Client's Name: _____

CHECKLIST & ACTION PLAN©

Yukon First Nations Version

Interior Health

BC INJURY research and prevention unit

January 2009

Table Of Contents

INSTRUCTIONS

Suggestions for you (**client and/or family member**) on how to complete this *Checklist & Action Plan:*

This ***Checklist and Action Plan*** is to help you stay healthy, independent and safe in your own home. You identify risks, and choose actions to decrease those risks.

You can complete it on your own, or with help from a family member or your Home and Community Care Coordinator or Home Support Worker (HCCC or HSW). When your HCCC OR HCW visits, you can chat about one or two questions. That way, you are still getting help with your care and working on keeping safe and healthy at the same time.

Your family members or HCCC OR HCWs or Home Health Professionals (case manager, nurse or therapist) can be your coach.

- Use a pencil so you can revise/update easily
- Try to choose one section at a time. Try to complete that section before doing another one.
- For each question, answer YES or NO.
  - ✓ If your answer is **YES:**
    - You do not identify a risk
    - No action is needed at this time
    - Put a date in that box

- If your answer is **NO**:
  - You are identifying a health risk
  - An **ACTION** is recommended
  - Read the suggested actions
  - Decide on a plan of **Action** (this does not need to be one of the suggested actions – it can be another of your choosing):

    ☑ Check "**None**" when you do not have a plan yet or are unable to do anything about the identified risk

    ☑ Check **Planned**" when you have made your Action plan

    ☑ Check "**Completed**" when you have completed the action you chose. Congratulations! You have decreased that risk

    ☑ When you are working on your Action plan, or it is an action you need to keep on doing, like eating fruits and vegetables each day, or doing regular physical activity, check "**Ongoing**"

Suggestions for **Community Health Workers** or **Home Health Professionals** on how to assist your client with the completion of this *Checklist and Action Plan:*

The role of the HCCC OR HCW or HHP is that of a coach. This Checklist is about your client identifying their risks and deciding what they want to do about it. Your role is to be supportive of their decisions by giving information about resources or where they can get help if needed; and to be their cheerleader when they make plans and take action.

To promote the use of this tool, you are asked to sign and date each section once it is completed by your client. Once all the questions in a section are answered, write your first name and date at the end of each section. A section is considered complete when all the questions have either a "Yes" or "No" response and one of the 'Action' boxes have been checked.

- Discuss the *Checklist and Action Plan* with your client.
    - Ask your client to choose the section they will start with.
    - Go with the client to the area of their home that is being discussed so that you can consider potential risks together.
    - Pay attention to those areas where the client spends most of their time. Ask them to show you how they get in and out of their bed and their favorite chair, and how they reach for objects in their bedroom, kitchen or bathroom. Use this information to help them identify priority risk areas.
    - Over time, coach your client to read and answer all the sections. Assist as needed.

- Support and encourage the client to follow through with planned actions

- Remember the final decision about what, if any actions to take and when, is for your client to make

- Refer any actions that are beyond your role to the Home Health Professional

- Review the Checklist with your client, on a regular basis

- Reaffirm their "yes" responses. If they have selected "yes" ensure date is entered, as their situation may change over time. These questions should be reviewed every few months to see if the client's status has changed and a risk is present that wasn't before.

- Regularly review the status of their "Planned" and "Ongoing" Actions

- Coach the client to update their Checklist and Action Plan

BEDROOM

1. Can you get in and out of bed easily on your own?	
☐ **Yes**: No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** ○ Consider getting a bed assist rail and/or raising the bed, or replacing your mattress ○ Contact your home health professional for more information or for a referral to a community occupational therapist **Action:** ☐ Completed ☐ Planned ☐ None
2. Do you have a phone beside your bed?	
☐ **Yes**: No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Plug in another phone next to your bed or keep a portable phone beside your bed. O If you have access to Line of Life services, always wear your personal alarm system so you can call for help from your bed if needed. **Action:** ☐ Completed ☐ Planned ☐ None
3. Can you turn on a light before you get out of bed?	
☐ **Yes**: No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Use a bedside lamp or 'touch light' that you can reach easily. O Install a motion sensor nightlight in the bedroom that will automatically turn on when you get up. O Get a reliable, lightweight flashlight with an easy to use on/off switch and put it at the side of your bed in case of power failure. Have spare batteries in your bedside drawer. **Action:** ☐ Completed ☐ Planned ☐ None

