

Level 1

'Screen' for Falls or Risk of Falling for clients over 65 yrs.

Client Name: _____

Address: _____

Telephone Number: _____

Consent Obtained: Yes ☐ No ☐

Question 1

Ask: Client ☐ and / or Carer ☐

"In the past year have you had any fall, including a slip or trip, in which you lost your balance and landed on the floor or ground or lower level?"

☐ No → Proceed to Question 2

☐ Yes → (A) How many times did you fall in the past year? _____

(B) How did you fall? Please describe:

Activity:

Place:

Time:

☐ Single Fall → Gait & Balance Test* (see below) - ☐ Pass → Proceed to Question 2 & 3

or

☐ Fail → Multi-factorial Assessment.

☐ Recurrent Falls (two or more falls in the previous year) → Multi-factorial Assessment

Question 2

Ask Client: "Are you afraid of falling?"

☐ No (If no, proceed to question 3)

☐ Yes → Multi-factorial Assessment if considered clinically significant (Level 2)

(Significant = interfering with activities of daily living)

Question 3

Ask Client: "Have you any difficulty with your walking or balance?"

☐ No → No further Intervention

☐ Yes → Gait and Balance and, if fail, then Multi-factorial Assessment (Level 2)

*Gait and Balance Test (Please refer to Appendix 6 for rationale and references for Get Up and Go protocol)

The client is asked to do the following (normal mobility aid can be used):

- Client is asked to sit in a standard height arm chair (approx seat height of 46cm), arms resting on the arms of the chair
- Then he/she is asked to stand up, walk a distance of approximately 3 metres at normal pace
- Turn,
- Walk back and sit down again
- The subject wears their regular footwear and uses their customary walking aid (none, cane, or walker). No physical assistance is given.
- The observed performance is scored as steady or unsteady.

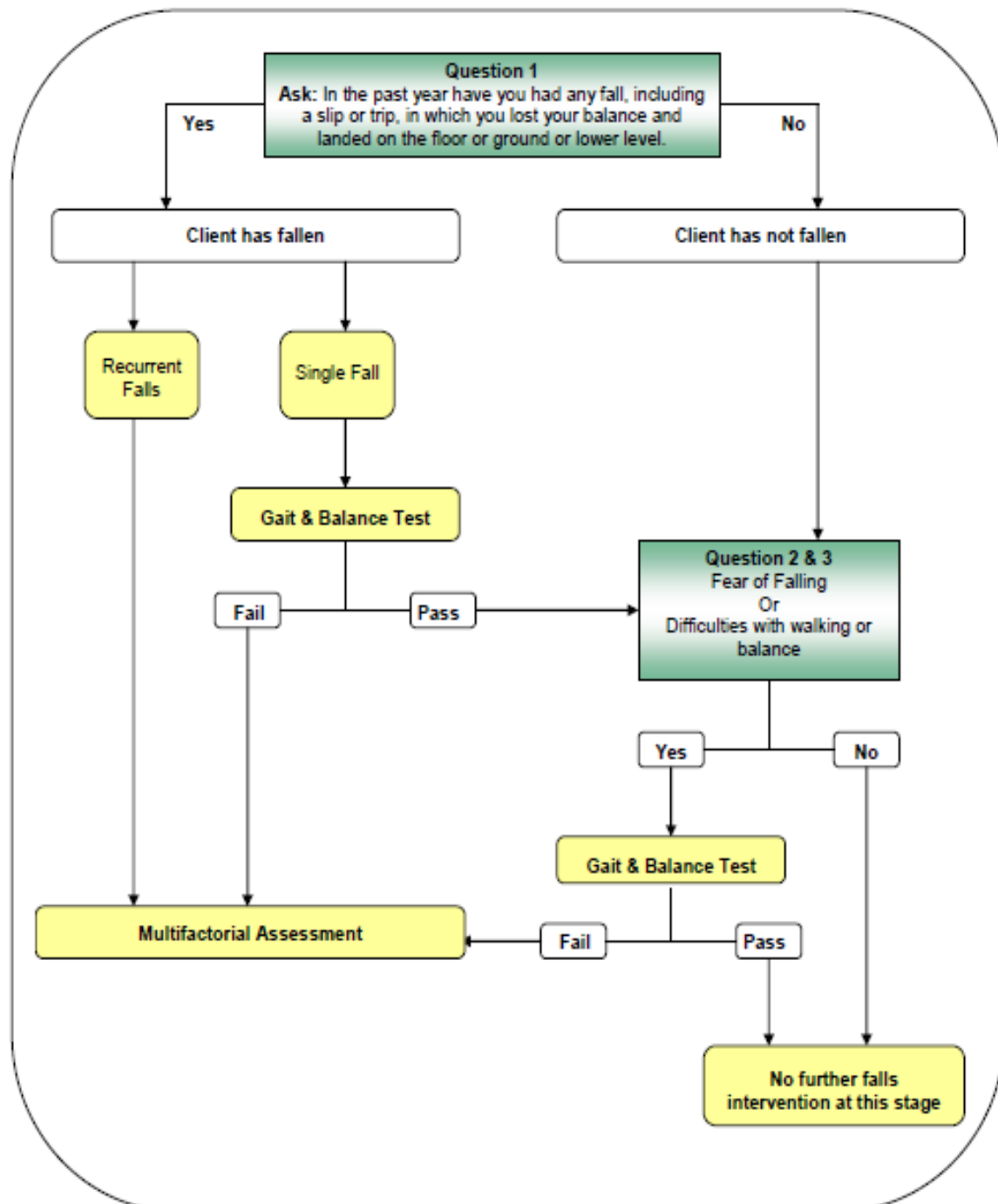
Individuals fail the test if they are unable to perform/complete the test, or have difficulty or demonstrate unsteadiness performing any component of the test

