Balance Assessment Practices of Saskatchewan Physiotherapists: A Brief Report of Survey Findings

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ABSTRACT

Purpose: This study was conducted to determine the balance assessment practices of physiotherapists in Saskatchewan. **Methods:** Practising physiotherapists who assess and treat adults with balance and mobility impairments were eligible to participate in this cross-sectional, online survey. The questions investigated the use of balance assessment measures, the balance components assessed, and practice area. **Results:** Of the 72 respondents, most reported regularly assessing five or more of the nine balance components listed. Movement observation was the most commonly reported measure used, followed by the Berg Balance Scale, single-leg stance test, and tandem standing/walking. **Conclusions:** Most physiotherapists in Saskatchewan use a variety of tools to assess balance. Gaps in practices related to fall prevention were noted in the mismatch between the tools used and the components reportedly assessed.

Key Words: accidental falls; outcome and process assessment (health care); postural balance; survey.

RÉSUMÉ

Objectif: déterminer les pratiques d'évaluation de l'équilibre qu'utilisent les physiothérapeutes de la Saskatchewan. **Méthodologie:** les physiothérapeutes en exercice qui évaluent et traitent des adultes ayant des problèmes d'équilibre et de mobilité pouvaient participer à ce sondage transversal en ligne. Les questions portaient sur le recours aux mesures d'évaluation de l'équilibre, les aspects de l'équilibre évalués et le secteur de pratique. **Résultats:** la plupart des 72 répondants ont déclaré évaluer régulièrement au moins cinq des neuf aspects de l'équilibre énumérés. L'observation du mouvement était la mesure la plus déclarée, suivie de l'échelle d'équilibre de Berg, du test d'appui unipodal et de la combinaison du lever et de la marche. **Conclusions:** la plupart des physiothérapeutes de la Saskatchewan font appel à divers outils pour évaluer l'équilibre. Les chercheurs ont remarqué des écarts de pratique liés à la prévention des chutes à cause du décalage entre les outils utilisés et les aspects évalués.

In 2010, fall-related injuries cost the Canadian economy \$8.7 billion,¹ and in Saskatchewan, falls are the leading cause of all injury costs (\$319 million).¹ Most of these falls occur on level ground¹ and may be a result of impaired balance.² Clinical practice guidelines for fall screening and prevention emphasize the importance of assessing and treating balance.³ Balance is a modifiable fall risk factor, one that can be improved through targeted rehabilitation and prevention programmes;⁴ therefore, to design and deliver effective interventions, it is imperative to carry out a comprehensive assessment.

Physiotherapists play an important role in assessing and treating balance impairments. A thorough balance assessment can provide essential information for identifying impairments, developing tailored programmes, and evaluating change over time.⁵ Although many measures are available, only a limited number assess all components of balance,⁶ making clinical care of balance and mobility impairments difficult.

Compared with other Canadian provinces, Saskatchewan has a small population that is widely distributed across a challenging geographical landscape, and it has few high-

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density population areas.⁷ Previous research has reported on balance assessment practices in Ontario,⁸ a larger, more populated province; however, the consistency of assessment practices across Canada are unknown.

This study aimed to determine the current balance assessment practices of physiotherapists in Saskatchewan who assess and treat adults with balance and mobility impairments, including which measures were used and which balance components were assessed regularly. We hypothesized that the most commonly used measures and balance components assessed would be similar to those reported for Ontario physiotherapists, highlighting the fact that most popular measures do not comprehensively assess all balance components.⁸

METHODS

We administered a cross-sectional, online survey (see the Appendix) that targeted those practising physiotherapists in Saskatchewan who were assessing and treating adults (aged ≥ 18 y) with balance and mobility impairments at the time they completed the survey (March–April 2014). The link to the survey was sent to 699 licensed physiotherapists by the Saskatchewan College of Physical Therapists twice, 1 week apart, and then to a subset of those recipients ($n = 457$) by the Saskatchewan Physiotherapy Association twice, 1 month apart. We sent these communications to physiotherapists in all practice areas and populations across Saskatchewan (e.g., pediatrics, upper limb), so not all recipients were eligible to participate. As a result, a true sampling frame could not be determined. The University of Saskatchewan Research Ethics Board approved this study. Eligible participants provided informed consent by initiating the survey.

