Falls Risk Screening and Assessment

Frances Batchelor
“I’ve never had a fall, I’m just lucky …”

“An absolute classic fall ...broke all the rules in the book...slipped when I was mopping the floor ... and I just went flat and that was purely my own fault “

(Focus group data from “Implementation of a balance screening and home exercise program through existing community health services” project, 2010)
As a professional carer.....
Falls risk factors

- Age
- Health problems
- Environment

Stable vs changing

Modifiable vs non-modifiable

Intrinsic vs extrinsic

Medications
Falls risk screening

Falls risk assessment

Management
Falls Risk Screening

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

“As part of a multi-component program, 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

American Geriatrics Society / British Geriatrics Society guidelines:
JAGS 2011, 59: 148-157
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
# 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)

**Date of screen:** / /

## FALLS HISTORY

<table>
<thead>
<tr>
<th>Number of falls in the past 12 months?</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>1 fall</td>
<td>1</td>
</tr>
<tr>
<td>2 falls</td>
<td>2</td>
</tr>
<tr>
<td>3 or more</td>
<td>3</td>
</tr>
</tbody>
</table>

## FUNCTION: ADL status

<table>
<thead>
<tr>
<th>Prior to this fall, how much assistance was the individual requiring for instrumental activities of daily living (eg cooking, housework, laundry)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>o None (completely independent)</td>
</tr>
<tr>
<td>o Supervision</td>
</tr>
<tr>
<td>o Some assistance required</td>
</tr>
<tr>
<td>o Completely dependent</td>
</tr>
</tbody>
</table>

- If no fall in last 12 months, rate current function

## BALANCE

<table>
<thead>
<tr>
<th>When walking and turning, does the person appear unsteady or at risk of losing their balance?</th>
</tr>
</thead>
<tbody>
<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>

- Observe the person standing, walking a few metres, turning and sitting. If the person uses an aid observe the person with the aid. Do not base on self-report.
- If level fluctuates, tick the most unsteady rating. If the person is unable to walk due to injury, score as 3.

## Total Risk Score

[ ]

## Total score

<table>
<thead>
<tr>
<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>0.25</td>
<td>0.7</td>
<td>1.4</td>
<td>4.0</td>
<td>7.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Risk of being a faller

| 0 - 3 | Low risk |
| 4 - 9 | High risk |

## Grading of falls risk

| 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 |

**Date:** / /

Name  Signature  Designation
Falls Risk for Older People – Community setting (FROP-Com)

Personal details
Name: ___________________________
Personal Code #: __________________
Date of Assessment: __/__/____

Address: ________________________
DOB: __________________________
Telephone: ______________________

Marital Status:
Single / Married (defacto) / Widowed / Divorced (separated) / Unknown (circle)

Usual living arrangements:

Recent health / community services use:
1. Community Aged Care Package/Services Y/N
2. Community Rehabilitation Y/N
3. Doctors Appointment Y/N
4. Doctor Home Visit Y/N
5. Home Help Y/N
6. Home Modifications Y/N
7. Home Rehabilitation Y/N
8. Linkages Package Y/N
9. Meals on Wheels Y/N
10. OT Home visit Y/N
11. Outpatient Appointment Y/N
12. Other Y/N
13. Post Acute Care Y/N
14. Personal Care Y/N
15. Respite Care Y/N
16. District Nursing Services Y/N
17. Physiotherapist Appointment Y/N
18. Dietician Y/N
19. Podiatrist Y/N
20. Personal Alarm Y/N
21. Day Centre Y/N
22. Falls and Balance clinic Y/N

Comments: ________________________

• Is English the individuals preferred language? If not, what is? ......................... o Yes o No
• Does the individual have complete English? ................................................ o Yes o No

History of falls (0-3 points)

1. Number of falls in the past 12 months?
   o No falls (0)
   o 1 fall (1)
   o 2 falls (2)
   o 3 or more (3) [ ]

2. Was an injury sustained in any of the falls in the past 12 months?
   o No (0)
   o Minor injury, did not require medical attention (1)
   o Minor injury, did require medical attention (2)
   o Severe injury (fracture, etc) (3) [ ]

3. Describe the circumstances of the most recent fall in the past 12 months.
   Time of fall: AM / PM (please circle)
   Location of fall: inside home / outside home / community
   Direction of fall: left / right / forward / backward / down / can’t remember / other
   Cause of fall: trip / slip / loss of balance / knees gave way / fainted / feeling dizzy or giddy / alcohol or meds / fell out of bed / unknown
   Comments: __________________________ [ ]

Injuries: __________________________

Sub total for this page [ ]

Sub total for this page [ ]
# FALLS RISK ASSESSMENT TOOL (FRAT)

## PART 1: FALL RISK STATUS

<table>
<thead>
<tr>
<th>RISK FACTOR</th>
<th>LEVEL</th>
<th>RISK SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECENT FALLS (To score this, complete history of falls, everfall)</td>
<td>none in last 12 months</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>one or more between 3 and 12 months ago</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>one or more in last 3 months</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>one or more in last 3 months whilst inpatient/resident</td>
<td>8</td>
</tr>
<tr>
<td>MEDICATIONS (Sedatives, Anti-Depressants, Anti-Parkinson’s, Diuretics, Anti-hypotensives, hypnotics)</td>
<td>not taking any of these</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>taking one</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>taking two</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>taking more than two</td>
<td>4</td>
</tr>
<tr>
<td>PSYCHOLOGICAL (Anxiety, Depression, Incooperation, Insight or Judgement esp. re mobility)</td>
<td>does not appear to have any of these</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>appears mildly affected by one or more</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>appears moderately affected by one or more</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>appears severely affected by one or more</td>
<td>4</td>
</tr>
<tr>
<td>COGNITIVE STATUS (AMTS: Hockinson Abbreviated Mental Test Score)</td>
<td>AMTS 9 or 10/10 OR intact</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>AMTS 7-8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>AMTS 5-6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>AMTS 4 or less</td>
<td>4</td>
</tr>
</tbody>
</table>

(Risk Score: Low Risk: 5-11 Medium: Risk: 12-15 High Risk: 16-20)

## Automatic High Risk Status: (if ticked then circle HIGH risk below)

- Recent change in functional status and / or medications affecting safe mobility (or anticipated)
- Dizziness / postural hypotension

## FALL RISK STATUS: (Circle): LOW / MEDIUM / HIGH

**IMPORTANT:** IF HIGH, COMMENCE FALL ALERT

[List Fall Status on Care Plan/Flow Chart]
New medical condition e.g. UTI

Falls
Active Service Model

• Do we involve a carer or support person in the assessment?

• Do we ask why a client is unable to perform a particular activity and find out if the underlying problem has been investigated?

• Do we talk with the client to find out about their life and to get a sense of their personal and professional interests, their goals and aspirations?
Debate

• Should all people over the age of 65 years be assessed for falls risk?

Why?

Why not?

Who should complete the assessment?