-Com) Screen

Screen all people aged 65 years and older (50 years and older Aboriginal & Torres Strait Islander peoples)

<table>
<thead>
<tr>
<th>FALLS HISTORY</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of falls in the past 12 months?</td>
<td></td>
</tr>
<tr>
<td>o None</td>
<td>(5)</td>
</tr>
<tr>
<td>o 1 fall</td>
<td>(1)</td>
</tr>
<tr>
<td>o 2 falls</td>
<td>(2)</td>
</tr>
<tr>
<td>o 3 or more</td>
<td>(3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FUNCTION: ADL status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Prior to this fall, how much assistance was the individual requiring for instrumental activities of daily living (e.g. cooking, housework, laundry)?</td>
</tr>
<tr>
<td>o None (completely independent)</td>
</tr>
<tr>
<td>o Some assistance required</td>
</tr>
<tr>
<td>o Completely dependent</td>
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<table>
<thead>
<tr>
<th>BALEANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. When walking and turning, does the person appear unsteady or at risk of losing their balance?</td>
</tr>
<tr>
<td>o No unsteadiness observed</td>
</tr>
<tr>
<td>o Yes, minimally unsteady</td>
</tr>
<tr>
<td>o Yes, moderately unsteady (needs supervision)</td>
</tr>
<tr>
<td>o Yes, consistently and severely unsteady (needs constant hands on assistance)</td>
</tr>
</tbody>
</table>

## Total Risk Score [ ]

### Total score

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.25</td>
<td>0.7</td>
<td>1.4</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Risk of being a faller</td>
<td>Low risk</td>
<td>High risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Grading of falls risk

<table>
<thead>
<tr>
<th></th>
<th>0-5</th>
<th>4-9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk</td>
<td>High risk</td>
<td></td>
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</tbody>
</table>

### Recommended actions

Further assessment and management if functional balance problem identified (score of one or higher)

Perform the Full FROP-Com assessment and/or corresponding management recommendations

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Date: / / 

Name Signature Designation
# Falls Risk for Older People – Community Setting (FROG-Com)

## Personal Details

- **Name:**
- **Personal Code:**
- **Date of Assessment:**

## Address:

- **DoB:**
- **Telephone:**

## Mental Status:

- Social withdrawal
- Memory deficits
- Wandering

## General Wellbeing:

- **Recent health/Community services use:**
  - Community Care Package
  - Doctor
  - Home Help
  - Meals on Wheels
  - Outpatient Appointment
  - Day Hospital
  - Respite Care
  - Day Centre
  - Physical therapy
  - Nursing
  - Physiotherapy
  - Medical
  - Personal care
  - Other
  - Falls

## Comments:

- **English the individual performed better if not, what is:**
- **Does the individual have functional English:**

## History of Falls (in years):

1. **Number of falls in the past 12 months:**
   - [ ] No falls (0)
   - [ ] 1 fall (1)
   - [ ] 2 falls (2)

2. **Date of fall:**
   - [ ] Yes
   - [ ] No
   - [ ] 1 fall (1)

3. **Describe the circumstances of the most recent fall:**
   - [ ] Abnormal
   - [ ] Yes
   - [ ] No

4. **Injuries:**
   - [ ] None
   - [ ] Minor
   - [ ] Severe

## Medications (max 3 points):

1. **Number of prescription medications taken:**
   - [ ] None (0)
   - [ ] 1 prescription (1)
   - [ ] 2 or more (2)

2. **Number of over-the-counter medications:**
   - [ ] None (0)
   - [ ] 1 (1)
   - [ ] 2 or more (2)

3. **Does the individual take any of the following:**
   - [ ] None (0)
   - [ ] Yes (1)

## Sensory Info:

1. **Does the client have an uncorrected sensory deficit which limits their functional ability:**
   - [ ] Vision
   - [ ] Sensory

## Foot & Fotome:

1. **Does the client have foot problems (e.g. corns, bunions, swelling, etc.):**
   - [ ] Yes (0)
   - [ ] No (1)

## Cognitive Status (max 2 points):

1. **Number of correct responses:**
   - [ ] 0 (0)
   - [ ] 1 (1)
   - [ ] 2 (2)

## Conclusion:

1. **Does the individual regularly have to go to the toilet in the night (1 or more times):**
   - [ ] No (0)
   - [ ] Yes (1)
   - [ ] Never (2)
Elderly Falls Screening Test

- EF1. How many times in the last year have you fallen down?
  - No falls (0) 1 fall (1) 2 or more falls (2) (if no falls go to question EF3.)
- EF2. Did you hurt yourself?
  - No (0) Yes (1)
- EF3. Nearly falling down is when you nearly fall but manage to grab something and then don’t fall? How many times in the last year did you nearly fall down?
  - Never (0) A few times eg. 1-10 times (1) Lots of times (more than 10) (2)

*Need measuring tape and stop-watch*
- EF4. Ask the person to walk at normal speed over a 5m distance.
  - Record the time it takes them to walk 5 metres with a stopwatch.
  - Walking speed is faster than 10 seconds over 5 M (0)
  - Walking speed is slower than 10 seconds over 5 M (1)
  - Unable to do
- EF5. Observe the person’s gait/ walking style
  - Gait is even, straight and feet are raised with each step (0)
  - Gait is uneven, shuffling, on a wide base, or unsteady (1)
  - Unable to do

Additional falls question (from FROP Com): Do not ask if they answered “never” to EF1 and EF3
- EF6. How come you fell/nearly fell (the EF6. last time you fell down)?
  - trip slip lost balance knees gave way fainted felt dizzy alcohol or meds fell out of bed don’t know

**EF TOTAL SCORE**
Assessment Tool used in the Kimberley

• 289 older indigenous people (>45 years)
• Falls, FROP-Com, FROP-Com Screen, EFT

• FROP-Com and FROP-Com screen highest accuracy for identifying fallers

• But will need some modification – cut-off score
  
  *Hill et al 2015*

• Mix of Risk factors most commonly rated as high among indigenous sample:
  – Medication use
  – Impaired vision
  – Poor home safety
  – Poor balance

• Modifications to tool due to difficulty assessing
  – Cognition (?KICA), Home environ (?images), feet and footwear, weight loss