

# HOME ENVIRONMENT SAFETY EVALUATION

**Check Yes, No or N/A (Not Applicable) for each of the following items. For all "No" responses identify, in the space provided, item number, action plan to correct the problem and document the date the patient was instructed.**

		YES	NO	N/A
1.	There is a working telephone and emergency numbers are accessible.			
2.	Electrical cords and outlets appear to be in good repair in the patient area (i.e., cords not frayed, outlets not overloaded, etc.).			
3.	There are functional smoke alarm(s).			
4.	Fire extinguisher is available and accessible.			
5.	Access to outside exits is free of obstruction.			
6.	Alternate exits are accessible in case of fire.			
7.	Walking pathways are level, uncluttered and have non-skid surfaces.			
8.	Stairs are in good repair, well lit, uncluttered and have non-skid surfaces. Handrails are present and secure.			
9.	Lighting is adequate for safe ambulation and ADL.			
10.	Temperature and ventilation are adequate.			
11.	Medicines and poisonous/toxic substances are clearly labeled and placed where patient can reach, if needed, yet not within reach of children.			
12.	Bathroom is safe for the provision of care (i.e., raised toilet seat, tub seat, grab bar, non-skid surface in tub, etc.).			
13.	Kitchen is safe for the provision of care (i.e., working appliances, hygienic area for food prep, etc.).			
14.	Environment is safe for effective oxygen use.			
15.	Overall environment is adequately sanitary for the provision of care.			
16.	Other			

**FOR ALL ITEMS CHECKED "NO" ABOVE, SPECIFY ACTION PLAN AND DOCUMENT DATE PATIENT WAS INSTRUCTED**

ITEM NO.	DATE INSTRUCTED	TEACHING MATERIALS PROVIDED	MATERIALS REVIEWED	ACTION PLAN

**CHECK ANY OF THE FOLLOWING THAT NEED TO BE OBTAINED**

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Raised toilet seat      | <input type="checkbox"/> Plug covers     | <input type="checkbox"/> Wheelchair             | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tub seat                | <input type="checkbox"/> Cabinet latches | <input type="checkbox"/> Lifeline or other PERS | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Grab bar                | <input type="checkbox"/> Window locks    | <input type="checkbox"/> Car seat               | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Non-skid surface (bath) | <input type="checkbox"/> Ipecac syrup    | <input type="checkbox"/> Seat/bed cushion       | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Infant tub              | <input type="checkbox"/> Smoke alarm     | <input type="checkbox"/> First aid kit          | <input type="checkbox"/> Other _____ |

Emergency preparedness plan discussed with/provided to patient?  Yes  No, explain: \_\_\_\_\_

SIGNATURE OF PERSON COMPLETING EVALUATION \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

CARE MANAGER SIGNATURE/TITLE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**PART 1 – Clinical Record      PART 2 – Patient**

PATIENT NAME - Last, First, Middle Initial	ID#
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