Choosing the Correct Walker
Cameron R. Hernandez, MD, Mount Sinai School of Medicine
Rosa Collell-Olucha, PT, Director Rehabilitation Services Mount Sinai Queens

Assistive devices, such as walkers, are being used more often as the population ages. Walkers provide more stability than canes, which are discussed in another edition of Elder Care.

In general, walkers are given to patients to keep them stable when walking. If the correct type of walker is prescribed, and if patients are taught how to use the walker correctly, walkers can decrease the risk of falls and promote independence. However, if not adjusted to patient’s height or if used inappropriately, they can make falls more likely.

Thus, knowing when a walker is necessary and which type to prescribe is important to patient safety. This edition of Elder Care will discuss the three most commonly used walkers: the standard walker, the two-wheeled walker, and the four-wheeled walker.

Standard Walker
The standard walker is fitted with 4 rubber-tipped legs. Because it does not have wheels is the most stable type of walker (Figure 1). It is used for patients who need to bear a significant amount of weight on the device. Standard walkers are used in older patients who are very unstable with a cane, who have lower-extremity disease, or who do not have the ability to control a rolling walker. For maximum stability when using this device, the patient should place all four legs of the walker on the ground before taking a step forward.

Besides stability, another advantage of the standard walker is that it’s light weighted, and it is easy to fold and transport. The disadvantages of the standard walker are that 1) it truncates the patient’s walk, 2) it needs to be lifted with every step, 3) it makes the patient’s gate slow, and 4) patients can fall when lifting the walker. Often times patients stop using this type of walker because they get tired of picking it up with every step.

Two-Wheeled (Rolling) Walker
Rolling walkers have two front wheels and two back sliders (Figure 2). They are used for patients who have gait instability but do not need to bear a substantial amount of weight on the device.

A key advantage of rolling walkers over standard walkers is that they provide a more normal and dynamic walking pattern, as the walker is being pushed forward instead of

TIPS FOR CHOOSING THE CORRECT WALKER
- Recommend a standard walker for patients who have an unstable gait and need to bear a significant amount of weight on the walker.
- Recommend a two-wheeled (rolling) walker for patients who have an unstable gait but do not need to bear a substantial amount of weight on the walker.
- Recommend a four-wheeled (Rollator) walker for patients who need a walker only for balance but not for weight bearing.
- Be sure patients receive and understand instructions for how to use their walker, as improper use can lead to injury.
Continued from front page

lifed off the ground with each step. Furthermore, the wheel- and-slider combination makes it easy to maneuver on many different surfaces. And, just like the standard walker, they can be easily collapsed.

The disadvantages of a rolling walker relative to a standard walker are that 1) it is less stable, 2) it requires more cognition, and 3) the front wheels are fixed (i.e., do not rotate), which makes for a large turning arc. Because of the large turning arc, many patients will pick up the walker during the turning process, and creating the possibility of a fall. The correct way to turn with a rolling walker is multiple small turns until the patient and the device are facing in the new direction.

**Four-Wheeled Walker (Rollator)**

The Rollator has four wheels: 2 fixed in the back and 2 fully rotating front wheels. Rollators also have brakes, a seat, and often a basket (Figure 3). It is used for patients to enhance balance but not for weight-bearing. It is easier to propel and less restrictive on normal gait pattern than a two-wheeled walker. It is also easier to maneuver around turns and does not need to be lifted when turning. The seat is helpful for people who fatigue easily or with diseases that require frequent resting (e.g., heart failure or COPD). The basket allows carrying items hands-free.

![Figure 3. Four-Wheeled Walker (Rollator)](image)

Most of these advantages can be disadvantages, too. Easy to propel means that the Rollator can roll away from a patient. Easy to maneuver means that the patient needs to have good core strength to keep from falling.

Patients should not rely on the breaks to stop the walker, therefore patients require good coordination and cognition. The breaks should be engaged when patients are about to rest and sit down on the rollator. To prevent falls, the rollator should be positioned against a sturdy surface like a wall, apply the permanent brakes, and then sit down. Patients should never be transported on the seat of the rollator as this is a setup for a serious fall and possible head injury.

Although rollators do fold, they are heavier and not as compact as the other walkers. There is, however, a 3-wheel rollator that is lighter, foldable and more compact. This 3-wheel-rollator does not have a seat, therefore is not an option for patients that use this device outdoors and fatigue easily.

**Final Comments**

Walkers can decrease falls and increase independence for patients when prescribed and used appropriately. Walkers are more stable than canes because they provide more support, especially for patients with lower extremity disease. When assessing the need for a walker, it is important to take into account the various features available, as specified in the table below.

Also note that assistive device maintenance is as important as prescribing the correct device. Checking the condition of the rubber tips, sliders, brakes and screws on walkers should be part of every visit with the patient.

### References and Resources


---

### Interprofessional care improves the outcomes of older adults with complex health problems.

Editors: Mindy Foin, MD; Jane Mohler, NP-c, MPH, PhD; and Barry D. Weiss, MD

Interprofessional Associate Editors: Tracy Carroll, PT, CHT; MPH; David Coon, PhD; Marilyn Gilbert, MS, CHES; Jeannie Lee, PharmD, BCPS; Linea Nagel, PA-C, MPAS, Marisa Mendola, PhD; Francisco Moreno, MD; Lisa O’Neill, DBH, MPH; Floribella Redondo; Laura Vitkus, BA

The University of Arizona, PO Box 245069, Tucson, AZ 85724-5069 | (520) 626-5800 | [http://aging.arizona.edu](http://aging.arizona.edu)

Supported by: Donald W. Reynolds Foundation, Arizona Geriatrics Workforce Enhancement Program and the University of Arizona Center on Aging

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1QHP28721, Arizona Geriatrics Workforce Enhancement Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.