



Ongoing fall prevention behaviour after participation in the Stepping On fall prevention program
Follow up questionnaire

Name: _____ Date: _____

1. When did you complete the *Stepping On* program?

Month _____ Year _____

2. Did you complete the whole *Stepping On* program? Yes / No

If not, why didn't you complete the whole program? (please tick all that apply)

Ill health Did not enjoy the program Carer responsibilities

Did not find the program useful Difficulty accessing transport to attend

Other (please specify reason) _____

3. Have you experienced a fall since taking part in the *Stepping On* program?

(Include any fall including a slip or trip in which you lost your balance and landed on the floor or ground or lower level)

No Yes If yes, how many falls? _____

If yes, how many of these falls required medical attention? _____

If yes, how many of these falls resulted in a fracture? _____

4. To what extent do you agree or disagree with the following statements?:

a) The *Stepping On* program has made me more aware of the problem of falls

Strongly agree Agree Neutral Disagree Strongly disagree

b) The *Stepping On* program made me more motivated to improve my safety compared to before I participated in *Stepping On*

Strongly agree Agree Neutral Disagree Strongly disagree

c) The *Stepping On* program made me more motivated to regain my independence compared to before I participated in *Stepping On*

Strongly agree Agree Neutral Disagree Strongly disagree



d) I feel more independent as a result of taking part in the *Stepping On* program

Strongly agree Agree Neutral Disagree Strongly disagree

e) I would recommend the *Stepping On* program to friends and family

Strongly agree Agree Neutral Disagree Strongly disagree

5. After completing the *Stepping On* program did you participate in a regular exercise program aimed at improving strength and balance and preventing falls? (select the response that applies)

Yes, I was already doing such a program before *Stepping On* and have continued at least once / week

I am doing a: home-based program group-based both

Program details _____

Yes, I commenced a new exercise program and am still taking part at least once / week

I am doing a: home-based program group-based both

Program details _____

Yes, but have now ceased participation

I was doing a: home-based program group based both

Program details _____

Why did you stop participating? _____

No, but intend to start a program soon

I will commence a: home-based program group based both

Program details _____

No, and do not intend to take part in a program in the future

No, I was doing such a program before *Stepping On* and have now stopped

Program details _____

If no, what barriers prevent you from doing so? _____



Is there anything that would motivate you to take up an exercise program in the future?

6. After completing the *Stepping On* program did you use any other strategies to reduce your risk of falling? Please tick all that apply:

- I had cataract surgery
- I use some safe walking strategies (e.g., heel-toe walking, scanning ahead as I walk, non-glare sunglasses for outdoors)
- I installed better lighting in my home
- I changed the environment at home to improve safety (such as non-slip strips on step edges, installed grab rails, , outdoor sensor lights, removed some of the clutter in walkways etc).
- I saw my GP or pharmacist to review my medications and discuss how to manage medications that may increase risk of falls
- I have started taking a Vitamin D supplement
- I have checked my shoes and slippers to make sure they fit well and the soles are not too slippery
- Other, please specify _____

7. Physical Activity (Incidental and Planned Exercise Questionnaire)

a) In the past three months, how much time did you spend in the following physical activities on average per week?

Never [] (please go to question b)

Activity type	Number of times/week	Number of minutes per session				
		<30	30-45	45+	1-2hrs	2-4hrs
Exercise class	_____	[]	[]	[]	[]	[]
Home activity (e.g. stationary bicycle, stretching)	_____	[]	[]	[]	[]	[]
Other activity 1 (please specify)	_____	[]	[]	[]	[]	[]
Other activity 2 (please specify)	_____	[]	[]	[]	[]	[]
Other activity 3 (please specify)	_____	[]	[]	[]	[]	[]

b) During the past three months, how often have you been on walks specifically for activity on average per week? (i.e. walking in the park, in the streets, cross-country walking, walking the dog etc).

- Every day []
- 3-6 times/week []
- Twice/week []
- Once/week []
- Less than once/week []
- Never (please go to question d) []



c) In these walks for activity, how long did you walk for?

- Less than 15mins/day []
- 15mins to less than 30mins/day []
- 30mins to less than 1 hour/day []
- 1 hour to less than 2 hours/day []
- 2 hours to less than 4 hours/day []
- 4 or more hours/day []

d) During the past three months, how often have you been on other walks (i.e. walk to general practitioner, pharmacy, or store) on average per week.

- Every day []
- 3-6 times/week []
- Twice/week []
- Once/week []
- Less than once/week []
- Never (please go to question f) []

e) In these other walks, how long did you walk for?