Assessor: _____

Profession: _____

Date: _____

Falls Algorithm



REFERENCE: HSE, Dept. of Health and Children (2008) 'Strategy to Prevent Falls and Fractures in Ireland's Ageing Population'. National Council on Aging and Older People, Report of the National Steering Group on the Prevention of Falls in Older People and the Prevention and Management of Osteoporosis throughout life. Available from www.hse.ie.

Level 2: Multi-factorial Falls Risk Assessment

The form is intended to be completed by any healthcare professional on a primary care team. As local arrangements may vary the assessor/health care professional should complete the form in so far as their scope of practice allows and refer to their colleagues as required for full completion of the appropriate parts. The Clinician who initiates the process should maintain the record of the assessment and a register should be maintained by the Primary Care Team or Administration Support. This register would allow clients to be called back for follow up as required.

Assessor: _____ Date: _____

Information obtained from: ☐ Client ☐ Carer ☐ Other (Specify _____)

Demographic details

Name:	Next of kin:
Address:	Relationship:
Telephone number:	Tel. No:
Date of Birth:	GP:
GMS/LTI Card No:	Address:
	Tel. No:

Past Medical History

Social History

Living Alone ☐ Yes ☐ No Carer ☐ Yes ☐ No

1. Falls History

History of Falls: ☐ Yes ☐ No

Number of falls in last 12 months? : _____

Location of fall(s): Indoors ☐ _____ Outdoors ☐ _____

Time of the day falls occurred? _____

How did the fall occur/what was the activity at the time? _____

What (in the person's opinion) was the cause of the fall(s)? _____

Has the person changed their routine or environment since the fall? ☐ Yes ☐ No

Did the person receive any injuries as a result of the fall? ☐ Yes ☐ No

Episodes of dizziness associated with falling? ☐ Yes ☐ No

Episode of blackout ☐ Yes ☐ No

Was the person able to get up from the floor? ☐ Yes ☐ No

Was the person able to summon help following the fall? ☐ Yes ☐ No

Does the person have a pendant alarm? ☐ Yes ☐ No

(If yes, was the person wearing pendant alarm at time of fall? ☐ Yes ☐ No

Client:

DOB:

2. Gait and Balance			
Gait analysis (unsteady on feet/shuffles/uneven stride length etc):			
Poor balance:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Reported difficulty climbing stairs/steps to house:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Walking aid:	<input type="checkbox"/> Yes (please specify): _____		<input type="checkbox"/> No
3. Functional Ability			
Activities of Daily Living: Ask the client are they: Independent (I), requires Assistance (A), or Dependent (D) with each of the following tasks?			
Personal Activities of Daily Living (Dressing, Bathing, Toileting)	<input type="checkbox"/> I	<input type="checkbox"/> A	<input type="checkbox"/> D
Transfers (Toilet, Bed, Chair)	<input type="checkbox"/> I	<input type="checkbox"/> A	<input type="checkbox"/> D
Domestic Activities of Daily Living (Housework, Meal Preparation, Shopping)	<input type="checkbox"/> I	<input type="checkbox"/> A	<input type="checkbox"/> D
4. Fear of Falling			
Fear of falling or restricting any activity they appear capable of doing			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, details: _____			
5. Home Safety			
Does the client have:			
Steps / Stairs in the home either inside or outside unprotected by a rail?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
A shower with step or a bath without grab rails?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Indoor hazards present (cluttered rooms, rugs, cords)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Perceived Functional Ability			
Demonstrates decreased awareness in reporting falls, risks and consequences of falls			<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Cognitive Function			
Complete The Abbreviated Mental Test Score – Appendix 7			
8. Urinary Incontinence			
Urinary Incontinence <input type="checkbox"/> Yes <input type="checkbox"/> Urgency <input type="checkbox"/> Nocturia <input type="checkbox"/> Other _____)			
<input type="checkbox"/> No			
9. Foot Problems and Footwear			
Foot problems i.e. corns, bunions, swelling, overgrown toenails			<input type="checkbox"/> Yes <input type="checkbox"/> No
Inappropriate, poorly fitting or worn footwear			<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Assessment of Mood			
During the last month have you been bothered by feeling sad, depressed or hopeless?			<input type="checkbox"/> Yes <input type="checkbox"/> No
During the last month have you often had little interest or pleasure in doing things?			<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Nutrition			
11(i)			
Weight loss (within previous 12 months)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there issues impacting on dietary intake			<input type="checkbox"/> Yes <input type="checkbox"/> No
(If client answers "yes" carry out 11(ii) as appropriate ('MUST' screening - refer to MUST tool in Appendix 4)			
11(ii) 'MUST' screening:			
Height :	Weight (kg):	BMI (kg/m ²):	'MUST' Score: _____ 0 – Low risk: Monitor. 1 – Med risk: Implement 'First Line Dietary' advice (Appendix 4). ≥ 2 – High risk: Implement 'First Line Dietary' advice (Appendix 4) & refer to dietitian.

Client:	DOB:	
12. Bone health		
Previous low trauma fracture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Xray evidence of osteopenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Corticosteroid Use (i.e. prednisolone for ≥3months)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family history of osteoporosis (especially maternal hip fracture)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other clinical risk factors: height loss, kyphosis, low Body Mass Index (<19kg/m ²)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Possible secondary osteoporosis (primary hyperparathyroidism, poorly controlled thyrotoxicosis, malabsorption, rheumatoid arthritis, liver disease, alcoholism, primary hypogonadism)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Untreated oestrogen deficiency (history of surgical or natural menopause <45 years, secondary amenorrhoea > 6 months not due to pregnancy or primary hypogonadism)	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
13. Drug History		
Medications:		
Is the client on 4 or more medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the client on psychotropic medication, e.g. night sedation, anti depressants, anxiety meds?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List all medications (including dosage): Document below or attach print out		
Alcohol:		
Does the client have alcohol dependency issues?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, alcohol units per week: _____		
14. Vision		
15(i) Does person report any vision related problems e.g. poor eyesight, cataracts etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>(If client answers "yes" complete part (ii) below or complete onward referral for completion)</i>		
Under 70: Has the client had an eye test in last 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
70 or over: Has the client had an eye test in last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the client wear bifocals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15(ii) Visual acuity test: R = L =		
Are visual fields normal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Clinical observations		
Record BP and HR after 2 minutes lying:	BP: ____/____	HR: ____
Record BP and HR after 1 minute standing:	BP: ____/____	HR: ____
(Postural hypotension: fall of 20mmHg systolic or 10mmHg diastolic with dizziness)		
Assessor:	Profession:	Date:



Féilthneannacht na Seirbhíse Sláinte
Health Service Executive

XXX Primary Care Team

Date: _____

Dear _____,

I have conducted the Multi-factorial Falls Risk Assessment on

Client Name: _____

Client Address: _____

Client Date of Birth: _____

I would be grateful if you would complete the following sections of the Multi-factorial Falls Risk assessment:

Please return your completed sections me at the address below and please contact me with any further enquiries regarding this matter.

