SENIOR SAFETY ADVICE

AFTER VISIT REALITY CHECK

THE COMPLETE FAMILY WORKBOOK

for Adult Children Concerned About an Aging Parent

OBSERVE. DOCUMENT. PLAN.

UNDERSTAND WHAT THEY MEAN.

KNOW WHAT TO DO NEXT.

A STEP-BY-STEP GUIDE FOR ADULT CHILDREN
who visited their elderly parent(s) and came home worried about what they saw.

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After Visit Reality Check

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How to Use This Workbook

This workbook is designed to do three things, in order.

First, it helps you record exactly what you observed during your visit, in enough detail to be useful, to you, to other family members, and to her doctor.

Second, it walks you through each area of concern with clinical context, so you understand what you may be looking at and why it matters.

Third, it helps you build a concrete action plan, with priorities, timelines, and next steps, so you leave this workbook knowing what to do, not just what to worry about.

> **Who this is for:** Adult children (and other close family members) who have visited an elderly parent and noticed changes that concern them. No medical background is required. This workbook is written in plain language, with clinical guidance woven in where it helps.

How to work through it:

- Complete the sections in order, they build on each other.
- Be specific in your observations. "He/She seemed off" is less useful than "He/She repeated the same story three times and couldn't tell me what day it was."
- You don't have to complete it in one sitting. Come back to sections as you remember things or gather more information.
- When you're done, the Doctor Conversation Guide in Section 5 will be ready to use at their next appointment.

> **A note on tone:** This workbook is not designed to alarm you, it's designed to inform you. Noticing changes is not the same as a diagnosis. Many of the issues covered here are treatable, manageable, or preventable with the right support. Your job right now is to observe clearly and act thoughtfully.

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SECTION 1

About This Visit — Setting the Scene

Before you start recording observations, capture the basics of this visit. Details that seem obvious now can become important later.

Visit Information

Date of visit: _____ ***How long were you there?*** _____

Who was present during the visit? (List all people)

How long has it been since your last visit?

What was the purpose of this visit? (Holiday, family event, routine visit, concern-driven, etc.)

Your Overall Impression

In your own words, what was your overall impression of how your mother/father is doing?

What was the first thing you noticed that gave you pause, the moment something felt different?

Did he/she say anything during the visit that concerned you? Write it down as close to the exact words as you can.

Why this matters: Doctors rely on specific, timestamped observations from family members. "She seemed off" is a starting point. "When I visited on May 10th, he repeated the same question four times in 20 minutes and didn't know what day it was" is clinical information. Be as specific as possible.

SECTION 2

The Observation Log — 6 Areas of Concern

Check everything you noticed. Use the notes column to be as specific as possible, what exactly you saw, heard, or were told.

2A — Movement & Balance

☐	**Walking slower than before**	*Notes:* _____
☐	**Shuffling or dragging feet**	*Notes:* _____
☐	**Holding onto walls or furniture**	*Notes:* _____
☐	**Hesitating before steps or thresholds**	*Notes:* _____
☐	**Difficulty rising from a chair**	*Notes:* _____
☐	**Sitting down too fast / plopping**	*Notes:* _____
☐	**Stooped or changed posture**	*Notes:* _____
☐	**Complained of pain while moving**	*Notes:* _____
☐	**Mentioned a recent fall or near-fall**	*Notes:* _____

Describe the most notable movement or balance issue you observed in detail:

2B — Home Environment

☐	**Clutter in walkways or hallways**	*Notes:* _____
☐	**Furniture moved / used for support**	*Notes:* _____
☐	**Dishes, mail, or trash piling up**	*Notes:* _____
☐	**Bathroom not cleaned recently**	*Notes:* _____
☐	**Spoiled or expired food**	*Notes:* _____
☐	**Evidence of forgotten stove / oven**	*Notes:* _____
☐	**Unpaid bills or financial papers out**	*Notes:* _____
☐	**Broken items not addressed**	*Notes:* _____
☐	**Lights burned out / not replaced**	*Notes:* _____
☐	**Unsafe rugs, cords, or obstacles**	*Notes:* _____

What did the overall state of the home tell you about how he/she is managing day to day?

