

FALL PREVENTION TOOLKIT

FOR HEALTHCARE PROFESSIONALS

Finding Balance

NOVA SCOTIA

Trauma NB

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All adults 65 years and older should be screened at least once a year to help identify and manage their fall risk factors. While family physicians and nurse practitioners play an essential role in ensuring that screenings and interventions occur based on best available evidence for clinical practice, it's important to remember that a collaborative approach can facilitate the delivery of comprehensive individualized care - especially for older patients with complex needs.

For more fall-related information not covered in this Toolkit, visit www.FindingBalanceNS.ca. You are also encouraged to visit www.fallsloop.com to connect with more than 1,000 Community of Practice members—peers and experts in fall prevention from across Canada.

For information on government programs and services available to older adults in Nova Scotia call:

- 2-1-1
- NS Health Continuing Care toll-free at 1-800-225-7225.

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IDENTIFYING
FALL RISK FACTORS

Did you know?

- Approximately 10 hospital admissions occur each day in Nova Scotia due to fall-related injuries in older adults.
- Women are two times more likely to be admitted to hospital due to a fall.
- The average length of stay in hospital due to a fall is 23 days.

As a primary healthcare provider, you are already aware that falls are a serious threat to the health and well-being of older adults.

The more risk factors a person has, the greater their chances of falling. Healthcare providers can help lower an older adults' risk of injury by addressing the fall risk factors that have been identified during the medical examination.

Risk factors known to be associated with falls include:

