Clinical assessment / management plans never replace clinical judgement.

Care outlined in this assessment / management plan must be altered if it is not clinically appropriate for the individual client.

This assessment / management plan is to be used for adults in conjunction with Health Behaviours ONI Profile.

Clinical staff need to complete this form at the time of the initial assessment, or when a change in condition/medication occurs.

Screening: The patient has fallen in the last 6 months?

- [ ] Yes  ➜  • Continue with Falls Assessment and Management Plan
  • Refer to physiotherapist to complete gait and balance assessment

- [ ] No  ➜  • Continue with Falls Assessment and Management Plan

Risk factors

- The client requires supervision or assistance for transfer or personal ADL
  Conduct environmental assessment
  Provide education by clinician
  Complete ADL assessment if appropriate

- Pre-existing neurological disorder that affects balance (e.g., Parkinson’s, stroke) and/or uses a mobility aid
  The client should have a gait and balance assessment with a physiotherapist if aid is non-prescribed or has not reviewed in past 12 months.
  Review client footwear and / or foot problems.

- New onset or existing incontinence
  Refer new onset incontinence for investigation. The client should have a continence assessment and be provided with education by clinician.

- The client is on medications for any of the following: blood pressure, sleeping, to treat depression, to treat mental health conditions
  The client is on high risk medications. Encourage regular three monthly review of medications with GP.

- The client is on more than 4 medications
  Encourage regular three monthly review of medications with GP to attempt medication simplification.

- The client is visually impaired
  Conduct or refer for visual assessment.
  Conduct or refer for environmental audit, consider lighting and contrast taping.

- The client reports postural symptoms (e.g., regular dizziness, light headedness)
  The client should have postural blood pressure checked and be provided with education by clinician.

- History of syncope (loss of consciousness)
  Liaise with GP for evaluation of cardiac cause of syncope.

- The client is usually confused
  Conduct or refer for cognitive assessment. Liaise with GP for further investigation of treatable causes of dementia.
  Refer to OT for home hazard assessment as indicated

- There is a history of new onset confusion in this client
  Conduct or refer for cognitive assessment. Liaise with GP for further investigation of treatable causes of confusion and delirium.

- The client has a minimal trauma fracture (any fracture sustained in a fall from standing height or without trauma)
  Refer client for assessment for causes of osteoporosis. Treatment option for osteoporosis include regular Vit D and Calcium in addition to a bisphosphonate or strontium or raloxifene.

- No risks identified. Continue with planned care. Following assessment, inform client of outcome with an explanation of the planned strategies.

Assessment completed by:

Name: ____________________________  Designation: ____________________________  Signature: ____________________________  Date: ____________________________

(Affix patient identification label here)