2C — Weight & Nutrition

☐	**Looks noticeably thinner**	*Notes:* _____
☐	**Clothes fitting differently**	*Notes:* _____
☐	**Refrigerator / pantry nearly empty**	*Notes:* _____
☐	**Food he/she couldn't have prepared herself**	*Notes:* _____
☐	**Difficulty chewing or swallowing**	*Notes:* _____
☐	**Mentioned not feeling hungry**	*Notes:* _____
☐	**Skipping meals**	*Notes:* _____
☐	**Eating very little during the visit**	*Notes:* _____
☐	**Unexplained weight gain**	*Notes:* _____

What did you observe about his/her eating habits or food situation?

2D — Memory & Cognition

☐	**Repeated the same story or question**	*Notes:* _____
☐	**Confused about recent events**	*Notes:* _____
☐	**Difficulty finding the right words**	*Notes:* _____
☐	**Confusion about time or day**	*Notes:* _____
☐	**Got lost mid-sentence or mid-thought**	*Notes:* _____
☐	**Didn't recognize someone familiar**	*Notes:* _____
☐	**Confused about where things are kept**	*Notes:* _____
☐	**Seemed disoriented in familiar space**	*Notes:* _____
☐	**Poor judgment (financial, safety, etc.)**	*Notes:* _____

Record specific examples of any memory or cognition concerns you noticed:

2E — Medications

☐	**No system for medications**	*Notes:* _____
☐	**Couldn't name his/her medications**	*Notes:* _____
☐	**Didn't know what medications are for**	*Notes:* _____
☐	**Pill organizer behind or unused**	*Notes:* _____
☐	**Expired medications present**	*Notes:* _____
☐	**Multiple prescribers / pharmacies**	*Notes:* _____
☐	**Bottles running low / running out**	*Notes:* _____

☐ **Complaints about side effects**	*Notes:* _____
☐ **Mentions skipping doses**	*Notes:* _____

List any medications you saw, along with any concerns:

2F — Social & Emotional

☐ **Stopped going out / socializing**	*Notes:* _____
☐ **No longer driving or avoiding it**	*Notes:* _____
☐ **Mentioned loneliness or isolation**	*Notes:* _____
☐ **Withdrawn or flat affect**	*Notes:* _____
☐ **Tearful or more emotional than usual**	*Notes:* _____
☐ **Expressed hopelessness or sadness**	*Notes:* _____
☐ **Unexplained bruises**	*Notes:* _____
☐ **Signs of fear or anxiety**	*Notes:* _____
☐ **Seemed unkempt / not grooming**	*Notes:* _____

What did you observe about his/her emotional state and social life?

SECTION 3

Understanding What You Saw — Clinical Context

This section gives you the clinical background behind each area you observed. Understanding why something matters helps you communicate it clearly and advocate effectively.

Changes in Gait and Movement

How a person walks tells us a great deal about what's happening in their body. Gait changes are one of the earliest and most reliable indicators of declining health in older adults, and one of the most overlooked.

A change in walking speed, step length, or steadiness can indicate pain (arthritis, hip problems, plantar fasciitis), neurological changes (early Parkinson's, peripheral neuropathy), inner ear or vestibular issues, medication side effects, cardiovascular changes, or simply deconditioning from reduced activity.

Fear of falling is itself a gait risk. Once an older adult has a fall, or a near-fall, they often change how they walk, becoming more cautious, taking smaller steps, and holding onto surfaces. This actually increases fall risk over time because it reduces muscle activation and balance practice.

> **What to do:** A referral to a physical therapist (PT) for a gait and balance evaluation is a reasonable and non-alarming first step. A PT can identify the cause, recommend assistive devices if needed, and design a targeted exercise program. Ask their doctor for a referral at the next appointment.