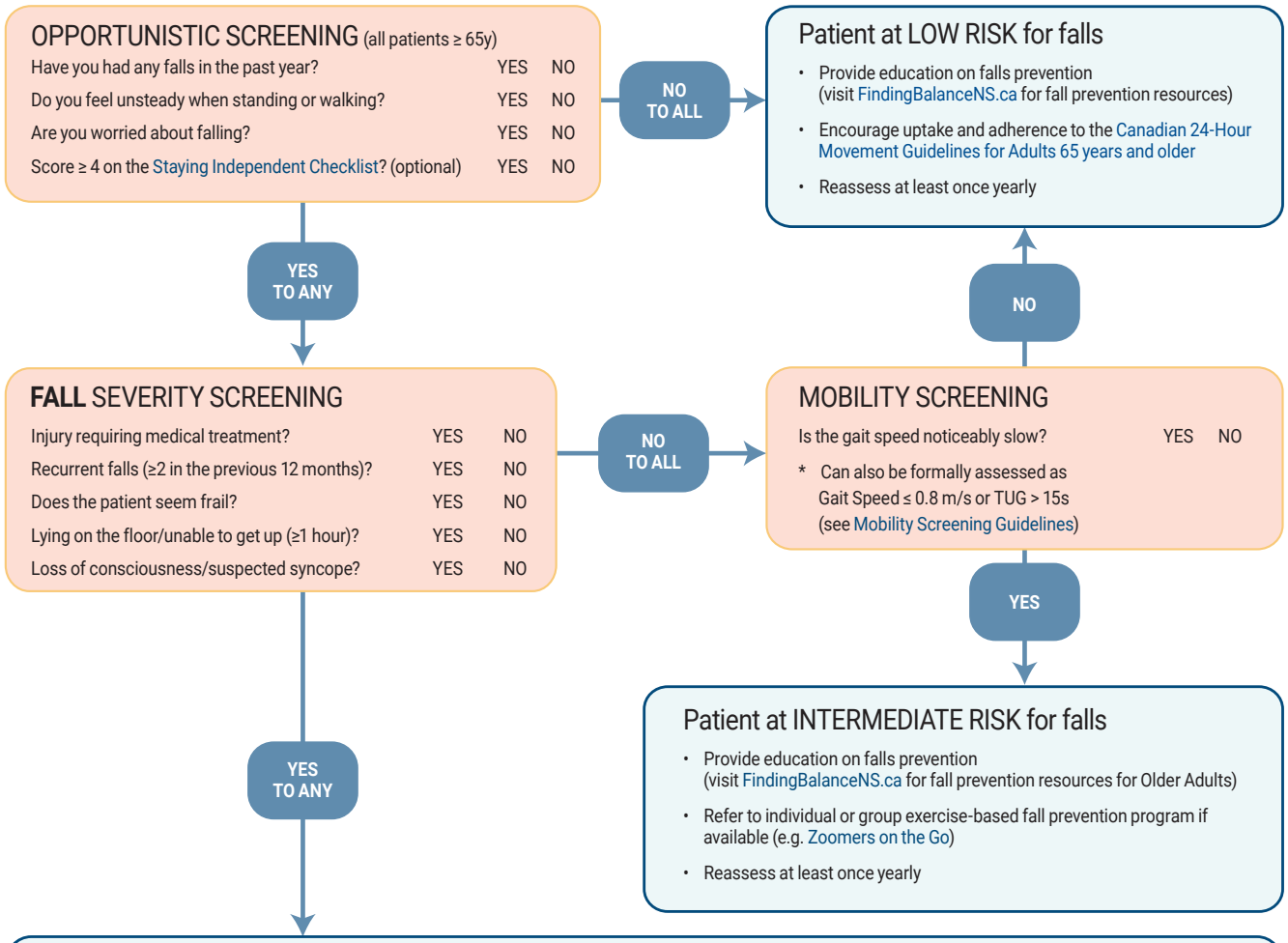
Biological	Behavioral	Social & Economic	Environmental
• Impaired mobility • Balance deficit • Gait deficit • Muscle weakness • Advanced age • Chronic illness / disability: - Cognitive impairment - Stroke - Parkinson's disease - Diabetes - Arthritis - Heart disease - Incontinence - Foot disorders • Visual impairment • Acute illness	• History of falls • Fear of falling • Multiple medications • Use of: - Anti psychotics - Sedative/hypnotics - Antidepressants • Excessive alcohol • Risk-taking behaviours • Lack of exercise • Inappropriate footwear/clothing • Inappropriate assistive devices use • Poor nutrition or hydration • Lack of sleep	• Low income • Lower level of education • Illiteracy / language barriers • Poor living conditions • Living alone • Lack of support networks • Lack of social interactions • Lack of transportation	• Poor building design and/or maintenance • Inadequate building codes • Stairs • Home hazards • Lack of: - Handrails - Curb ramps - Rest areas - Grab bars • Poor lighting or sharp contrasts • Slippery or uneven surfaces • Obstacles and other tripping hazards

Table adapted from: Scott V., Dukeshire S., Gallagher E., Scanian A. (2001). A Best Practice Guide for Prevention of Falls Among Seniors Living in the Community.

We encourage you to adopt a coordinated approach to implementing best clinical practice guidelines for fall prevention. The Algorithm for Fall Risk Screening, Assessment and Intervention located on the other side of this page, outlines the recommended process to address fall risk factors of concern with an older patient. This tool will be updated on an ongoing basis as new research, best practice and resources are available.

Keep in mind that your clinical judgement should also take into account the older adults ability or readiness to address their risk factors, their preferences and the availability of family support during the development of an individualized care plan.

ALGORITHM FOR
FALL RISK SCREENING AND INTERVENTION



Patient at HIGH RISK for falls

- Optimize the management of underlying acute and chronic medical issues. Complete a physical exam and routine labs (including B12, Vit D and TSH levels)
- Complete a medication review to deprescribe fall-risk-increasing drugs. Consider a referral to a pharmacist
- Check for orthostatic hypotension with lying and standing BP, and manage if present (systolic drop ≥ 20 mm Hg or diastolic drop ≥ 10 mm Hg)
- Assess and manage concerns about falling with validated tool (e.g. Staying Confident Checklist). Consider a referral for occupational therapy and/or cognitive behavioural therapy
- Refer to an optometrist to assess and optimize vision
- Screen for osteoporosis and treat if present
- Refer for OT home safety assessment and modifications (e.g., EMP, outpatient or private)
- Provide education on falls prevention (visit FindingBalanceNS.ca for fall prevention resources for Older Adults)
- Refer to PT for gait aid assessment, and optimization of strength/balance (e.g., EMP, outpatient or private)
- Plan follow-up within 3 months to review the individualized care plan

