ASSESSMENT TOOLS TO EVALUATE RISK FOR FALLS

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COMMON MISCONCEPTION

If I tell anyone I’ve fallen I’ll lose my independence.

Don’t worry! I fell too, but after my fall:

- I had a check up to make sure I was well
- Some of my medicines were changed
- I was given advice on how to make my home safer
- I was given information about suitable exercise classes
Which Tool Do I Use?

The Best Fall Risk Tools

Results

- Reliable and Accurate,
- Easy to Administer,
- Quick to Use,
- Consistent Assessments,
- Accurate Targeting of Interventions,
- Identified up to 80% of Fallers.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of falling</td>
<td>no 0</td>
</tr>
<tr>
<td>History of falling</td>
<td>yes 25</td>
</tr>
<tr>
<td>Secondary diagnosis</td>
<td>no 0</td>
</tr>
<tr>
<td>Secondary diagnosis</td>
<td>yes 15</td>
</tr>
<tr>
<td>Ambulatory aid</td>
<td>0</td>
</tr>
<tr>
<td>- None / bed rest / nurse assist</td>
<td>0</td>
</tr>
<tr>
<td>- Crutches / cane / walker</td>
<td>15</td>
</tr>
<tr>
<td>- Furniture</td>
<td>30</td>
</tr>
<tr>
<td>IV or IV Access</td>
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</tr>
<tr>
<td>IV or IV Access</td>
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<tr>
<td>Gait</td>
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<tr>
<td>- Normal / bed rest / wheelchair</td>
<td>0</td>
</tr>
<tr>
<td>- Weak</td>
<td>10</td>
</tr>
<tr>
<td>- Impaired</td>
<td>20</td>
</tr>
<tr>
<td>Mental status</td>
<td>0</td>
</tr>
<tr>
<td>- Oriented to own ability</td>
<td>0</td>
</tr>
<tr>
<td>- Overestimates or forgets</td>
<td>15</td>
</tr>
<tr>
<td>limitations</td>
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</table>
Stopping elderly accidents and deaths

- Contains resources and tools that will help make fall prevention an integral part of your clinical practice.

- User friendly

- Evidenced based tools

- Based on a simple algorithm
The Timed Up and Go (TUG) Test

**Purpose:** To assess mobility

**Equipment:** A stopwatch

**Directions:** Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters or 10 feet away on the floor.

**Instructions to the patient:**
When I say “Go,” I want you to:

1. Stand up from the chair
2. Walk to the line on the floor at your normal pace
3. Turn
4. Walk back to the chair at your normal pace
5. Sit down again

On the word “Go” begin timing.
Stop timing after patient has sat back down and record.

**Time:** ________ seconds

*An older adult who takes ≥12 seconds to complete the TUG is at high risk for falling.*

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

**Circle all that apply:** □ Slow tentative pace  □ Loss of balance
□ Short strides  □ Little or no arm swing  □ Steadying self on walls
□ Shuffling  □ En bloc turning  □ Not using assistive device properly

**Notes:**

For relevant articles, go to: [www.cdc.gov/injury/STEADI](http://www.cdc.gov/injury/STEADI)
The 30-Second Chair Stand Test

**Purpose:** To test leg strength and endurance

**Equipment:**
- A chair with a straight back without arm rests (seat 17” high)
- A stopwatch

**Instructions to the patient:**
1. Sit in the middle of the chair.
2. Place your hands on the opposite shoulder crossed at the wrists.
3. Keep your feet flat on the floor.
4. Keep your back straight and keep your arms against your chest.
5. On “Go,” rise to a full standing position and then sit back down again.
6. Repeat this for 30 seconds.

On “Go,” begin timing.

If the patient must use his/her arms to stand, stop the test.
Record “0” for the number and score.

Count the number of times the patient comes to a full standing position in 30 seconds.

If the patient is over halfway to a standing position when 30 seconds have elapsed, count it as a stand.

Record the number of times the patient stands in 30 seconds.

**Number:** ______  **Score** ______  See next page.

A below average score indicates a high risk for falls.

**Notes:**

For relevant articles, go to: [www.cdc.gov/injury/STEADI](http://www.cdc.gov/injury/STEADI)
### Chair Stand-Below Average Scores

<table>
<thead>
<tr>
<th>Age</th>
<th>Men</th>
<th>Women</th>
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<tbody>
<tr>
<td>60-64</td>
<td>&lt;14</td>
<td>&lt;12</td>
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<td>65-69</td>
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<td>&lt;11</td>
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<tr>
<td>70-74</td>
<td>&lt;12</td>
<td>&lt;10</td>
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<tr>
<td>45-79</td>
<td>&lt;11</td>
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<td>80-84</td>
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<td>85-89</td>
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<td>90-94</td>
<td>&lt;7</td>
<td>&lt;4</td>
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</table>
The 4-Stage Balance Test

**Purpose:** To assess static balance

**Equipment:** A stopwatch

**Directions:** There are four progressively more challenging positions. Patients should not use an assistive device (cane or walker) and keep their eyes open.

Describe and demonstrate each position. Stand next to the patient, hold his/her arm and help them assume the correct foot position.

When the patient is steady, let go, but remain ready to catch the patient if he/she should lose their balance.

If the patient can hold a position for 10 seconds without moving his/her feet or needing support, go on to the next position. If not, stop the test.

**Instructions to the patient:** I’m going to show you four positions.

Try to stand in each position for 10 seconds. You can hold your arms out or move your body to help keep your balance but don’t move your feet. Hold this position until I tell you to stop.

For each stage, say “**Ready, begin**” and begin timing.

After 10 seconds, say “**Stop.**”

See next page for detailed patient instructions and illustrations of the four positions.

For relevant articles, go to: [www.cdc.gov/injury/STEADI](http://www.cdc.gov/injury/STEADI)
4 Stage Balance Test

Instructions to the patient:

1. Stand with your feet side by side.                           Time: __________ seconds

2. Place the instep of one foot so it is touching the big toe of the other foot. Time: __________ seconds

3. Place one foot in front of the other, heel touching toe.     Time: __________ seconds

4. Stand on one foot.                                          Time: __________ seconds

An older adult who cannot hold the tandem stance for at least 10 seconds is at increased risk of falling.

Notes:
Measuring Orthostatic Blood Pressure

1. Have the patient lie down for 5 minutes.
2. Measure blood pressure and pulse rate.
3. Have the patient stand.
4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes.

A drop in bp of ≥20 mm Hg, or in diastolic bp of ≥10 mm Hg, or experiencing lightheadedness or dizziness is considered abnormal.

<table>
<thead>
<tr>
<th>Position</th>
<th>Time</th>
<th>BP</th>
<th>Associated Symptoms</th>
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<tbody>
<tr>
<td>Lying Down</td>
<td>5 Min</td>
<td>BP _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HR ______</td>
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</tr>
<tr>
<td>Standing</td>
<td>1 Min</td>
<td>BP _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HR ______</td>
<td></td>
</tr>
<tr>
<td>Standing</td>
<td>3 Min</td>
<td>BP _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HR ______</td>
<td></td>
</tr>
</tbody>
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For relevant articles, go to: www.cdc.gov/injury/STEADI
WRAP UP

Find a RITUAL

- Review self-assessments
- Identify risk factors
- Test gait and balance
- Undertake various assessments
- Apply interventions
- Later, follow-up

Website for the STEADI toolkit

http://www.cdc.gov/homeandrecreationalsafety/Falls/steadi/index.html#practice
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