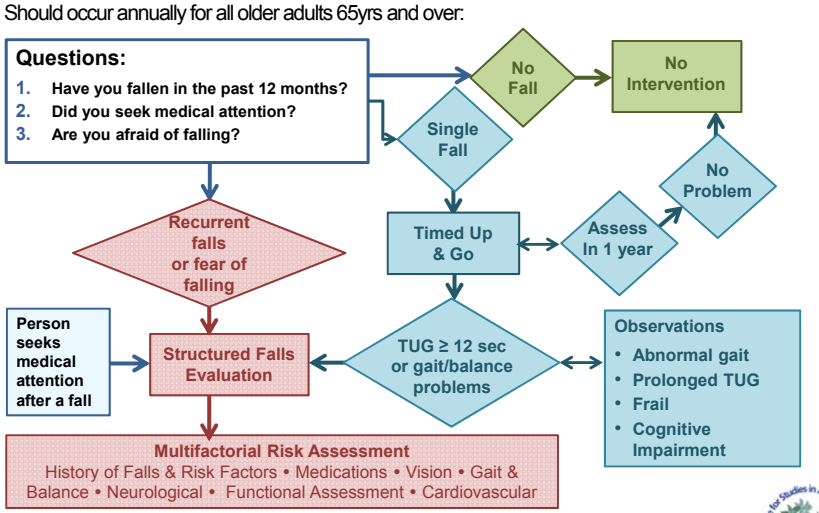
Overview of Falls & the Older Adult

Education for Health Care Professionals

Part 3: Recommendations for Screening

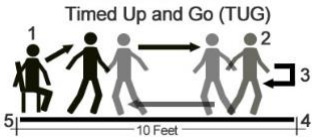
Screening - Assessment Algorithm

Should occur annually for all older adults 65yrs and over:



Adapted from: American Geriatrics Society, British Geriatrics Society, and American Academy of Orthopaedic Surgeons Panel on Falls Prevention. (2001). Guideline for the prevention of falls in older persons. Retrieved from http://fallpreventiontaskforce.org/wp-content/uploads/2014/10/GuidlineforthePreventionofFallsinOlderPersonsAmericanGeriatricsSociety.pdf

Timed Up and Go (TUG) Test



Click this image to watch a video on how to perform the TUG test with your older adult patients 65 years and over.

1. You will need a stopwatch, a chair with arms and a line marking 3 meters. Patients are to complete the test with any mobility aids they normally use and wear their regular footwear.
2. Provide the following instructions to your patient;
   When I say "Go", I want you to:
   (a) Stand up from the chair **(b)** Walk to the line on the floor at your normal pace
   (c) Turn back towards the chair **(d)** Walk back to the chair at your normal pace and **(5)** Sit down
3. Record how many seconds it took. If the patient took 12 seconds or longer the individual is at high risk for falling.
4. Note any of the following:
   ☐ slow tentative pace ☐ loss of balance ☐ short strides ☐ little or no arm swing ☐ shuffling
   ☐ steadying self on walls ☐ TURNING EN BLOC ☐ not using mobility aid properly

(Centre for Disease Control [Video], 2015; Centre for Disease Control, 2015)

Multifactorial Fall Risk Assessment



Components include:

A. Detailed and focused history

B. Clinical examinations including physical, cognitive and functional assessment

C. Intervention strategies: environmental, mobility, balance, flexibility, strength and education

D. Appropriate management and follow-up

(PHAC, 2014)

Detailed and Focused History

History of ALL falls

- collect information about the circumstances of the fall(s) – such as activity when fall occurred, where the fall occurred, if there were any injuries incurred or other consequences resulting from the fall

Medication review

- review all prescribed and non-prescribed pharmacological drugs taken with dosages. **History of relevant risk factors**
- record any acute or chronic problems such as:
  - acute illness (uti, pneumonia)
  - pain
  - diseases such as diabetes, osteoporosis, arthritis, renal disease, respiratory problems
  - Traumatic Brain Injury (TBI), Acquired Brain Injury (ABI) and Cardiovascular Accident (CVA)
  - obesity
  - substance abuse
  - fear of falling
  - fatigue, and/or sleep difficulties
  - incontinence

(PHAC, 2014; Queensland Government, 2008a)

Clinical Examination - Physical

The physical examination should include the following:

- **Neurological**
  - cognition, lower extremity peripheral nerves, reflexes, proprioception
- **Mobility**
  - gait, balance, mobility levels, joint function, muscle strength and coordination
- **Cardiovascular**
  - heart rate & rhythm, postural pulse, blood pressure and blood pressure response to carotid sinus stimulation
- **Vision**
  - eye examination, use of prescription eyewear
- **Feet and footwear**
  - condition, sensation, type of footwear and use
- **Functional Assessment**
  - Including use of footwear, prescription / adaptive aids and fear of falling
- **Nutrition & Hydration**
  - Identify malnutrition or nutritional deficiency, dehydration

(PHAC, 2014; Keller, 2012)

Clinical Examination - Cognitive

Older adults with cognitive disorders or impairments are at higher risk of falling than others.

- Having dementia or other cognitive disorders increases ones risk of falling and sustaining an injury by 2-3 times.
- Having a neurodegenerative disease such as dementia may result in rapid changes in posture needed to maintain balance and avoid falls more challenging.
- Depression and other mood disorders are often associated with fatigue, insomnia, aches and pains and a stooped gait which can increase the risk of falling.
- Medications and/or medication side effects can impact risk.
- Screening should include determining if the older adult understands their own limits and lives within them.

(PHAC, 2014; Morse, 1993)

Clinical Examination - Functional

Activities of daily living

- Assess activities of daily living (ADLs) including the use of mobility aids and adaptive equipment.

Perceived functional ability

- Determine if learned helplessness is limiting the individuals independence and activity levels.

Fear of falling

- Consider the extent to which fear of falling is reasonable and if the person is safety conscious (e.g., appropriate within their abilities).
- Is a fear of falling contributing to deconditioning and/or a compromised quality of life.

(PHAC, 2014)