Based on the World guidelines for falls prevention and management for older adults: a global initiative, Age and Ageing, 2022 Sep 2;51(9):afac205 and the Summary of the updated American Geriatrics Society/British Geriatrics Society clinical practice guideline for prevention of falls in older persons. J Am Geriatr Soc. 2011; 59 (1): 148-157.

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FALLS RISK SCREENING
AND INTERVENTIONS CHECKLIST

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PATIENT_____ DATE_____ TIME_____

OPPORTUNISTIC SCREENING (completed at least once a year for all patients aged 65 and older)

		Notes
Have you had any falls in the past year?	☐ Yes ☐ No	
Do you feel unsteady when standing or walking?	☐ Yes ☐ No	
Are you worried about falling?	☐ Yes ☐ No	
Patient scored ≥ 4 on the Staying Independent Checklist (optional)?	☐ Yes ☐ No	

☐ The patient answered NO to all key questions. Therefore, I will proceed with ensuring the delivery of interventions for a person at LOW RISK for falls (see reverse side)

☐ The patient answered YES to any of the key questions. Therefore, I will proceed with screening for the following fall severity characteristics they might have had over the past year.

FALL SEVERITY SCREENING

		Notes
Injury requiring medical treatment?	☐ Yes ☐ **No**	
Recurrent falls (≥ 2 in the previous 12 months)?	☐ **Yes** ☐ **No**	
Does the patient seem frail?	☐ **Yes** ☐ **No**	
Lying on the floor/unable to get up (≥ 1 hour)?	☐ **Yes** ☐ **No**	
Loss of consciousness/suspected syncope?	☐ **Yes** ☐ **No**	

☐ One or more fall severity characteristics were present. Therefore, I will proceed with ensuring the delivery of interventions for a person at HIGH RISK for falls (see reverse side)

☐ NONE of the fall severity characteristics have been identified. Therefore, I will proceed with Mobility Screening

MOBILITY SCREENING

		Notes
Is the gait speed noticeably slow? *Can also be formally assessed as Gait Speed ≤ 0.8 m/s or TUG > 15s (see Mobility Screening Guidelines)	☐ **Yes** ☐ **No**	

☐ The patient has NO significant impairment with their gait. Therefore, I will proceed with ensuring the delivery of interventions for a person at LOW RISK for falls (see reverse side)

☐ The patient demonstrated or reported difficulties with their mobility. Therefore, I will proceed with ensuring the delivery of interventions for a person at INTERMEDIATE RISK for falls (see reverse side)

Based on the World guidelines for falls prevention and management for older adults: a global initiative, Age and Ageing, 2022 Sep 2;51(9):afac205 and the Summary of the updated American Geriatrics Society/British Geriatrics Society clinical practice guideline for prevention of falls in older persons. J Am Geriatr Soc. 2011; 59 (1): 148-157.

Ensure the delivery of the following recommended interventions for patients at LOW, INTERMEDIATE and HIGH risk for falls. Use clinical judgement to determine the need to assess and manage additional modifiable fall risk factors.

PATIENT AT LOW RISK FOR FALLS

- ☐ Provide education on falls prevention (visit www.FindingBalanceNS.ca for fall prevention resources for Older Adults)
- ☐ Encourage uptake and adherence to the Canadian 24-Hour Movement Guidelines for Adults 65 years and older
- ☐ Reassess at least once yearly

PATIENT AT INTERMEDIATE RISK FOR FALLS

- ☐ Provide education on falls prevention (visit www.FindingBalanceNS.ca for fall prevention resources for Older Adults)
- ☐ Refer to individual or group exercise-based fall prevention program if available (e.g., Zoomers on the Go)
- ☐ Reassess at least once yearly

PATIENT AT HIGH RISK FOR FALLS

Consider developing a feasible individualized care plan that takes into consideration the priorities, beliefs, preferences, and resources of the older adult.

- ☐ Optimize the management of underlying acute and chronic medical issues
  Complete a physical exam and routine labs (including B12, Vit D and TSH levels)
- ☐ Complete a medication review to deprescribe fall-risk-increasing drugs
  Consider a referral to a pharmacist for a comprehensive medication review
- ☐ Check for orthostatic hypotension with lying and standing BP, and manage if present
  Defined as a systolic drop ≥ 20 mm Hg or diastolic drop ≥ 10 mm Hg
- ☐ Assess and manage concerns about falling with validated tool (e.g., Staying Confident Checklist)
  Consider a referral for occupational therapy and/or cognitive behavioural therapy
- ☐ Refer to an optometrist to assess and optimize vision
- ☐ Screen for osteoporosis and treat if present
- ☐ Refer for OT home safety assessment and modifications (e.g., EMP, outpatient or private)
- ☐ Provide education on falls prevention (visit www.FindingBalanceNS.ca for fall prevention resources for Older Adults)
- ☐ Refer to PT for gait aid assessment, and optimization of strength/balance (e.g., EMP, outpatient or private)
- ☐ Plan follow-up within 3 months to review the individualized care plan

For more fall prevention information and **resources for healthcare professionals, caregivers, and older adults**, visit the Finding Balance NS website at ***www.FindingBalanceNS.ca***

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ANYONE CAN FALL

Prevent it from happening to you

Staying Independent Checklist

Falls are one of the main reasons many older adults lose their autonomy. To help determine your risk of falling, you should consult your primary care provider at least once a year.

Before your next appointment, you are also encouraged to answer the statements on the reverse side of this page to evaluate your own risk of falling. Remember to bring this self-screening checklist with you since it may be used by your primary care provider (family physician or nurse practitioner) to help guide the discussion about your personal fall risk factors. Your provider may ask about the following:

- Previous falls in the past year
- If you are worried about falling
- Any problems with your feet and footwear
- If you feel unsteady when standing or walking
- Any difficulties with your vision and hearing
- Medications that you are taking

FALLS ARE NOT A NORMAL PART OF AGING.
Talk to your health care provider if you have had a fall.

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Check Your Risk for Falling

Circle "Yes" or "No" for each statement below			Why it matters
Yes (2)	**No (0)**	I have fallen in the past 6 months.	People who have fallen once are likely to fall again.
Yes (2)	**No (0)**	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	**No (0)**	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	**No (0)**	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	**No (0)**	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	**No (0)**	I need to push with my hands to stand up from a chair.	Strengthening your leg muscles can reduce your risk of falling and being injured.
Yes (1)	**No (0)**	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	**No (0)**	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	**No (0)**	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	**No (0)**	I take medicine that sometimes makes me fee light headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	**No (0)**	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	**No (0)**	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
TOTAL _____		**Answer the statements above then add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Remember to bring this checklist to your primary healthcare provider to discuss your risk factors.**	

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and assessment tool (Rubenstein et al. J Safety Res; 2011: 42(6)493-499). Adapted with permission of the authors.



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Staying Confident Checklist

Any older adult who falls, with or without sustained injury, may develop a fear of falling. This may cause curtailment of activities, leading to reduced mobility and physical fitness, and increasing risk of falling and injury. Assessment of fear of falling, followed by appropriate interventions, is crucial to promote independence, mobility, function, wellness, and safety of older adults.

The Falls Efficacy Scale-International (FES-I) is a short, easy to administer tool that measures the level of concern about falling during 16 social and physical activities inside and outside the home whether the person does the activity or not.

We would like to ask some questions about how concerned you are about the possibility of falling.

