CP 4.4: Falls Risk Assessment

Updated:
Reviewed:

Purpose

To assist the Community Paramedic to conduct a falls risk assessment using a variety of falls risk screening tools.

Policy Statements

The Community Paramedic (CP) will conduct a falls risk assessment on clients in response to a referral from a health authority or primary health care provider. It is expected that the CP will document findings and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

The falls risk screen should be conducted in conjunction with a home safety assessment screen to determine if there are any safety hazards that may impact the client's risk for falls within the home environment.

If for whatever reason (cognitive, psychological or physical), the client is unable to perform the screening tests or demonstrates confusion in following instructions, the CP will discontinue testing, document findings and contact the primary health care provider or team for direction.

A CP does not perform the role of a physical therapist or occupational therapist and will therefore not be analyzing the persons gait or movement, nor advising about exercises or physical therapy. If a CP notices the client is having difficulty moving around, they will bring it to the attention of the primary health care provider, as well as other members of the health care team as appropriate. In addition to connecting the client with the primary health care provider so that appropriate referrals, such as to a physical therapist or occupational therapist, the CP may make suggestions with respect to necessary referrals to organizations that can provide walkers, canes and other mobility devices.

Definitions

Falls Risk is based on:

- Falls history – a history of falls in the past three months increases falls risk
- Timed Get Up and Go (TUG) – clients with time greater than 15 seconds are at higher risk for falls
- Romberg test positivity increases falls risk
- Chair stand test – below average rating indicates a high risk for falls
- Tandem stance test – inability to hold stance for 10 seconds indicates a high risk for falls
- Clinical judgment based on observations

Timed Get Up and Go (TUG) test: a quick and simple test to assess an individual's gait and balance by having them rise from a chair, walk a designated distance and return to the chair and be seated. It measures, in seconds, the time taken by an individual to perform the test. The greater the time, the higher the risk for falls.

Romberg test: a tool used to diagnose sensory ataxia. The test is done by requesting the client to keep his/her feet firmly together, arms by his/her side and eyes open. Balance is noted for 15 seconds. Then the client is asked to close his/her eyes and balance is again noted for 15 seconds. If with eyes open, balance is not good, it may indicate cerebellar ataxia. If closing the eyes causes worsening balance, the test is said to be Romberg positive and indicates that the client is excessively reliant on vision to maintain balance and may indicate sensory ataxia. Clients with either cerebellar or sensory ataxia are at higher risk of falls.

Chair stand test: a short, easy and simple to administer test to assess a client's leg strength and endurance. It is also useful for tracking improvements in strength and falls risk because it can easily be repeated after implementing interventions. To perform the test, the client sits in a straight back chair against a wall, with their feet shoulder width apart, flat on the floor and with arms crossed over their chest. From the sitting position, the client stands completely up, then completely back down, and this is repeated for 30 seconds. The total number of complete chair stands (up and down equals one stand) are counted and recorded. A below average rating indicates a high risk for falls.

Tandem Stance Test: a short, easy and simple to administer test of balance. It is also useful for tracking improvements in balance and falls risk because it can easily be repeated after implementing interventions. To perform this test, the client is instructed to stand with one foot in front of the other, heel to toe and to hold this stance for 10 seconds without holding on or taking a step. An individual who cannot hold the tandem stance for at least 10 seconds is at increased risk of falling.

Procedure

1. **ASK** question: "Have you had a fall in the past 3 months?" If yes, **EXPLORE** further as to what happened, how fall occurred, what were the circumstances that caused the fall, etc.
2. **PERFORM** one or more of the following screening tests to determine the client's falls risk.
    1. **Timed Up and Go test:**
        1. Client should wear their regular footwear and use a walking aid if needed. Select an appropriate chair and mark out a 3 metre walking
        2. **GIVE** client instructions on how to do test and allow them to have a practice before timing.
        3. Using a stopwatch or second hand on a clock/watch, **RECORD** time it takes patient to get up from chair, walk 3 metres and return to chair and sit.
        4. **OBSERVE** how client stands up, with/without using arms; observe stability on turning and any assistance required; observe postural stability, gait pattern and sway; hearing, vision & cognition; proper use of walking aid if used.
    2. **Romberg test:**
        1. Instruct client to stand with feet together, arms at the side, and eyes open and observe for postural sway or break in position for 15 seconds. If client sways considerably or breaks position, do not continue
        2. If minimal/no sway and no break in position, instruct clinet to maintain that position and close his or her eyes for 15 seconds (Reassure client that you will stand close by to catch him/her should he/she start to fall).
        3. Individuals with normal balance may sway slightly upon closing their eyes, but it is usually minimal, and they do not break position. The Romberg test is positive (abnormal) if the sway is considerable and the client breaks position.
    3. **Chair stand test:**
        1. Instruct client to sit with back straight in the middle of a chair with hands on the opposite shoulder crossed at the wrists and feet flat on the floor.
        2. Instruct client rise to a full standing position and then sit back down again on the word "go" and to repeat this for 30 seconds.
        3. On "Go", begin timing and count the number of times the client comes to a full standing position in 30 seconds. If he/she is over halfway to a standing position when 30 seconds have elapsed, count it as a stand.
        4. Record the number of times the client stands in 30 seconds.
    4. **Tandem Stance Test:**
        1. Demonstrate how to stand with one foot in front of the other, heel to toe. Client can hold onto a chair until he/she feel
        2. Instruct client to let go when you say "**Go**" and to keep his/her feet in this position without holding on or taking a step until you say "**Stop**".
        3. Say "**Go**" and begin timing. After 10 seconds, say "**Stop**".

Documentation

DOCUMENT falls risk screen and screening test results on BCEHS Community Paramedicine Falls Risk Screen Record.

DOCUMENT details of the visit on the CP Initial Assessment Form and/or progress notes and notify primary health care provider or health care team of findings and any concerns.

References

1. Eagle County Paramedic Services. Community Paramedic Protocols Manual. 2013. [Link]
2. General Practice Services Committee. Chronic Disease Management Tools and Resources: Fall Prevention Resources. [Link]
3. McMichael KA, et al. Simple Balance and Mobility Tests Can Assess Falls Risk When Cognition Is Impaired. 2008.

[Link]

4. Tri-County Health Care Emergency Medical Services. Community Paramedic Policy & Procedure Manual. 2016. [Link]