Thank you

Signature: _____

Name: _____

Profession: _____

Address: _____

Contact Phone No.: _____

Please attach a copy of the Multifactorial Falls Risk Assessment with this letter.

Falls risk factor present	Suggested referral options and interventions
History of Falls (Review incident(s), identifying precipitating factors)	<ul style="list-style-type: none"> • Refer to GP, nurse, physiotherapist, occupational therapist as appropriate. • Refer for personal alarm and/or hip protectors. • Consider referral to a specialist falls assessment service where there is a complex interaction of risk factors, or unexplained, multiple falls or falls continuing despite local actions
Dizziness Blackout Postural Hypotension	<ul style="list-style-type: none"> • GP review with onward referral where indicated • Onward referral by the GP for investigations to out-rule cardiovascular disorders should be considered in older persons who present with transient loss of consciousness with amnesia or transient hypotensive episodes or where heart rate or rhythm abnormalities are detected on clinical examination.
Gait / Balance/Strength Impairment	<ul style="list-style-type: none"> • Refer to physiotherapist for gait, balance and strength rehabilitation • Exercise may be performed in groups or as individual (home) exercises, as both are effective in preventing falls. • Exercise programmes should take into account the physical capabilities and health profile of the older person, (i.e. be tailored) and be prescribed by qualified health professionals or fitness instructors. • The exercise programme should include regular review, progression and adjustment of the exercise prescription as appropriate. • Initiating exercise programmes with patients who have limited mobility and are not used to exercising should be done with caution as some studies have shown that exercise may increase the rate of falls in this population.
Difficulty with activities of daily living (A.D.L.s)	<ul style="list-style-type: none"> • Refer to occupational therapist (OT) for review of A.D.L.s / prescription of assistive equipment as appropriate • Refer to physiotherapist for walking aid assessment where indicated • Ensure assistive devices are in good working condition and provide education on correct use of assistive devices (if indicated).
Fear of Falling	<ul style="list-style-type: none"> • Discuss fear of falling & realistic preventative measures • Refer to PT/OT where appropriate • Refer to psychologist where appropriate
Home Safety Concerns	<ul style="list-style-type: none"> • Refer to occupational therapist (OT) for review of A.D.L.s , prescription of assistive equipment or home modifications as appropriate • Intervention should include mitigation of identified hazards in the home, and evaluation and interventions to promote the safe performance of daily activities.
Cognitive Function	Refer to GP +/- OT for detailed cognitive assessment with onward referral to specialist where indicated
Urinary Incontinence	Refer to GP, nursing, physiotherapist or occupational therapist as appropriate. Management of urinary incontinence as appropriate
Foot Problems and Footwear	<ul style="list-style-type: none"> • Refer to chiropodist/ podiatrist / physiotherapist as appropriate • Treatment of foot problems • Footwear Advice - Older people should be advised that walking with shoes with low heel height and high surface contact area may reduce the risk of falls

Falls risk factor present	Suggested referral options and interventions	
Mood	Refer to GP or Psychologist as appropriate	
Nutrition	<ul style="list-style-type: none"> • GP review • Refer to dietician 	
Bone Health	Refer to GP, physiotherapist or dietician as appropriate. Refer for bone mineral density testing Management of osteopenia /osteoporosis as appropriate	
Neurological Disorders	Physiotherapy Assessment and treatment as appropriate GP review with referral to neurologist where indicated	
Drug History	On 4 or more medication	Consider referral to GP/Pharmacist for review of all medications & dosage - consider withdrawal or minimisation (Appendix 8)
	On psycho-active medications or other culprit medications	Refer to GP for review of psychoactive medications or other culprit medication (e.g. class 1a antiarrhythmic medications, digoxin, diuretics) - consider withdrawal or minimisation with appropriate tapering if indicated (Appendix 8)
	Determine if the client is able to manage their medications safely.	
Visual Related Problems	<ul style="list-style-type: none"> • GP review • Refer to optician • Refer to occupational therapist for home safety assessment • Treatment of remediable abnormalities, particularly cataracts. • An older person should be advised not to wear multifocal lenses while walking, particularly on stairs. 	