Please answer the questions thinking about how you usually do the activity. If you currently don't do the activity (e.g. if someone does your shopping for you), please answer to show whether you think you would be concerned about falling IF you did the activity. For each of the following activities, please tick the box which is closest to your own opinion to show how concerned you are that you might fall if you did this activity

		NOT AT ALL CONCERNED - 1	SOMEWHAT CONCERNED - 2	FAIRLY CONCERNED - 3	VERY CONCERNED - 4
1	Cleaning the house *(e.g. sweep, vacuum or dust)*	1 ☐	2 ☐	3 ☐	4 ☐
2	Getting dressed or undressed	1 ☐	2 ☐	3 ☐	4 ☐
3	Preparing simple meals	1 ☐	2 ☐	3 ☐	4 ☐
4	Taking a bath or shower	1 ☐	2 ☐	3 ☐	4 ☐
5	Going to the shop	1 ☐	2 ☐	3 ☐	4 ☐
6	Getting in or out of a chair	1 ☐	2 ☐	3 ☐	4 ☐
7	Going up or down stairs	1 ☐	2 ☐	3 ☐	4 ☐
8	Walking around in the neighbourhood	1 ☐	2 ☐	3 ☐	4 ☐
9	Reaching for something above your head or on the ground	1 ☐	2 ☐	3 ☐	4 ☐
10	Going to answer the telephone before it stops ringing	1 ☐	2 ☐	3 ☐	4 ☐
11	Walking on a slippery surface *(e.g. wet or icy)*	1 ☐	2 ☐	3 ☐	4 ☐
12	Visiting a friend or relative	1 ☐	2 ☐	3 ☐	4 ☐
13	Walking in a place with crowds	1 ☐	2 ☐	3 ☐	4 ☐
14	Walking on an uneven surface *(e.g. rocky ground, poorly maintained pavement)*	1 ☐	2 ☐	3 ☐	4 ☐
15	Walking up or down a slope	1 ☐	2 ☐	3 ☐	4 ☐
16	Going out to a social event *(e.g. religious service, family gathering or club meeting)*	1 ☐	2 ☐	3 ☐	4 ☐
	Subtotal				

Answer the statements above and add up the number of points for each column in the corresponding subtotal. Then, add up each of the 4 subtotals to obtain your total score. If you obtain a score of 28 points or more, the older adult may have a high level of concern about falling.

TOTAL _____

This checklist was developed in a collaborative effort with members of the Prevention of Falls Network Europe (ProFaNE) and is a validated self-assessment tool (Yardley L, Todd C, et al. Development and initial validation of the Falls Efficacy Scale-International (FES-I) Age and Aging 2005; 34(6): 614-619).



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Mobility Screening Guidelines

Fall risk screening involves a three-part process: Opportunistic Screening, Fall Severity Screening and Mobility Screening. Gait or balance disturbances should be assessed only if the older patient DID NOT sustain a severe fall in the past 12 months according to their Fall Severity Screening. For more information about Fall Severity Screening in addition to recommended interventions for patients at LOW, INTERMEDIAT E and HIGH risk for falls, consult the Fall Risk Screening and Interventions Checklist.

GAIT SPEED TEST (4-METRE)

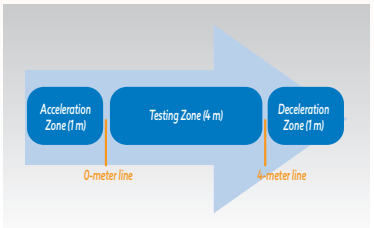
(RECOMMENDED TEST)

Purpose:

Predicting falls risk

Equipment:

- A measuring tape
- A stopwatch



Directions:

Identify with masking tape or another marker, the 3 zones along a level surface as indicated. Ask the patient to walk down a specified direction through a 1-metre zone for acceleration, a central 4-metre "testing" zone, and a 1-metre zone for deceleration.