Our survey measured the frequency of assessment of nine distinct balance components:^{6,9} (1) functional stability limits, (2) underlying motor systems, (3) static stability, (4) verticality, (5) reactive postural control, (6) anticipatory postural control, (7) dynamic stability, (8) sensory integration, and (9) cognitive influences, as well as use of more than 20 validated measures of balance,^{6,8} respondent practice area, and demographics.⁸ The balance components were operationally defined and based on previous work,⁶ which has adapted the Systems Framework for Postural Control.⁹

Pilot testing with four physiotherapists outside the research team ensured the readability and level of comprehension of the survey before data collection. Responses were captured using Qualtrics (Qualtrics, LLC, Provo, UT) 5 weeks after the final communication. We analyzed the data using IBM SPSS Statistics, version 22 (IBM Corp., Armonk, NY) and considered responses relative to the total number of responses for individual questions. We defined regular use of a balance measure or regular assessment of a balance component as 60% or more of the time in the respondent's primary practice.⁸

We summarized demographics and practice area data using descriptive statistics. Primary outcomes were the percentages of respondents who (1) regularly used balance measures and (2) regularly assessed balance components. For each balance measure and component, the frequency of use across practice areas was compared using χ^2 analysis. When significant results were found ($p < 0.05$), odds ratios (ORs) were calculated for the practice area that had the highest count compared with all other categories combined.¹⁰ We included the five standardized balance measures most regularly used in the analysis.

RESULTS

A total of 77 participants answered the qualifying question that determined eligibility. Five of those participants were not eligible, leaving 72 participants who completed the survey (94% completion). Respondents ranged in age from 30 years or younger to 60 years or older, and the majority were female (65; 90%). Of these, 44 (61%) had been practising with adults with balance and mobility impairments for more than 10 years. Four practice areas were identified: orthopaedics, including sports injuries (25; 35%); geriatrics (19; 26%); multiple or complex conditions (19; 26%), including vestibular, cardiorespiratory, mixed, and intellectual disabilities; and neurology (9; 13%). A large majority (58; 81%) practised in an urban setting. Most worked on an inter-professional team (59; 82%) and in a general hospital (30; 42%), community health centre (17; 24%), or solo or group professional practice (11; 15%). The demographics and other characteristics of the respondents are set out in Table 1.

Movement observation was the most regularly used assessment approach (51; 71%). A slight majority (39; 54%) reported using more than one of the other standardized balance measures. The five standardized measures most regularly used were the Berg Balance Scale (BBS; 36; 50%), single-leg stance test (30; 42%), tandem standing/walking (30; 42%), functional reach (14; 19%), and the timed up-and-go (TUG) test (13; 18%). When we compared these measures across practice areas, we found significant differences only for the BBS ($p = 0.010$) and the single-leg stance test ($p = 0.007$), not for any other measures. The BBS was more often used in geriatrics than in all the other practice areas combined (OR = 2.05). The single-leg stance test was more often used in orthopaedics than in all other practice areas combined (OR = 6.09).

The balance components most regularly assessed were static stability (65; 90%), underlying motor systems (64; 89%), and dynamic stability (60; 83%). Anticipatory control, verticality, and functional stability limits were regularly assessed by 38 (53%), 36 (50%), and 34 (47%) respondents, respectively. The least regularly assessed components of balance were reactive postural control (27; 38%), cognitive influences (18; 25%), and sensory integration (17; 24%). Only 4 (6%) respondents reported

Table 1 Demographics and Characteristics of Respondents

Characteristic	Entire sample (<i>N</i> = 72), no. (%)	Practice area			
		Neurology (<i>n</i> = 9), no. (%)	Orthopaedics (<i>n</i> = 25), no. (%)	Geriatrics (<i>n</i> = 19), no. (%)	Multiple and/or complex conditions (<i>n</i> = 19), no. (%)
Age, y					
≤30	11 (15.3)	0 (0)	3 (12.0)	6 (31.6)	2 (10.5)
31–40	18 (25.0)	2 (22.2)	7 (28.0)	5 (26.3)	4 (21.1)
41–50	22 (30.6)	3 (33.3)	9 (36.0)	3 (15.8)	7 (36.8)
51–60	20 (27.8)	4 (44.4)	5 (20.0)	5 (26.3)	6 (31.6)
>60	1 (1.4)	0 (0)	1 (4.0)	0 (0)	0 (0)
Sex					
Female	65 (90.3)	8 (88.9)	22 (88.0)	17 (89.5)	18 (94.7)
Male	7 (9.7)	1 (11.1)	3 (12.0)	2 (10.5)	1 (5.3)
Years practising with current population					
<2	8 (11.1)	1 (11.1)	4 (16.0)	3 (15.8)	0 (0)
2–5	10 (13.9)	0 (0)	3 (12.0)	4 (21.1)	3 (15.8)
6–10	10 (13.9)	0 (0)	4 (16.0)	3 (15.8)	3 (15.8)
>10	44 (61.1)	8 (88.9)	14 (56.0)	9 (47.4)	13 (68.4)
Facility type					
General hospital	30 (41.7)	2 (22.2)	9 (36.0)	10 (52.6)	9 (47.4)
Community health centre	17 (23.6)	2 (22.2)	6 (24.0)	4 (21.1)	5 (26.3)
Rehabilitation hospital	9 (12.5)	5 (55.6)	1 (4.0)	2 (10.5)	1 (5.3)
Professional practice	11 (15.3)	0 (0)	8 (32.0)	1 (5.3)	2 (10.5)
Residential care facility	4 (5.6)	0 (0)	0 (0)	2 (10.5)	2 (10.5)
Other*	1 (1.4)	0 (0)	1 (4.0)	0 (0)	0 (0)
Facility location					
Urban	58 (80.6)	8 (88.9)	19 (76.0)	16 (84.2)	15 (78.9)
Rural†	14 (19.4)	1 (11.1)	6 (24.0)	3 (15.8)	4 (21.1)