The Home as a Health Indicator

A home reflects its occupant's executive function, the brain's ability to plan, organize, initiate tasks, and follow through. When an older adult's home begins to deteriorate in ways that are out of character, it often signals that executive function is declining, or that physical limitations are making routine tasks too difficult.

Clutter in walkways is also a direct fall hazard. Loose rugs, cords across pathways, and furniture moved out of its usual place all increase fall risk significantly. From an occupational therapy standpoint, the home environment is part of the clinical picture, not a separate concern.

> **What to do:** An occupational therapist (OT) or a certified aging in place specialist (CAPS) can conduct a formal home safety evaluation, identify specific hazards, and recommend modifications, from grab bar placement to lighting improvements to rearranging furniture. Many home health agencies offer this service, sometimes covered by Medicare following a hospitalization.

Weight Loss and Nutrition

Unintentional weight loss of 5% or more of body weight in 6–12 months is considered clinically significant in older adults. It's associated with increased mortality, hospitalization risk, and functional decline, and it's frequently underreported because older adults often don't notice or mention it.

Causes are wide-ranging: difficulty cooking or shopping, swallowing problems (dysphagia), dental pain, depression, medication side effects, cancer, thyroid disease, and social factors like eating alone. No single explanation should be assumed without a medical evaluation.

What to do: Bring this issue to their doctor's attention with as much specificity as possible, when you last saw him/her, how he/she looks different, whether he/she mentioned eating less. A physician can order labs, assess for dysphagia, and refer to a registered dietitian if needed.

Memory and Cognitive Changes

Not all memory changes mean dementia. This is one of the most important things to understand. Many conditions cause cognitive symptoms in older adults that are fully reversible: urinary tract infections (UTIs), thyroid dysfunction, vitamin B12 deficiency, medication side effects, depression, dehydration, and sleep disorders can all produce memory and confusion symptoms.

What distinguishes concerning change from normal aging: normal aging may slow recall but doesn't typically produce repetition within a single conversation, confusion about current events, or difficulty with familiar tasks. If you observed those things, they warrant a medical evaluation, not alarm, but action.

What to do: A cognitive screening (such as the MoCA or MMSE) can be administered by their primary care physician in the office. If the results suggest concern, a referral to a neurologist or geriatric psychiatrist may follow. The key is not to wait, early evaluation opens more options.

Medication Management

Medication mismanagement is the leading preventable cause of hospitalization in older adults. Polypharmacy, taking five or more medications, dramatically increases the risk of drug interactions, falls (many common medications cause dizziness or orthostatic hypotension), cognitive side effects, and non-adherence.

An older adult who cannot tell you what he/she takes or why is at serious risk. This is not a judgment, medication regimens in older adults are often genuinely complex, with multiple prescribers who are not always communicating with each other.

What to do: Request a medication reconciliation from their primary care physician, a review of every medication he/she is taking, why it was prescribed, and whether it is still appropriate. Many pharmacies also offer medication review services. A blister pack or automatic dispenser with alarms can significantly improve adherence.

Social Withdrawal and Emotional Health

Social isolation is not a personality trait or a preference to be respected without question. Research consistently shows that loneliness and social isolation in older adults accelerate cognitive decline, increase depression and anxiety, worsen physical health outcomes, and are independently associated with earlier death.

Withdrawal is often driven by specific, addressable issues: fear of incontinence in public, hearing loss making conversation difficult, fear of falling on unfamiliar terrain, depression following loss, or loss of driving independence. Treating the underlying cause can restore social engagement.

What to do: Gently ask what's changed. Is he/she still going to the places he/she used to go? If not, ask why, specifically. If he/she mentions a practical barrier (can't drive, worried about the bathroom), that's something that may be solvable. If he/she seems sad or hopeless, depression screening through his/her doctor is an appropriate next step.