4. Does your bedspread or top blanket always stay on your bed without hanging down onto the floor?	
☐ **Yes**: No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Make sure your bedspread does not hang down on the floor or remove it at night so that it does not create a tripping hazard. O Make sure your bedding allows you to get in and out of bed easily without getting tangled up **Action:** ☐ Completed ☐ Planned ☐ None
5. Do you sleep through the night without getting up to go to the bathroom?	
☐ **Yes**: No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O If you get up frequently (3 or more times each night), tell your doctor. Consider using a urinal or commode beside your bed. Consider not drinking anything after dinner. O Ask your doctor for a referral to a specialist (e.g. nurse continence advisor, urologist, physiotherapist) **Action:** ☐ Completed ☐ Planned ☐ None
	Is your bathroom on the same level as your bedroom? - If not, then make sure that there is good lighting between the bed and bathroom, the stairs have handrails on both sides, the stair edges have a contrasting colour. Get help going to the bathroom from others living with you. Have a monitor to let others know that you are getting out of bed.

	Do you have a clear path between your bed and bathroom? = make sure that floor and stair surfaces are uncluttered and have non-slip surfaces

First name of CHW or HHP who reviewed this section: _____
Date (1st reviewed): _____ Date (2nd reviewed): _____

LIVING ROOM & SITTING AREA

1. Can you get in and out of your favorite chair or sofa easily on your own?	
☐ **Yes**: No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Raise the height of the chair or sofa to knee level or higher. Make sure it is stable. O Consider buying a new chair with firm seating, solid armrests and fits your body size. O Avoid swivel and rocking chairs that do not lock. O Consider an electric lift chair O Contact your home health professional for more information or for a referral to a community occupational therapist for help in finding the most appropriate solution for you. **Action:** ☐ Completed ☐ Planned ☐ None
2. Are your walking areas clear of furniture and tripping hazards?	
☐ **Yes**: No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Electrical cords can be fastened to the floor along the base of the wall with clips or tape to keep them off the walking path. O Remove tripping or slipping hazards that clutter your walking pathways (e.g. newspaper/magazine holders, waste basket) **Action:** ☐ Completed ☐ Planned ☐ None

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Use of proper equipment or mobility aid decreases fall risk. Some examples of equipment to consider using:

- hand rails along walk-ways and hallways
- rest areas with stable, supportive chairs with armrests
- grab bars in the shower or tub, and on the wall
- personal alert devices
- prescribed walker, cane, wheelchair
- bed rails to assist with getting out of bed
- adapted toilet seat
- bath stool or bench
- hand-held shower
- permanent slip-resistant strips for shower, tub or floor
- hip protectors

BATHROOM

1. Can you move around in the bathroom easily without holding onto towel rails, taps, the toilet roll holder, shower screens, walls or doors?	
☐ **Yes**: No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** ○ Contact your home health professional for more information or for a referral to a community occupational therapist for help in finding the most appropriate solution for you. **Action:** ☐ Completed ☐ Planned ☐ None
2. Are you able to get in and out of the tub or shower easily on your own?	
☐ **Yes**: No new action needed at this time *Date*: _____	☐ **No**, then ☐ Do you have help to shower? If no, then **Suggested Action:** O Contact your home health professional for a referral to a community occupational therapist or to discuss your bathing needs further **Action:** ☐ Completed ☐ Planned ☐ None

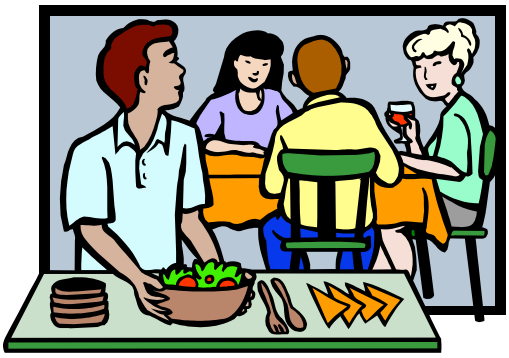
3. Can you get on and off the toilet easily on your own?	
☐ **Yes**: No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Get a raised toilet seat or high toilet O Contact your home health professional for more information or for assistance in finding the most appropriate solutions for you. **Action:** ☐ Completed ☐ Planned ☐ None
4. Do you have slip-resistant strips or non-slip surface on the bottom of your shower or tub?	
☐ **Yes**: No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Install slip-resistant strips or apply a slip resistant finish to the bottom of the shower or tub, or get a non slip rubber mat O If you use a non-slip mat, make sure it is securely attached to the tub/shower floor before stepping on it and make sure both sides are cleaned well after each use, and hung to dry. O Replace the non-slip rubber mat regularly before it starts to get worn and lose its grip. ***Note:*** Rubber mats can become slip hazards if not securely attached to the tub/shower floor. **Action:** ☐ Completed ☐ Planned ☐ None