*E.g., post-secondary educational institution or school board.

†Indicates locations with a population less than 10,000.

regularly assessing all nine balance components, whereas 38 (53%) regularly assessed five to eight components, 29 (40%) regularly assessed one to four components, and 1 (1%) reported regularly ($\geq 60\%$ of the time) assessing none of the components. No significant differences were found in the balance components assessed across practice areas.

DISCUSSION

Saskatchewan physiotherapists use a wide range of tools to assess many components of balance. The most commonly used standardized measures provide valuable information and are easy to implement, but are limited in their comprehensive assessment of balance.⁶ Aside from the TUG test, which may include a cognitive component if a dual task is added, none of the most commonly used measures assess reactive postural control, verticality, and cognitive influences on balance. Assessing these balance components is critical for controlling balance and preventing falls.^{11,12}

The most commonly used assessment approach was movement observation rather than any standardized measure; this result is similar to results reported in a comparable study conducted in Ontario.⁸ The frequent

use of observation as an assessment tool is not surprising: Previous research has suggested that movement observation may be more trusted and valued than standardized assessment options^{13,14} and that it is often used to guide clinical practice and the use of standardized tests.^{13–15} In addition to using observation to assess balance, most respondents reported using more than one standardized measure. Although qualitative assessment is important for physiotherapy practice, standardized measures serve as an important adjunct to movement observation, enabling physiotherapists to make more reliable comparisons over time, among groups, or with respect to comparative norms.

Across practice areas, the more frequent use of the BBS in geriatrics was expected because it was originally developed and validated for older adults.^{16,17} The greater use of the single-leg stance test in orthopaedics was also expected because it is a standard assessment practice and one that is included in an orthopaedic scan to determine unilateral lower extremity weakness or signs of trunk or pelvis instability.¹⁸

Of the 72 respondents, 53% reported regularly assessing at least five of the balance components—mirroring previous research in Ontario⁸—and 6% reported regularly

assessing all nine components. These results are not surprising given that most balance measures do not adequately assess all balance components or that the scoring does not facilitate interpretation of individual components.⁶ Tests that do assess most balance components—such as the Balance Evaluation Systems Test (BESTest) and Fullerton Advanced Balance (FAB) Scale—are relatively new tools, and fewer than 3% of respondents regularly used them.

In addition to reporting on physiotherapist practices in Saskatchewan, the results of the current study revealed some differences between practices there and in Ontario.⁸ For example, relatively more Ontario physiotherapists reported regularly using the single-leg stance test (79%) and TUG test (28%) than Saskatchewan physiotherapists (41% and 18%, respectively). Similarly, relatively more Ontario physiotherapists reported regularly assessing cognitive influences (55%) and sensory integration (60%) than those in Saskatchewan (25% and 24%, respectively). The reasons for these inter-provincial differences may be related to differences in research protocol (e.g., survey instrument, recruitment strategy) or differences in the characteristics of the respondents in each study (e.g., training, experience, and practice area). For example, the single-leg stance test was used by all respondents practising in orthopaedics in the Ontario study,⁸ whereas it was reported to be used regularly by 68% of respondents practising in orthopaedics in our study. In addition, relatively fewer respondents reported practising primarily in orthopaedics in Saskatchewan (35%) compared with Ontario (46%).

The TUG test may be used more regularly in neurological practice because it can differentiate between individuals with stroke and healthy older adults.¹⁹ The relatively smaller number of respondents practising primarily in neurology in this study (13%) compared with the Ontario study (21%) may account for the difference in regular use of the TUG test between these two provinces.

Despite Saskatchewan's smaller, more widely distributed general population, physiotherapy practices are similar to those in Ontario. Although there are no recommended, gold-standard balance measures for assessing fall risk,²⁰ the limited use of comprehensive measures may not meet multi-factorial recommendations in clinical guidelines. A better understanding of the balance components and practical experience with the measures²¹ may increase the use of more comprehensive tools (e.g., BESTest and FAB Scale).

