Role of the Healthcare Providers in Fall Prevention

Below is a list of roles in fall prevention based on profession to assist you in delegating tasks to members of your interdisciplinary team during your NFPAD event.

Physical Therapy:

- Review fall history and/or have the patient complete the 12-item questionnaire "Stay Independent Brochure" to check their risk of falling. If *yes* to either of the below questions, further assessment is indicated.
    - Question 1: Have you fallen in the last year?
    - Question 2: Do you ever worry about falling or feel unsteady when moving around?
- Once previous falls are identified, assess the circumstances of falls. Consider the use of the SPLATT acronym:
    - Symptoms: Did the patient experience any dizziness or pain prior to fall?
        - *Assist with assessing for orthostatic hypotension or vestibular pathologies*
    - Position: Was the patient standing or sitting when they fell?
        - *Assists in understanding if impairments related to position are affecting status*
    - Location: Where did the fall occur? Indoors? Outdoors? Bathroom? Bedroom? Entryway?
        - *Provides information on location where safety education should be provided*
    - Activity: What were they doing when they fell?
        - *Provides information on ICF impairments related to fall*
    - Time: What time of day was it? (Follow up question: When did you take your medications that day?)
        - *Assists in assessing if medications are placing patient at increased risk for falls*
    - Trauma: Did they sustain an injury from the fall?
        - *Indicates severity of fall and provides opportunity for screening of osteoporosis (ie: wrist fractures)*
- Perform balance screen/postural instability (ie: 4 Stage Balance Test, modCTSIB, etc).
- Identify mobility deficits, strength deficits (ie: Timed Up and Go, 30 Second Sit to Stand Test).
- Identify sensory deficits. Consider questions that identify peripheral neuropathy or 10 point protective sensation testing on dorsum of feet.
- Identify foot problems and ideal footwear. Recommend podiatry referral or shoe orthotics as appropriate

- Identify vestibular deficits. Consider using questions regarding occurrence of dizziness, vertigo and onset/causes.
- Screen for depression and/or mental health issues which might increase fall risk.
- Screen for cognitive deficits (such as Mild Cognitive Impairment or dementia) which might increase fall risk.
- Identify Osteoporosis risk. Consider questions or observations regarding age, history of fractures, history of parents with fractures, Caucasian, history of smoking or alcohol abuse, or slender frame.
- Recommend home modifications. Consider using the Check for Safety Brochure.
- Recommend fall prevention interventions including appropriate exercise groups in your area, referral to PT services, if warranted.

Occupational Therapy:

- Review fall history and/or have the patient complete the 12-item questionnaire "Stay Independent Brochure" to check their risk of falling. If *yes* to either of the below questions, further assessment is indicated.
    - Question 1: Have you fallen in the last year?
    - Question 2: Do you ever worry about falling or feel unsteady when moving around?
- Screen for intrinsic and extrinsic fall risk factors.
- Screen for visual deficits.
- Screen for hearing deficits.
- Screen for depression and/or mental health issues which might increase fall risk.
- Screen for cognitive deficits (such as Mild Cognitive Impairment or dementia) which might increase fall risk.
- Recognize and address fear of falling.
- Screen and address fall risk factors related to their activity roles and routines and their home environment to maximize independence for older adults.
- Provide education on energy conservation for older adults.
- Screen for and assist in breaking the cycle of inactivity and sedentary lifestyle, which increases one's risk of falling.

Speech Therapy:

- Review fall history and/or have the patient complete the 12-item questionnaire "Stay Independent Brochure" to check their risk of falling. If *yes* to either of the below questions, further assessment is indicated.
    - Question 1: Have you fallen in the last year?
    - Question 2: Do you ever worry about falling or feel unsteady when moving around?
- Screen for hearing deficits.

- Screen for visual deficits.
- Screen older adults for intrinsic and extrinsic fall risk factors.
- Recognize and address fear of falling.
- Screen for depression/or and mental health issues which might increase fall risk.
- Screen for cognitive deficits (such as Mild Cognitive Impairment or dementia) which might increase fall risk.
- Instruct in nutrition/hydration guidelines when swallowing deficits present.
- Screen and address fall risk factors related to their functional cognition to maximize independence for older adults.

Nursing:

- Review fall history and/or have the patient complete the 12-item questionnaire "Stay Independent Brochure" to check their risk of falling. If *yes* to either of the below questions, further assessment is indicated.
    - Question 1: Have you fallen in the last year?
    - Question 2: Do you ever worry about falling or feel unsteady when moving around?
- Screen for depression and/or mental health issues which might increase fall risk.
- Screen for cognitive deficits (such as Mild Cognitive Impairment or dementia) which might increase fall risk.
- Assist in performing a thorough medication review to identify potential high-risk drugs.
- Perform assessment of vitals, including evaluation of orthostatic hypotension, if warranted.
- Screen for urinary incontinence and associated risk factors.
- Screen for visual deficits.
- Screen for hearing deficits.

Pharmacists:

- Review fall history and/or have the patient complete the 12-item questionnaire "Stay Independent Brochure" to check their risk of falling. If *yes* to either of the below questions, further assessment is indicated.
    - Question 1: Have you fallen in the last year?
    - Question 2: Do you ever worry about falling or feel unsteady when moving around?
- Assess to identify modifiable risk factors, such as medication use
    - SAFE Medication Review
    - 2019 BEERS Criteria
- Educate patient regarding medications that increase fall risk.
- Screen for depression and/or mental health issues which might increase fall risk.

- Screen for cognitive deficits (such as Mild Cognitive Impairment or dementia) which might increase fall risk.
- Intervene to use effective clinical and community strategies to reduce fall risk.
- Communicate medication findings to PCP.
    - Recommend medication alternatives.

Physicians & Advanced Medical Practitioners:

- Review fall history and/or have the patient complete the 12-item questionnaire "Stay Independent Brochure" to check their risk of falling. If *yes* to either of the below questions, further assessment is indicated.
    - Question 1: Have you fallen in the last year?
    - Question 2: Do you ever worry about falling or feel unsteady when moving around?
- Identify medical conditions that may impact fall risk.
- Perform medication review to identify medications that increase risk of falls using the following tools
    - SAFE Medication Review
    - 2019 BEERS Criteria
- Screen for depression and/or mental health issues which might increase fall risk.
- Screen for cognitive deficits (such as Mild Cognitive Impairment or dementia) which might increase fall risk.
- Assess feet/footwear. Recommend podiatry care and/or diabetic footwear as appropriate.
- Assist in encouraging individuals to contact their primary care provider to address the above related issues, if warranted.
- Screen for visual deficits.
- Screen for hearing deficits.

Registered Dietician:

- Review fall history. If they answer *yes* to either of the below questions, further assessment is indicated.
    - Question 1: Have you fallen in the last year?
    - Question 2: Do you ever worry about falling or feel unsteady when moving around?
- Screen for vitamin and mineral deficiencies which could lead to increased fall risk.
- Assess nutritional status of individuals at risk for falls to ensure proper macronutrient and micronutrient intake.
- Assess adequate hydration status and provide education on the importance of hydration in physical health status.

Social Worker:

- Review fall history and/or have the patient complete the 12-item questionnaire "Stay Independent Brochure" to check their risk of falling. If *yes* to either of the below questions, further assessment is indicated.
    - Question 1: Have you fallen in the last year?
    - Question 2: Do you ever worry about falling or feel unsteady when moving around?
- Screen for depression and/or mental health issues which might increase fall risk.
- Screen for cognitive deficits (such as Mild Cognitive Impairment or dementia) which might increase fall risk.
- Screen and address fall risk factors related to their functional cognition to maximize independence for older adults.
- Assist in encouraging individuals to contact their primary care provider to address the above related issues, if warranted.
- Recommend home modifications. Consider using the Check for Safety Brochure.
- Screen for visual deficits.
- Screen for hearing deficits.