5. Do all the mats or throw rugs on your bathroom floor stay securely in place if you step on them and push with your foot?	
☐ **Yes**, then: No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** o Use mats with non-slip backing to prevent them from moving around on the floor. ***Note***: It is best to remove all loose mats or hang them up at all times other than when showering **Action:** ☐ Completed ☐ Planned ☐ None
6. Do you avoid using bath oils or talcum powder in your bathroom?	
☐ **Yes**, then: No new action needed at this time *Date*: _____	☐ If **No**, then: **Suggested Action:** o Best to not use these products o If you must use talcum powder, use it over a carpeted surface and then shake carpet out **Action:** ☐ Completed ☐ Planned ☐ None

First name of CHW or HHP who reviewed this section: _____
Date (1st reviewed): _____ Date (2nd reviewed): _____

Slippery or uneven surfaces are fall hazards. Some examples are:

- Liquid on the floor,
- Shiny floors
- Bath oil in the tub or shower,
- Ice or snow outside

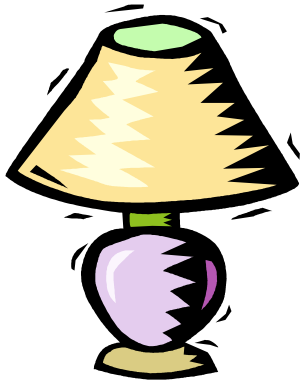


DINING AREA & KITCHEN

1. Can you sit down or stand up from your chair at the table or walk to your table without any difficulty?	
☐ **Yes,** or ☐ Not applicable No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Avoid using a chair with wheels O Try a chair which slides fairly easily, but not too easy O If you eat with others, after your meal, remain sitting until there is a clear open path from your table O If you use a walker or a cane or a wheelchair, make sure it is ready beside you before leaving the table. Take extra care. O Contact your home health professional for more information or for help in finding the most appropriate solution for you. **Action:** ☐ Completed ☐ Planned ☐ None
2. Can you easily reach kitchen items you use frequently without having to lift your arms above your shoulders or below your knees?	
☐ **Yes,** or ☐ Not applicable No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Move kitchen items you use frequently to a more convenient location so that you do not have to climb on something or bend or reach for them. O Consider installing shelves that slide out of the cupboard O Have someone else do the kitchen work **Action:** ☐ Completed ☐ Planned ☐ None

3. Is there a counter area next to the stove or oven that you can safely move hot dishes onto without turning or taking more than one step?	
☐ **Yes,** or ☐ Not applicable No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Arrange your kitchen so that you can move hot items from the stove without turning or taking a step. O Have your oven mitts are well insulated and are within easy reach. O Have someone else do the kitchen work **Action:** ☐ Completed ☐ Planned ☐ None
4. Are spills cleaned up as soon as they happen?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Keep a long-handled mop in the kitchen to wipe up small spills as soon as they happen. ***Note***: Do not bend over to clean up spills as this may increase your risk of falling. O If it is hard for you to clean up a spill yourself, ask someone else to clean up the spills as quickly as possible O In the meantime, try to avoid that area of your home **Action:** ☐ Completed ☐ Planned ☐ None

First name of CHW or HHP who reviewed this section: _____
Date (1st reviewed): _____ Date (2nd reviewed): _____



LIGHTING

1. Do you have lights and lamps that are bright enough for you to see clearly?	
☐ **Yes** No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** o Install 75-100 watt bulbs or use fluorescent lights, unless the light manufacturer recommends otherwise. o Halogen bulbs also give off good light, but can become hot when on for a long time. **Action:** ☐ Completed ☐ Planned ☐ None
2. Are all your lights working and have all old bulbs been replaced?	
☐ **Yes** No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** o Have all broken lights repaired or replaced. Get help to replace all burned out light bulbs. **Action:** ☐ Completed ☐ Planned ☐ None

First name of CHW or HHP who reviewed this section: _____
Date (1st reviewed): _____ Date (2nd reviewed): _____

Some examples of recommended physical activities include:

- Balance training, e.g., Tai Chi
- Strength training – using weights or resistance like thera-band
- Do exercises while standing at the kitchen sink
- Walking
- Water fitness
- Dancing

