In-home safety assessment

One of the benefits of Priority Health Medicare Advantage plans is an in-home safety assessment. Following is a sample form with minimum requirements for the assessment.

A critical element to the success of this initiative is relaying your findings to Priority Health to ensure the care team is able to follow up on the recommendations and care needs. When complete, please fax the "In-home safety assessment summary" at the end of this form to the Priority Health Healthcare Coordinator within Care Management at 616.942.0024.

Home entrance:

- ☐ Lack of handrails
- ☐ Poor outdoor lighting
- ☐ Unsafe/broken steps
- ☐ Raised threshold
- ☐ Lack of ramp
- ☐ Uneven/Cracked pavement
- ☐ Environmental issues
- ☐ Other:_____

Living room:

- ☐ Soft, low chair
- ☐ Swivel/rocking chair
- ☐ Obstructing furniture
- ☐ Extension cords in walking path
- ☐ Accessing light switches
- ☐ Poor lighting
- ☐ Throw rugs
- ☐ Clutter
- ☐ Other:_____

Kitchen:

- ☐ Unsafe appliances
- ☐ Inability to access items
- ☐ Difficulty carrying items
- ☐ Poor lighting
- ☐ Throw rugs
- ☐ Clutter/space
- ☐ Other:_____

Bathroom:

- ☐ Difficulty getting on/off toilet
- ☐ Difficulty getting in/out of tub
- ☐ Grab bars not present
- ☐ Tub door instead of curtain
- ☐ Slippery or wet floors
- ☐ Inaccessible tub/shower
- ☐ Lack of non-skid floor/mat in tub
- ☐ Doorway too narrow
- ☐ Poor lighting
- ☐ Clutter
- ☐ Throw rugs
- ☐ Lack of adaptive equipment
- ☐ Other:_____

Bedroom:

- ☐ Rolling beds
- ☐ Bed too low/high
- ☐ Difficulty managing bed linens or trip hazard
- ☐ Poor lighting
- ☐ Throw rugs
- ☐ Thick rug edge/threshold
- ☐ No clear path to bathroom (or no bedside commode, if needed)
- ☐ Difficulty getting in/out of bed
- ☐ No telephone by bed
- ☐ No night light
- ☐ Clutter
- ☐ Other:_____

In-home safety assessment
Patient name:_____ Patient DOB:_____

Stairs:
- ☐ Cannot negotiate
- ☐ No handrails
- ☐ Loose rugs
- ☐ Difficult to see
- ☐ Unable to use walker on stairs
- ☐ Steps to steep
- ☐ Poor lighting
- ☐ Clutter
- ☐ Other:_____

Home management:
- ☐ Inaccessible laundry area
- ☐ Difficulty getting mail
- ☐ Difficulty with meal prep
- ☐ Difficulty with light housework/cleaning
- ☐ Difficulty accessing dishwasher
- ☐ Unable to take out trash
- ☐ Insects/Rodents
- ☐ Other:_____

Medication management:
- ☐ Has outdated medications
- ☐ Medication list doesn't match medications in home
- ☐ Difficulty reading label
- ☐ Difficulty opening bottles
- ☐ Difficulty obtaining medications ordered by physician
- ☐ Difficulty understanding when/how to take medications
- ☐ Difficulty remembering when to take medications
- ☐ Difficulty using medication dispensing devices
- ☐ Difficulty seeing medications in bottle or dropped on floor
- ☐ Other:_____

Telephone:
- ☐ Difficult to reach
- ☐ Difficulty hearing ring
- ☐ Difficulty holding receiver
- ☐ Difficulty dialing numbers
- ☐ Does not know emergency numbers
- ☐ Unable to answer the phone
- ☐ Unable to make a call
- ☐ Other:_____

Other safety:
- ☐ Difficulty locking doors
- ☐ Difficulty opening/closing windows and shades
- ☐ Lack of smoke detectors
- ☐ Can't hear alarms, smoke detectors, phone ringing or doorbell
- ☐ Access to emergency exit
- ☐ Poor lighting
- ☐ Emergency numbers not posted
- ☐ Does not have appropriate footwear
- ☐ Unsafe oxygen use
- ☐ Unsafe smoking
- ☐ Cognitive issues noted putting patient at risk for safety issues
- ☐ Lack of outside support
- ☐ Other:_____

In-home safety assessment
Patient name:_____ Patient DOB:_____

Fall assessment (standard MAHC):

_____

_____

_____

_____

In-home safety assessment summary

Agency:_____

Date of assessment:_____ Evaluator:_____PT/OT/RN_____

Patient name:_____ Patient DOB:_____

When completed, please fax form to Priority Health Healthcare Coordinator within Care Management at 616.942.0024.

For questions, please contact 800.998.1037, ext. 68911 or 616.464.8818, ext. 68911.

☐ **No safety problem noted**

Safety recommendations as follows:

1._____

2._____

3._____

Durable Medical Equipment (DME) recommendations:

☐ 3-in-1 commode ☐ Grab bar ☐ Tub seat ☐ Tub transfer bench

Fall assessment:

_____

_____

_____

Consider:

☐ Skilled homecare for SN PT OT SP MSW
☐ Private duty care
☐ Telemonitoring
☐ Supplemental medication reconciliation RN home visit
☐ Referral for Comprehensive Mediation Review (CMR)
☐ Personal emergency response system
☐ Referral to social or behavioral health due to:_____
☐ Referral to additional resources including:_____
✓ **Adding Priority Health/PCP Outpatient Care Manager**

Other comments:

Clinician Signature

Date