- Less than 15mins/day []
- 15mins to less than 30mins/day []
- 30mins to less than 1 hour/day []
- 1 hour to less than 2 hours/day []
- 2 hours to less than 4 hours/day []
- 4 or more hours/day []

f) In the past three months, in addition to the walking you mentioned above, how much time did you spend each day out of your house doing other physical activity such as house maintenance and gardening?
(Excluding housework and activities inside the house)

- Never (i.e. no garden) []
- Less than 15mins/day []
- 15mins to less than 30mins/day []
- 30mins to less than 60mins/day []
- 1 hour to less than 2 hours/day []
- 2 hours to less than 4 hours/day []
- 4 or more hours/ day []

g) In the past three months, how many hours did you spend on your feet each day indoors at home doing tasks like housework, self care or care for another person?

- Never (i.e. living in hostel, assisted living) []
- Less than 15mins/day []
- 15mins to less than 30mins/day []
- 30mins to less than 60mins/day []
- 1 hour to less than 2 hours/day []
- 2 hours to less than 4 hours/day []
- 4 or more hours/day []



8. The Falls Behavioural (FaB) Scale for the Older Person

The FaB scale is a list of 30 statements that describes things we do in our everyday lives. Please read each statement carefully. Circle how much each statement describes the things you do in your daily life. For example:

Never	Some- times	Often	Always
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Only circle 'Doesn't apply' if the situation is something to which you are not exposed to (for example, if you do not have a phone)

Would this describe the things you do in your daily life?	Circle which one applies				
1. When I stand up I pause to get my balance	Never	Some- times	Often	Always	
2. I do things at a slower pace	Never	Some- times	Often	Always	
3. I talk with someone I know about things I do that might help prevent a fall	Never	Some- times	Often	Always	
4. I bend over to reach something only if I have a firm handhold	Never	Some- times	Often	Always	Doesn't apply
5. I use a walking stick or walking aid when I need it	Never	Some- times	Often	Always	Doesn't apply
6. When I am feeling unwell I take particular care doing everyday things	Never	Some- times	Often	Always	Doesn't apply
7. I hurry when I do things	Never	Some- times	Often	Always	
8. I turn around quickly	Never	Some- times	Often	Always	
Now, these are things you do indoors					
9. To reach something up high I use the nearest chair, or whatever furniture is handy, to climb on	Never	Some- times	Often	Always	Doesn't apply
10. I hurry to answer the phone	Never	Some- times	Often	Always	Doesn't apply
11. I get help when I need to change a light bulb	Never	Some- times	Often	Always	
12. I get help when I need to reach something very high	Never	Some- times	Often	Always	
13. When I am feeling ill I take special care of how I get up from a chair and move around	Never	Some- times	Often	Always	Doesn't apply
14. When I am getting down from a ladder or step stool I think about the bottom rung/ step	Never	Some- times	Often	Always	Doesn't apply
Now, these are about lighting and eyesight					
15. I notice spills on the floor	Never	Some- times	Often	Always	
16. I use a light if I get up during the night	Never	Some- times	Often	Always	
17. I adjust the lighting at home to suit my eyesight	Never	Some- times	Often	Always	
18. I clean my spectacles	Never	Some- times	Often	Always	Doesn't apply
19. When wearing bifocals or trifocals I misjudge	Never	Some-	Often	Always	Doesn't



a step or do not see a change in floor level		times			apply
Now, these are about shoes					
20. When I buy shoes I check the soles to see if they are slippery	Never	Some-times	Often	Always	
Now, these are things outdoors					
21. When I walk outdoors I look ahead for potential hazards	Never	Some-times	Often	Always	
22. I avoid ramps and other slopes	Never	Some-times	Often	Always	
23. I go out on windy days	Never	Some-times	Often	Always	
24. When I go outdoors I think about how to move around carefully	Never	Some-times	Often	Always	
25. I cross at traffic lights or pedestrian crossings whenever possible	Never	Some-times	Often	Always	Doesn't apply
26. I hold onto a handrail when I climb stairs	Never	Some-times	Often	Always	Doesn't apply
27. I avoid walking about in crowded places	Never	Some-times	Often	Always	
28. I keep shrubbery and plants trimmed back on the pathways to my front/ back doors	Never	Some-times	Often	Always	Doesn't apply
29. I carry groceries up the stairs only in small amounts	Never	Some-times	Often	Always	Doesn't apply
And, finally, these are about medications					
30. I ask my pharmacist or Dr questions about side effects of my medications	Never	Some-times	Often	Always	Doesn't apply

Thank you for completing this questionnaire