APPENDIX 8

BERG BALANCE SCALE

1. Purpose

The Berg's utility includes grading different patients' balance abilities, monitor functional balance over time and to evaluate patients' responses to treatment.

2. Content

The Berg is a test of 14 items; it is performance based and has a scale of 0-4 for each item (higher score for independent performance) with a maximum score of 56.

The Berg is considered the gold standard assessment of balance with good intra-rater reliability and inter-rater reliability and good internal validity.

3. Assessment

1. Sitting to standing

INSTRUCTIONS: Please stand up. Try not to use your hands for support

- 4 able to stand without using hands and stabilize independently
- 3 able to stand independently using hands
- 2 able to stand using hands after several tries
- 1 needs minimal aid to stand or to stabilize
- 0 needs moderate or maximal assist to stand

2. Standing unsupported

INSTRUCTIONS: Please stand for two minutes without holding

- 4 able to stand safely for 2 minutes
- 3 able to stand for 2 minutes with supervision
- 2 able to stand for 30 seconds unsupported
- 1 needs several tries to stand for 30 seconds unsupported
- 0 unable to stand for 30 seconds unassisted

3. Sitting with back unsupported but feet supported on floor or on a stool

INSTRUCTIONS: Please sit with arms folded for 2 minutes

- 4 able to sit safely and securely for 2 minutes
- 3 able to sit for 2 minutes under supervision
- 2 able to sit for 30 seconds
- 1 able to sit for 10 seconds
- 0 unable to sit without support for 10 seconds

4. Standing to sitting

INSTRUCTIONS: Please sit down

- 4 sits safely with minimal use of hands
- 3 controls descent by using hands
- 2 use back of legs against chair to control descent
- 1 sits independently but has uncontrolled descent
- 0 needs assistance to sit

5. Transfers

INSTRUCTIONS: Arrange chair(s) for a pivot transfer. Ask subject to transfer one way toward a seat with armrests and one way toward a seat without armrests. You may use two chairs, (one with and one without armrests), or a bed and a chair.

- 4 able to transfer safely with minor use of hands
- 3 able to transfer safely definite need of hands
- 2 able to transfer with verbal cueing and/or supervision
- 1 needs one person to assist
- 0 needs two people to assist or supervise to be safe

6. Standing unsupported with eyes closed

INSTRUCTIONS: Please close your eyes and stand still for 10 seconds

- 4 able to stand 10 seconds safely
- 3 able to stand 10 seconds with supervision
- 2 able to stand 3 seconds
- 1 unable to keep eyes closed 3 seconds but stays steady
- 0 needs help to keep from falling

7. Standing unsupported with feet together

INSTRUCTIONS: Place your feet together and stand without holding

- 4 able to place feet independently and stand for 1 minute safely
- 3 able to place feet together and stand for 1 minute with supervision
- 2 able to place feet together independently to hold for 30 seconds
- 1 need help to attain position but able to stand 15 seconds feet together
- 0 needs help to attain position and unable to hold for 15 seconds

8. Reaching forward with outstretched arm while standing

INSTRUCTIONS: Lift arm to 90°. Stretch out your fingers and reach forward as far as you can. (Examiner places a ruler at end of fingertips when arm is at 90°. Fingers should not touch the ruler while reaching forward). The recorded measure is the distance forward that the finger reaches while the subject is in the most forward lean position. (When possible, ask subject to use both arms when reaching to avoid rotation of the trunk.)

- 4 can reach forward confidentially >25 cm (10 inches)
- 3 can reach forward >12.5 cm safely (5 inches)
- 2 can reach forward >5cm safely (2 inches)
- 1 reaches forward but needs supervision
- 0 loses balance while trying/requires external support

9. Pick up object from the floor from a standing position

INSTRUCTIONS: Pick up the shoe/slipper, which is placed in front of your feet.