CLOTHING & FOOTWEAR

1. Are all the shoes and slippers that you wear in good repair and do they fit comfortably and securely on your feet when you walk?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Repair or replace poorly fitting shoes and slippers O Avoid all flip-flops and open heeled slippers or shoes O If your feet swell, shoes with Velcro straps or elastic laces are advised, so they can be adjusted for the swelling O Talk to your doctor about the swelling as it can affect your balance O Contact your home health professional for more information or help in finding the most appropriate solution for you. **Action:** ☐ Completed ☐ Planned ☐ None
2. Do you carry a small, lightweight purse that fits over your shoulder or around your waist?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Use a small lightweight handbag with an over-the-shoulder strap or use a fanny pack instead of a purse. O Put your purse in the basket of a four wheeled walker ***Note***: Heavy handbags and ones with short straps can make you loose your balance if you trip and leave you without a free hand for support. **Action:** ☐ Completed ☐ Planned ☐ None

3. Do you sit when dressing or putting on your shoes?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Place a sturdy chair to use where you dress or put on shoes. **Action:** ☐ Completed ☐ Planned ☐ None
4. Do you wear clothes (including night wear, pants, skirts, dresses, dressing gowns) that fit properly with no dangling cords or long hems that make walking difficult?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Alter clothing so that it is not a tripping hazard O Avoid walking on stairs in any clothing that be a tripping hazard (e.g. night wear, coats, skirts, dresses) **Action:** ☐ Completed ☐ Planned ☐ None
5. Do you always wear sturdy street shoes rather than slippers or sandals when you are outside – even for short outings?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Have your walking shoes under a chair that is near the door so that your shoes are handy and you can sit while putting them on. **Action:** ☐ Completed ☐ Planned ☐ None

First name of CHW or HHP who reviewed this section: _____
Date (1st reviewed): _____ Date (2nd reviewed): _____

PERSONAL SAFETY & EQUIPMENT

1. Can you walk around your home without holding onto furniture or leaning on counters or walls?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** o Consider using a walker or a cane. Contact your home health professional for more information or assistance. o Consider hand rails along the wall. Contact your home health professional for more information or assistance. o Contact your home health professional for a referral to a community physical or occupational therapist for help in finding the most appropriate solution for you. **Action:** ☐ Completed ☐ Planned ☐ None
2. Do you avoid carrying large or bulky items?	
☐ **Yes** No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** o Ask for help when carrying items. o Use a walker with a large basket or a grocery cart o If you must carry items up and down stairs, carry them in a bag with a handle that goes over your arm so that both hands are free, or carry small loads close to your body with one hand while using the handrail with the other hand. **Action:** ☐ Completed ☐ Planned ☐ None

3. If you use a mobility aid like a wheelchair, cane or walker, do you feel safe and steady using it?	
☐ **Yes**, or, ☐ No mobility aid No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** o Contact your home health professional for more information or assistance in finding the most appropriate solution for you. **Action:** ☐ Completed ☐ Planned ☐ None
4. Do you regularly check that your assistive aids are in good repair? (e.g. walking aides, wheelchair, "reacher", bath equipment)	
☐ **Yes**, or, ☐ No assistive aides No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** o Look over all your assistive aids such as a bath stool, walker raised toilet seat or cane. Check to make sure your walker or wheelchair brakes are in working order. o Contact a local medical equipment dealer to have any broken or worn assistive aids repaired or replaced. **Action:** ☐ Completed ☐ Planned ☐ None
5. Do you always wear your personal alert system and use it when needed?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** o Discuss with your CHW or HHP reasons that you have difficulty wearing and/or using the personal alert system. o Remember that it is there to call for help if you should fall and are injured or cannot get up. **Action:** ☐ Completed ☐ Planned ☐ None

First name of CHW or HHP who reviewed this section: _____
Date (1st reviewed): _____ Date (2nd reviewed): _____

PHYSICAL & SOCIAL ACTIVITY

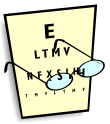
1. Do you do a minimum of 30 minutes of physical activity every day?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Walking is really good. Try to go for a walk each day. It will help maintain muscle strength, improve balance and ensure bones remain strong. O Increase physical activity gradually by doing extra walking, extra "sit to stands" or anything to keep your body moving, like tapping your toes every time a commercial comes on TV O Talk to your CHW or Home health professional about other ways to exercise, such as the SAIL home activity program. O Participate in a group activity program. Stretch and strength exercises, tai chi, osteofit, dance and aqua fit classes are offered in some senior's buildings and through various community programs. O Contact your home health professional for more information or assistance in finding helpful activities for you. **Action:** ☐ Ongoing ☐ Planned ☐ None