Start the timer with the first footfall after the 0-metre line and stop the timer with the first footfall after the 4-metre line.

Note: Patients may use an assistive device, if needed.

Instruct the patient to:

1. Walk at their normal/ natural pace.
2. The patient should not start to slow down before the 4-metre mark

Observations:

An older adult who takes longer than 5 seconds to walk 4 metres (<0.8 m/s) suggests an increased risk of falling.

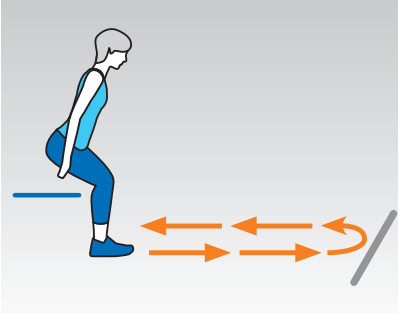
FALLS ARE NOT A NORMAL PART OF AGING.
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TIMED UP AND GO (TUG)
(ALTERNATIVE TEST)

Purpose:

To assess mobility



Equipment:

- A standard chair with a straight back and arm rests
- A measuring tape
- A stopwatch

Directions:

Patients should wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard chair and identify with masking tape or another marker, a line on the floor 3 meters or 10 feet away.

On the word "Go," begin timing and stop timing after the patient sits back down.

Note: Always stay by the patient for safety

Instruct the patient to:

1. Stand up from the chair when hearing the word "Go".
2. Walk to the line on the floor at a normal pace.
3. Turn around in order to face the chair.
4. Walk back to the chair at a normal pace.
5. Sit down again.

Observations:

Observe the patient's postural stability, gait, stride length, and sway.

Note all that apply:

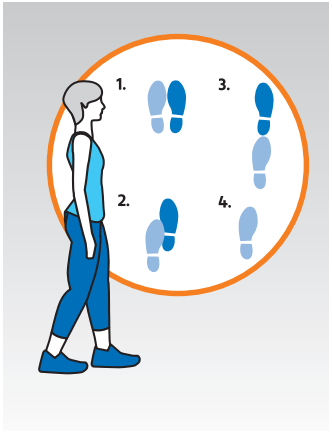
- Slow tentative pace
- Loss of balance
- Short strides
- Little or no arm swing
- Steadying self on walls
- Shuffling feet
- Turning "en bloc"
- Not using assistive device properly

An older adult who takes ≥12 seconds to complete the Timed Up And Go is at increased risk for falling.

4-STAGE BALANCE TEST
(ALTERNATIVE TEST)

Purpose:

To assess static balance



Equipment:

- A standard chair with a straight back and arm rests
- A stopwatch

Directions:

Describe and demonstrate each of the four progressively more challenging standing positions to the patient.

1. Parallel Stance
2. Semi-Tandem Stance
3. Tandem Stance
4. One-Legged Stance

Patient should not use an assistive device (cane or walker). However, they must keep their eyes open during the test. Patients may hold their arms out, or move their body to help keep their balance, but without moving their feet.

When the patient is steady, instruct them to let go of the chair and time how long they can maintain each position. On the word "Go", begin timing. After 10 seconds, say "Stop". If the patient can hold a position for 10 seconds without moving their feet or needing support, go to the next position. If not, stop the test.

Note: Stand next to the patient to help them assume the correct position and to remain ready to assist, in case they lose their balance.

Instruct the patient to:

1. Place their feet in the correct way for each of the four standing positions.
2. Hold onto the chair until they feel balanced.
3. Let go of the chair when they hear the word "Go".
4. Try to stand in the same position without holding on or taking a step until hearing the word "Stop".

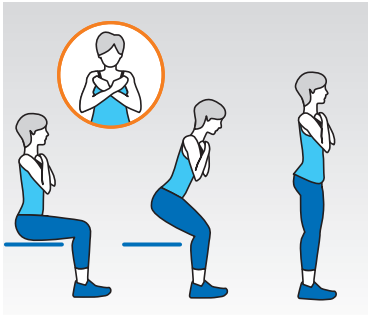
Observations:

Observe the patient's postural stability and the amount of sway. An older adult who cannot hold the tandem stance for at least 10 seconds is at increased risk of falling.