- 4 able to pick up slipper safely and easily
- 3 able to pick up slipper but needs supervision
- 2 unable to pick up, reaches 2-5cm (1-2 inches) from slipper, keeps balance
- 1 unable to pick up and needs supervision while trying
- 0 unable to try/needs assist to keep from losing balance or falling

10. Turning to look behind over left and right shoulders while standing

INSTRUCTIONS: Turn to look directly behind you over toward left shoulder. Repeat to the right. Examiner may pick an object to look at directly behind the subject to encourage a better twist turn.

- 4 looks behind from both sides and weight shifts well
- 3 looks behind one side only, turn to other side demonstrates less weight shift
- 2 turns sideways only but maintains balance
- 1 needs supervision when turning
- 0 needs assist to keep from losing balance or falling

10. Turn 360 degrees

INSTRUCTIONS: Turn completely around in a full circle. Pause. Then turn a full circle in the other direction.

- | | |
|---|--|
| 4 | able to turn 360 degrees safely in 4 seconds or less |
| 3 | able to turn 360 degrees safely one side only in 4 seconds or less |
| 2 | able to turn 360 degrees safely but slowly |
| 1 | needs close supervision or verbal cueing |
| 0 | needs assistance while turning |

12. Placing alternate foot on step or stool while standing unsupported

INSTRUCTIONS: Place each foot alternately on the step/stool. Continue until each foot has touched the step/stool four times.

- | | |
|---|---|
| 4 | able to stand independently and safely and complete 8 steps in 20 seconds |
| 3 | able to stand independently and complete 8 steps >20 seconds |
| 2 | able to complete 4 steps without aid with supervision |
| 1 | able to complete >2 steps needs minimal assist |
| 0 | needs assistance to keep from falling/unable to try |

13. Standing unsupported one foot in front

INSTRUCTIONS: (DEMONSTRATE TO SUBJECT)

Place one foot directly in front of the other. If you feel that you cannot place your foot directly in front, try to step far enough ahead that the heel of your forward foot is ahead of the toes of the other foot. (To score 3 points, the length of the step should exceed the length of the other foot and the width of the stance should approximate the subject's normal stride width)

- | | |
|---|---|
| 4 | able to place foot tandem independently and hold 30 seconds |
| 3 | able to place foot ahead of other independently and hold 30 seconds |
| 2 | able to take small step independently and hold 30 seconds |
| 1 | needs help to step but can hold 15 seconds |
| 0 | loses balance while stepping or standing |

14. Standing on one leg

INSTRUCTIONS: Stand on one leg as long as you can without holding.

- | | |
|---|--|
| 4 | able to lift leg independently and hold >10 seconds |
| 3 | able to lift leg independently and hold 5 – 10 seconds |
| 2 | able to lift leg independently and hold ≥ 3 seconds |
| 1 | tries to lift leg, unable to hold 3 seconds but remains standing independently |
| 0 | unable to try or needs assist to prevent fall |

TOTAL SCORE

(Maximum = 56)

Interpretation of Berg Scores

Please take note that these values are based on the Berg score alone and the patient mobilising without the assistance of a walking device. They do not take into account other falls risk factors

- A score of 45 or less indicates a greater risk of falls
- In the range of 56-54 each 1 point drop was associated with a 3-4% increase in falls risk
- In the range of 54-46 each point drop was associated with a 6-8% falls risk
- Below 36 falls risk is close to 100%

References

Wood-Dauphinee S, Berg K, Bravo G, Williams JI: The Balance Scale: Repsonding to clinically meaningful changes. Canadian Journal of Rehabilitation 10:35-50,1997

Berg K, Wood-Dauphinee S, Williams JI: The Balance Scale: Reliability assessment for elderly residents and patients with an acute stroke. *Scand J Rehab Med* 27:27-36, 1995

Berg K, Maki B, Williams JI, Holliday P, Wood-Dauphinee S: A comparison of clinical and laboratory measures of postural balance in an elderly population. *Arch Phys Med Rehabil* 73: 1073-1083, 1992

