

Rapid falls risk assessment tools

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falls prevention

The "Timed Up and Go" Test

Rational: This is possibly the single most useful screen for any patient with a history of falls, unsteadiness or an abnormality of balance or gait. It tests common position changes, which use a variety of muscle groups and balance mechanisms.

Test: The test involves getting up from a chair with arms (the patient may use their arms if necessary) walking 3 metres at normal pace (with walking aids if normally used), turning and walking back to the chair. Under normal circumstances this can be done within 10 seconds (in people over 80, up to 11- 12 seconds is acceptable, Hill et al). If this activity takes longer the patient is deemed 'At risk' = Multifactorial Falls Risk Factor Assessment. This test can also be used as a baseline assessment and for monitoring improvement or deterioration.

Romberg's Test

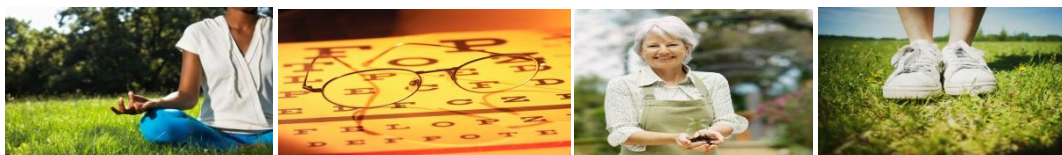
Rational: This test assesses capacity to withstand balance challenges with reduced visual input. Individuals commonly have some impairment of proprioception as well as impaired visual and vestibular function and all sensory input is important in maintaining balance without there necessarily being visual, neuropathic or related pathology. The patient with absent or reduced proprioception due to peripheral neuropathy or posterior column disease (B12 deficiency) will be able to stand stably with eyes open, but will tend to lose balance or even fall with eyes closed.

Test: The patient is asked to stand with feet comfortably close together with eyes initially open and, with stand by supervision and reassurance, close their eyes. If the patient loses balance they are deemed 'At risk' = Multifactorial Falls Risk Factor Assessment.

Sternal Push Test

Rationale: This evaluates balance mechanisms and strength in the lower legs. Functionally, it assesses a patient's ability to withstand some of the normal stresses experienced every day e.g. regaining balance after a perturbation.

Test: The patient stands with feet comfortably close together. The tester stands close to the patient. Often a chair a ½ step behind the patient is useful. After a warning, the patient is pushed firmly on the sternum. Observation is made of the patient's functional falls prevention actions. Average risk patient can resist the sternal push without stepping and utilise hip, trunk and upper limb strategies to assist in maintaining balance. If the patient takes one or even two protective steps but does not fall or takes no protective steps, the patient is deemed 'At risk' = Multifactorial Falls Risk Factor Assessment.



Adapted from the Falls prevention guidelines for general practitioners for assessing and managing older people, DHS, Melbourne. Barwon Health (2005).
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