2. Do you participate in regular social programs?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action**: O Keep in frequent contact with people who know you and care about you, e.g., phone calls, face to face visits, letters or email O Participate in group activities like games, hobbies or interest groups O Consider joining a social group (e.g., local seniors' center, church or other organization of interest). O Contact your home health professional for more information or assistance in finding helpful activities for you. ***Note***: It is important to keep your mind active as well as your body. **Action:** ☐ Ongoing ☐ Planned ☐ None

First name of CHW or HHP who reviewed this section: _____
Date (1st reviewed): _____ Date (2nd reviewed):_____

HEALTH MANAGEMENT

1. Have you discussed all your medications (over the counter, herbal and prescription) with your doctor or pharmacist in the last 12 months?	
☐ **Yes**, OR ☐ Not taking any medication No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Meet with your doctor or pharmacist to review all your medications (over the counter, herbal and prescription, including any puffers). Ask whether any of your medications may impact on your risk for falling. O Make sure that you know what medications you are taking and when, and how to take them. TAKE THEM as prescribed. ***Note*:** It is a good idea to put all the medications you take in a bag to bring with you when you meet with your doctor or pharmacist. **Action:** ☐ Completed ☐ Planned ☐ None
2. Can you walk around your building or grounds without becoming short of breath or weak in the legs?	
☐ If **Yes**, then**:** No new action necessary at this time *Date*: _____	☐ If **No**, then: **Suggested Action:** O Get a wheeled walker with a seat to sit on. O Make sure your doctor is aware you become short of breath or weak in the legs. O Gradually increase your physical activity O Contact your home health professional for more information or assistance in finding the most appropriate solutions for you. **Action:** ☐ Completed ☐ Planned ☐ None

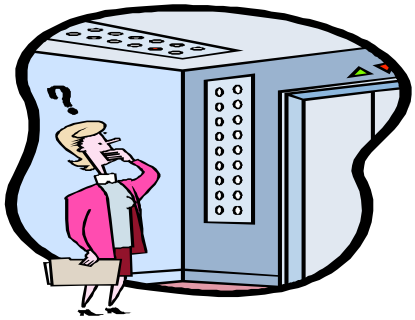
3. Have your eyes and vision been checked this past year?	
☐ **Yes** and I have followed what was needed to do (e.g. new glasses) No new action needed at this time *Date*: _____	☐ **No**, then:  **Suggested Action**: O If your vision is worsening, or if your glasses do not help you see well, have your vision tested by your optometrist, or ophthalmologist. ***Note:*** Donate old glasses that are no longer appropriate for you to CNIB or another non profit organization. **Action:** ☐ Completed ☐ Planned ☐ None
4. Are you able to stand or sit up without getting dizzy or light-headed?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action**: O Talk to your doctor or nurse and ask for your blood pressure to be taken when you are lying, sitting and standing. O Always take your time when getting up from the bed or chair **Action:** ☐ Completed ☐ Planned ☐ None
5. Are you satisfied with your ability to get to the toilet in time so that you are not incontinent?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action**: O Talk to your doctor or nurse about ways to better manage your incontinence (e.g. referral to continence specialist) O Use appropriate incontinence products O Wear clothing that is easy to get down and pull up **Action:** ☐ Completed ☐ Planned ☐ None

6. If you have had a fall in the past year, have you discussed how to prevent future falls with your doctor and/or a health care professional?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action**: O Discuss your most recent fall with your doctor and/or health care professional. Ask what you can do to prevent future falls **Action:** ☐ Completed ☐ Planned ☐ None
7. Do you drink 4 or more glasses of non-caffeinated fluids each day?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action**: O Drink four or more glasses of fluids each day that do not contain caffeine, such as water, juice or de-caffeinated beverages. Fluids that are high in caffeine include most coffees, teas, chocolate and soft drinks. **Action:** ☐ Ongoing ☐ Planned ☐ None
8. Do you eat at least 7 servings of fruits or vegetables each day?	
☐ **Yes** No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action**: O Eat a well balanced diet every day that includes grain products, fruits, vegetables and adequate protein O Ask your HHP for a referral to a dietitian if you are concerned about your weight O Phone Dial a Dietician at 1-800-667-3438 **Action:** ☐ Ongoing ☐ Planned ☐ None 