Berg K, Wood-Dauphinee S, Williams JI, Maki B: Measuring balance in the elderly: validation of an instrument. *Can. J. Pub. Health* July/August supplement 2:S7-11, 1992

Berg K, Wood-Dauphinee S, Williams JI, Gayton D: Measuring balance in the elderly: preliminary development of an instrument. *Physiotherapy Canada* 41:304-311, 1989

APPENDIX 9

Timed Up & Go Test (TUG)

Directions:

The timed “Up and Go” test measures, in seconds, the time taken by an individual to stand up from a standard arm chair, walk a distance of 3 meters, turn, walk back to the chair and sit down. The subject wears their regular footwear and uses their customary walking aid.

Instructions to the Patient:

“When I say ‘Go’, I want you to stand up and walk to the line, turn and then walk back to the chair and sit down again.
Walk at your normal pace.”

The test should be completed within 14 seconds

APPENDIX 10

Get Up & Go Test (GUG)

Directions:

The Get “Up and Go” test assesses an individual's ability to stand up from a standard arm chair, walk a distance of 3 meters, turn, walk back to the chair and sit down. The subject wears their regular footwear and uses their customary walking aid. Individuals fail the test if they are unable to perform or complete the test, or have difficulty or demonstrate unsteadiness performing any component of the test.

Instructions to the Patient:

“When I say ‘Go’, I want you to stand up and walk to the line, turn and then walk back to the chair and sit down again.
Walk at your normal pace.”

APPENDIX 11

Five times Sit to Stand Test:

Method:

Use a straight back chair with a solid seat that is 16" high. Ask participant to sit on the chair with arms folded across their chest.

Instructions:

"Stand up and sit down as quickly as possible 5 times, keeping your arms folded across your chest."

Measurement:

Stop timing when the participant stands the 5th time.

Outcomes:

- (Guralnik 2000)
Inability to rise from a chair five times in less than 13.6 seconds is associated with increased disability and morbidity
- (Buatois, et al., 2008)
The optimal cutoff time for performing the FTSS test in predicting recurrent fallers was 15 seconds (sensitivity 55%, specificity 65%). 2,735 subjects aged 65 and older in an apparently good state of health were tested.
- (Bohannon, 2006)
Metaanalysis results "demonstrated that individuals with times for 5 repetitions of this test exceeding the following can be considered to have worse than average performance" (Bohannon, 2006)
 - 60-69 y/o **11.4 sec**
 - 70-79 y/o **12.6 sec**
 - 80-89 y/o **14.8 sec**

References:

Guralnik, J. M., L. Ferrucci, et al. (2000). "Lower extremity function and subsequent disability: consistency across studies, predictive models, and value of gait speed alone compared with the short physical performance battery." *J Gerontol A Biol Sci Med Sci* 55(4): M221-31.

Buatois S, Miljkovic D, Manckoundia P, Gueguen R, Miget P, Vancon G et al. Five times sit to stand test is a predictor of recurrent falls in healthy community-living subjects aged 65 and older. *J Am Geriatr Soc* 2008; 56(8):1575-1577.

Bohannon RW. Reference values for the five-repetition sit- to- stand test: a descriptive metaanalysis of data from elders. *Percept Mot Skills* 2006; 103(1):215-222.

APPENDIX 12

Falls Efficacy Scale

Name _____

Date _____

On a scale from 1 to 10, with *1 being very confident and 10 being not confident at all*, how confident are you that you do the following activities without falling?

Activity	Score
	1 very confident 10 not confident at all
Take a bath or shower	
Reach into cabinets or closets	
Walk around the house	
Prepare meals not requiring carrying heavy or hot objects	
Get in and out of bed	
Answer the door or telephone	
Get in and out of a chair	
Getting dressed and undressed	
Personal grooming (i.e. washing your face)	
Getting on and off of the toilet	
Total Score	

A total score of greater than 70 indicates that the person has a fear of falling

Source: Tinetti, M., Richman, D., Powell, L. (1990). Falls Efficacy as a Measure of Fear of Falling. *Journal of Gerontology*. 45;239