30-SECOND CHAIR STAND TEST
(ALTERNATIVE TEST)

Purpose:

To assess leg strength and endurance



Equipment:

- A standard chair with a straight back without arm rests
- A stopwatch

Directions:

It is recommended to place the chair against a wall to prevent it from moving during the test. Begin by having the patient sit back in a chair without arm rests.

On the word "Go," begin timing. Count and record the number of times the patient comes to a full standing position in 30 seconds. Do not continue if you feel the patient may fall during the test.

Note: Always stay by the patient for safety

Instruct the patient to:

1. Sit in the middle of the chair.
2. Place their hands on the opposite shoulder crossed, at the wrists.
3. Keep their feet flat on the floor.
4. Keep their back straight, and to keep their arms against their chest.
5. Rise to a full standing position, and then sit back down again once they hear the word "Go".
6. Repeat this for 30 seconds

Observations:

Observe the patient's ability to get up from a seated position. If the patient is over halfway to a standing position when 30 seconds have elapsed, count it as a stand. If the patient must use their arms to stand, stop the test. Record the number "0" for their score. An older adult with a below average score for their age and sex indicates an increased risk for falls.

SCORING TABLE		
AGE	MEN	WOMEN
60-64	< 14	< 12
65-69	< 12	< 11
70-74	< 12	< 10
75-79	< 11	< 10
80-84	< 10	< 9
85-89	< 8	< 8
90-94	< 7	< 4



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Additional Resources

We all have a role to play in helping to prevent falls and falls-related injuries. However, as a healthcare professional, you play an essential role in ensuring that screenings, interventions, and necessary follow-ups occur based on best available evidence for clinical practice. To further support you with this process, you are encouraged to consult the following fall prevention resources and websites.

Fall Prevention Toolkit for Older Adults

Healthcare providers should provide an opportunity for older adults to receive additional information about their personal fall risk factors after their visit. The Fall Prevention Toolkit for Older Adults was developed to help older adult take action to prevent falls and stay independent. This recommended resource includes informative fact sheets on important fall prevention topics such as Medication Safety, Staying Physically Active and Moving Safely at Home along with a Fall Prevention Personal Action Plan.



Home Safety Checklist



Falls in older adults are often due to hazards that are easy to overlook but simple to fix. To help reduce their risk of falls at home, we recommend that older adults at LOW to INTERMEDIATE RISK for falls use the Home Safety Checklist. This resource along with its accompanying Personal Action Plan checklist will help those older adults with efforts to identify and manage some of the most common hazards in and around their home.

Finding Balance NS

Finding Balance is designed to raise awareness about the prevention of slips, trips, and falls among older adults. Finding Balance NS aims to foster a collaborative approach to facilitate the sharing of evidence-based information and resources for healthcare professionals, older adults, family members, concerned friends and any other interested individual. For a copy of the Fall prevention Toolkit for Older Adults, we encourage you to visit this central repository of fall prevention resources online at www.FindingBalanceNS.com.

Fall Talk

November is Falls Prevention Month across Canada. Be part of the effort to encourage older adults, their families, their friends, caregivers, healthcare professionals and others to talk about falls and ways to prevent them. For more information about the NS campaign, please visit www.PreventingFallsNS.ca.

Fall Prevention Community of Practice (LOOP)

Loop is a bilingual online communication platform that brings together peers and experts in fall prevention from across Canada to problem-solve and discuss how to implement evidence-informed and promising fall prevention practices. This Fall Prevention Community of Practice was also created to support the exchange information on how to create supportive communities where adults maintain their independence through fall prevention. By registering, you will have access to upcoming webinars, e-newsletters, and the knowledge center. For more information, visit www.fallsloop.com.