Several limitations to this study need to be considered. First, it may have overestimated assessment practices because the survey relied on self-reports.²² A response rate cannot be validly calculated because many recipients would not have met the inclusion criteria. Although we asked respondents about the measures they used and the balance components they assessed in separate questions, we did not ask which tools were used to assess

each component. Linking measures to individual components would suggest intentions in clinical practice. Another limitation is that the results of the Ontario study may have influenced the practice of the respondents of the current study; this is not likely, however, because the inadequate assessment of reactive balance was consistently reported and because previous research has suggested that the literature has a limited influence on the selection of methods for balance assessment.¹³

CONCLUSIONS

This study provides the first insight into the balance assessment practices of physiotherapists in Saskatchewan, and it adds to our understanding of clinical practice in that province. Physiotherapists in Saskatchewan most often use movement observation as well as a variety of standardized measures to assess balance in adult populations with balance and mobility impairments. The most commonly used standardized measures are limited in their ability to comprehensively assess balance; however, respondents reported regularly assessing the majority of balance components. Further work is needed to understand the use and perceptions of various measures in regular physiotherapy practice across Canada, although the similarities in the regular use of measures in Saskatchewan and Ontario suggests uniformity in clinical practice for balance assessment. The disparity between the components assessed and the measures used for fall prevention is also similar in the two provinces. Future work should investigate the reasons for such disparities and the methods used to improve balance assessment across Canada.

KEY MESSAGES

What is already known on this topic

Many of the available and commonly used standardized tools used to assess balance do not assess all the components of balance that are important for fall prevention.

What this study adds

Physiotherapists in Saskatchewan use measures similar to those of their colleagues in Ontario. Results from both provinces highlight a discrepancy in the reported assessment of certain balance components and the use of balance assessment measures. The most regularly used tools are not comprehensive and do not assess balance components that are important for fall prevention.

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APPENDIX

Saskatchewan Physiotherapists' Balance Assessment Practices

Note: To be consistent with the brief report, only questions included in the analysis are presented below. The formatting of the survey was different in the online version, but the content is identical.

Please refer to the following definitions when completing this survey:

Balance: maintaining stability during standing and moving

Mobility: moving from one position or place to another

Impairment: problems in body function or structure such as a significant deviation or loss

1. Do you currently assess and treat adults (ages 18 years and older) with balance and mobility impairments?

- ☐ Yes
☐ No

If No Is Selected, Then Skip To End of Survey

This section asks about the adult population you assess and treat with balance and mobility impairments as well as your general area of practice.

2. How long have you been assessing and treating adults with balance and mobility impairments?

- ☐ Years
☐ Months

3. What percentage of your practice includes children and infants (0–17 years), adults (18–64 years), and older adults (≥65 years)? (Must add up to 100%.)

_____ Children and Infants
 _____ Adults
 _____ Older Adults

4. In a typical week, what percentage of your current practice involves assessing and treating adults with balance and mobility impairments?

- ☐ 0%
☐ 1–19%
☐ 20–39%
☐ 40–59%
☐ 60–79%
☐ ≥ 80%

5. What are the first three digits of the postal code for your primary workplace? Postal codes will be used to describe the geographic region of your response. Your identity will remain anonymous.

FIRST THREE DIGITS OF POSTAL CODE (e.g., S7N):

6. Which best describes the facility at which you currently treat the greatest number of adults with balance and mobility impairments?

- ☐ General Hospital
☐ Community Health Centre
☐ Governmental Association
☐ Rehabilitation Hospital
☐ Group/Solo Professional Practice
☐ Industry, Manufacturing, and Commercial
☐ Residential Care Facility
☐ Solo Professional Practice
☐ Assisted Living Residence
☐ Post-Secondary Educational School or School Board
☐ Other (please specify): _____

7. Which best describes your work environment at this facility?

- ☐ Work alone
☐ Work with other physiotherapists only
☐ Work in an inter-professional team (with at least one other type of health professional)

[illegible]

14. Do you use any of the following available measures or tools in your assessment of balance and mobility?

[illegible]

This section asks about you.

21. How old are you?

- ☐ ≤30 years
- ☐ 31–40 years
- ☐ 41–50 years
- ☐ 51–60 years
- ☐ >60 years

22. What is your gender?

- ☐ Female
- ☐ Male

23. What is your entry-to-practice degree for physical therapy?

- ☐ Diploma
- ☐ Bachelor's
- ☐ Entry-level master's
- ☐ Other (specify): _____

24. What year did you graduate from your physical therapy program?

25. What is your highest degree attained?

- ☐ Diploma
- ☐ Bachelor's
- ☐ Entry-level master's
- ☐ Applied or research master's
- ☐ Doctoral
- ☐ Other (please specify): _____