First name of CHW or HHP who reviewed this section: _____
Date (1st reviewed): _____ Date (2nd reviewed):_____

If you had a fall, here are a number of things you can do:

- Don't panic
- Don't try to get up until you are sure that you are not injured
- If you feel pain, stay on the floor or ground and call for help. If you are alone at home, try to crawl to the telephone to call for help. If you have a personal alarm system, use it to get help.
- If you feel weak or unsteady but are not injured, crawl to a sturdy chair and use this as support to get into a sitting position. Sit for a while before trying to stand.
- If you have severe pain, are unable to use a limb, or feel faint when your try to stand, call 911 for emergency services. Don't try to stand, but keep warm by moving away from a draft or cold area and wrap a near by blanket or coat around you.



STAIRS & ELEVATORS

☐ **Check here if you don't use stairs or an elevator regularly. Go to the next section**

1. If you use stairs, can you see the edges of the steps clearly?	
☐ **Yes,** or ☐ Not applicable No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Increase the lighting over the stairs. O Consider painting each step edge or adding a contrast edging to make each step more visible. O Have your vision retested. **Action:** ☐ Completed ☐ Planned ☐ None
2. Do your stairs have sturdy, easy to grip handrails on both sides?	
☐ **Yes,** or ☐ Not applicable No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Install sturdy, well-made handrails on both sides of stairways with grips that you can wrap your hands around easily. O Contact your home health professional for more information or assistance. This information can include a handout from Canadian Mortgage and Housing called: "*About Your House: Preventing Falls on Stairs*", and information about funding for low income seniors for home renovations. **Action:** ☐ Completed ☐ Planned ☐ None

3. Do you have non-slip surfaces in good condition on indoor and outdoor stairs?	
☐ **Yes,** or ☐ Not applicable No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O If you use smooth plastic to protect carpets on stairs, remove it. Replace or repair damaged surfaces on steps. **Action:** ☐ Completed ☐ Planned ☐ None
4. Do you always feel safe and steady on your feet when using the elevator?	
☐ **Yes**, or ☐ Not applicable No new action needed at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Look to make sure the elevator is level with the floor before entering or exiting. O Take your time when entering or exiting. O Use your mobility aide on the elevator and hold on to the handrail when the elevator is moving. O Be aware about safety concerns like jarring movements or doors that don't stay open long enough for safe entering or existing O Avoid using the elevator at busy times. Wait for another elevator if it is overcrowded. O Read the instructions on the wall about what to do if the elevator does not work. **Action:** ☐ Completed ☐ Planned ☐ None

First name of CHW or HHP who reviewed this section: _____
Date (1st reviewed): _____ Date (2nd reviewed): _____

OUTSIDE OF HOME

1. Does someone keep the paths around your home level and, in good repair and do they keep any overhanging shrubs or grass trimmed back?	
☐ **Yes:** No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** o Ensure paths are maintained and clear. Identify who will provide this service. If you live in an apartment, speak with the apartment manager. **Action:** ☐ Completed ☐ Planned ☐ None
2. Do all the outside paths drain water away properly so the paths do not collect rain or sprinkler water during the warmer months, or ice in the winter?	
☐ **Yes:** No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** o Have someone mark the areas that collect water. o Identify who can repair areas to ensure water does not pool on the path **Action:** ☐ Completed ☐ Planned ☐ None

3. Are hoses, garden tools and lawn furniture always kept away from paths?	
☐ **Yes:** No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Identify who can help store garden equipment away from pathways and out of the way O If you live in an apartment, speak with the manager **Action:** ☐ Completed ☐ Planned ☐ None 
4. Do you have well lit pathways and adequate lighting at the main entrance to your home?	
☐ **Yes:** No new action necessary at this time *Date*: _____	☐ **No**, then: **Suggested Action:** O Arrange to install timed or motion sensor spotlights at entrances, pathways and in hallways. O If you live in an apartment, speak to the manager if the lighting is inadequate. **Action:** ☐ Completed ☐ Planned ☐ None

First name of CHW or HHP who reviewed this section: _____
Date (1st reviewed): _____ Date (2nd reviewed): _____

Your Falls Prevention Action List #1

This is your reminder of actions from your *Checklist & Action Plan* that you intend to take to stay healthy and safe.

Action	Completed by (Date)

Your Falls Prevention Action List #2

This is your reminder of actions from your *Checklist & Action Plan* that you intend to take to stay healthy and safe.

Action	Completed by (Date)