Purpose:
To provide screening and assessment for risk of falls to appropriate patients. To improve or mitigate risk factors to provide optimum mobility.

Considerations:
1. There is no single screening or assessment tool that identifies risk for falls.
2. Specific populations may benefit from falls screening and intervention including patients:
   a. Older adults 65 and older.
   b. With acute fall.
   c. With a history of multiple falls in the past year.
   d. With balance and/or gait difficulty.
3. Falls screening considerations should include multifactorial risks such as:
   a. Home environment assessment and modifications, as warranted.
   b. Review of polypharmacy with aim to minimize (or withdraw) from medications as indicated in conjunction with the primary care provider.
   c. Identification of postural hypotension.
   d. Assessment of muscle strength.
   e. Balance, gait and mobility assessment including assistive devices used or needed.
   f. Activities of Daily Living (ADL) assessment.
   g. Assessment of footwear and feet.
   h. Assessment of visual acuity.
   i. Correlation of comprehensive assessment key factors of pain, incontinence and cognition with fall risk.
   j. Patient self rated health including fear of falling, as appropriate.
4. Falls risk screening using multifactorial risk factors is strengthened when a valid standardized mobility test is administered.
5. A standardized definition of a fall should be used by all staff and explained to the patient to ensure common understanding of fall risk.
6. Epidemiological data reflects: increased risk of falls for ages over 65, women experience more injurious falls and many falls in ages 65 and older occur at home.

Equipment:
Standardized multifactorial screening process or tool; for OASIS process measure, additional standardized validated mobility tool
Materials needed for standardized mobility tool such as stopwatch, tape measure, etc.

Procedure:
1. Explain assessment process to patient and rationale for screening for falls risk.
2. Use consistent interview questions and examples.
3. Be prepared to provide examples and explanations to ensure common understanding by any patient.
4. Use guidelines for lowest patient language level to ensure understanding.
5. Be prepared to conduct falls risk assessment in patient’s primary language.
6. Provide adequate time for patient to consider screening questions or assessment tasks and respond accordingly.
7. Use instructions and follow procedure as standardized for mobility tool selected.

After Care:
1. Document in patient's record:
   a. Patient's response to falls risk assessment.
   b. Results of standardized test(s).
   c. Instructions given to patient/caregiver.
   d. Report concerns re: patient's fall risk to supervisor and physician.
   e. Any recommended follow-up actions based on findings from fall risk assessment.

References:


