Is the older person in your care at risk of falling?

Ask, assess, act is a process developed by the Health Quality & Safety Commission's national programme, Reducing Harm from Falls. The programme aims to reduce the risk of falling for older people, rate of falls, severity of fall-related injuries and to promote the best possible outcomes for those harmed in a fall.[1]

The Ask, assess, act process is an integration of current evidence-based guidance for falls prevention in older people:

- The 2013 United Kingdom based National Institute for Health and Care Excellence Clinical (NICE) guideline 161 Falls: assessment and prevention of falls in older people.
- The 2013 United States based Centers for Disease Control and Prevention (CDC) tool kit for primary health care providers: Stopping Elderly Accidents, Deaths & Injuries (STEADI).
- The 2010 American and British Geriatric Societies' Clinical Practice Guideline: Prevention of Falls in Older Persons.

Ask, assess, act is a conversation-based process which identifies falls-related problems and risks that are real for the older person, and which leads to shared decisions about actions which will be most helpful and manageable.

It involves the older person and their family/whānau and other carers - there are several resources in this package which support their involvement:

- A poster, 'Stay independent' for your waiting room
- A consumer brochure, 'Stay independent' which includes patient self-assessment of falls risk
- A resource for health practitioners 'Talking about falls prevention with your patient'.

The first step is screening, complemented by your patient's self-assessment of their falls risk. Reviewing the patient's self-assessment provides useful information about what they believe to be the cause of any falls, and prompts a discussion about their priorities.

Screening for falls risk involves asking three simple questions which quickly cover several important points:

1. Having fallen previously is predictive of falling again.
   Ask: Have you slipped, tripped or fallen in the last year?

2. Balance problems and lower-limb weakness increase the risk of falling – observing or asking whether the patient uses their hands to push up out of a chair is related to the chair stand test.[2]
   Ask: Can you get out of a chair without using your hands?

3. Restricting activities because of a fear of falling diminishes quality of life and can cause a loss of condition, which further increases the risk of falling.[3]
   Ask: Are there some activities you've stopped doing because you are afraid you might lose your balance? Do you worry about falling?

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If your patient has slipped, tripped or fallen in the previous year, you'll ask about the about the circumstances of the most recent fall(s) or near-fall(s), as part of determining the value of a full falls history. Falls explained as 'a simple accident' are worth further enquiry, as falls are often a complex interaction between a hazard in the environment and an older person's specific risk factors.[4]

A positive answer to any one of these three questions above leads to multi-factorial risk assessment and intervention, that is:

- Undertaking a systematic assessment of risk factors for older people at risk of falls. A consistent and standardised approach is recommended, to ensure risk factors aren't missed, but every older person is different, and each will have a different risk profile
- Actioning a plan of individualised care – referring to specialist input as needed, and putting in place interventions and supports to treat, modify or better manage the risk factors identified.

The algorithm sets out this process and what it involves. Your clinical judgement takes into account the older person's risk of falling, their ability or readiness to address their risk factors, along with their preferences and family support. Appropriate actions may range from giving information (such as the 'Standing up to falls' booklet) and referral for Green Prescription, to referral into a community-based falls prevention programme or to other specialist services. A small proportion of older people may benefit from referral for comprehensive geriatric assessment, e.g. those with complex falls risks related to frailty, impaired cognition or mobility.

The challenge for health practitioners is to make older people aware of their potential risk of falling without causing distress or denial of a problem.[5] A sense of partnership that aims to supporting their independence is key, whether your perspective is from primary care with a longer-term relationship, or a brief encounter as a coordinator in a 'single point of entry' falls referral service.

After a fall, assess or reassess the patient's risk factors in the light of that incident, and implement or modify a plan of care to address risk factors, in partnership with the patient and their family/whānau.

1. Health Quality & Safety Commission. Topic 10: An integrated approach to falls in older people: what is your part? 2014. Available from: www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/10-Topics/ (Accessed Sep, 2014).
2. Jones CJ, Rikli RE, Beam WC. A 30-s chair-stand test as a measure of lower body strength in community-residing older adults. Research Quarterly for Exercise and Sport 1999;70(2):113-9.
3. Delbaere K, Close JC, Brodaty H, et al. Determinants of disparities between perceived and physiological risk of falling among elderly people: cohort study. BMJ 2010; 341: c4165
4. Rubenstein L Z. Falls in older people: epidemiology, risk factors and strategies for prevention. Age and Ageing 2006; 35-S2:ii37-ii41.
5. Child S, Goodwin V, Garside R. Factors influencing the implementation of fall-prevention programmes: a systematic review and synthesis of qualitative studies. Implementation Science 2012;7(91): 1–14.

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