SECTION 4

The Action Plan — Priorities & Next Steps

Use this section to turn your observations into a concrete plan. For each area of concern, identify the specific action, who will take it, and when.

How to prioritize: Start with anything that poses an immediate safety risk (fall hazards, medication confusion, signs of cognitive impairment affecting judgment). Then move to medical follow-up. Then longer-term support planning.

Immediate Actions (This Week)

What are the 1-3 most urgent things that need to happen in the next 7 days?

Who is responsible for each of these actions?

Medical Follow-Up

- [ ] Call his/her primary care physician to share observations
- [ ] Request a gait / balance evaluation (PT referral)
- [ ] Request a home safety evaluation (OT referral)
- [ ] Request a medication review / reconciliation
- [ ] Ask about cognitive screening (MoCA or similar)
- [ ] Ask about depression screening
- [ ] Ask about a dietitian referral (if weight loss is a concern)
- [ ] Schedule a follow-up visit with her doctor within 30 days

Who will call the doctor, and when? What will you say?

Home Safety Priorities

- [ ] Remove loose rugs or secure them with non-slip backing
- [ ] Clear clutter from hallways and walkways
- [ ] Add nightlights to bedroom, hallway, and bathroom
- [ ] Install grab bar in shower / tub (if not already present)
- [ ] Install grab bar near toilet
- [ ] Ensure adequate lighting in all areas
- [ ] Move frequently used items to accessible heights
- [ ] Remove or secure cords that cross walking paths
- [ ] Consider a raised toilet seat or shower chair
- [ ] Schedule professional home safety evaluation (OT)

Support Services to Explore

- [ ] Meal delivery service (Meals on Wheels or similar)
- [ ] Non-medical home care aide (companion / personal care)
- [ ] Transportation assistance (medical transport, rideshare programs)
- [ ] Senior center programs or adult day services
- [ ] Medication management service or automatic dispenser
- [ ] Grocery delivery or grocery pickup service
- [ ] Housekeeping or home maintenance help
- [ ] Geriatric care manager assessment

Which of these services would be most helpful, and what is the first step to look into them?

Longer-Term Planning

Based on what you observed, where do you think your parent(s) will be in 6-12 months if nothing changes?

What is the ideal outcome — what does "better" look like for him/her?

What is one thing you can commit to doing differently as a result of this visit?

SECTION 5

The Doctor Conversation Guide

This section is designed to be completed and brought to his/her next doctor's appointment, either by you, with him/her, or shared with the physician in advance.

Important note: You can share information with his/her physician without their consent. The physician cannot share information back without their consent (unless he/she is incapacitated). Calling ahead with your observations is appropriate and welcomed by most geriatric-aware physicians.

About My Parent

Full name: ***Date of birth:***

Primary care physician name and practice:

Other physicians or specialists she sees:

Known diagnoses / medical history (list what you know):

Current medications (list all you are aware of):

What I Observed — Summary for the Doctor

Use your notes from Section 2 to fill this in. Be specific, dates, examples, exact words he/she used.

Changes in movement or balance I noticed:

Changes in the home / daily functioning I noticed:

Changes in memory or cognition I noticed:

Changes in weight, nutrition, or eating I noticed:

Medication concerns I observed:

Changes in mood, social life, or emotional state I noticed:

Questions I Want to Ask the Doctor

Check the questions you want to raise, and add your own below.

- [ ] Can you do a gait and balance assessment today, or refer to a PT?
- [ ] Can you order a cognitive screening (MoCA or MMSE)?
- [ ] Can you do a depression screening?
- [ ] Can you review all of his/her medications for interactions and appropriateness?
- [ ] Can you refer to an occupational therapist for a home safety evaluation?
- [ ] Should we be concerned about the weight change I've described?
- [ ] Are there any labs you would recommend given what I've described?
- [ ] What warning signs should prompt an urgent call or visit?
- [ ] Is there a geriatric specialist or geriatric care manager you would recommend?
- [ ] What is your honest assessment of where he/she is right now?

Additional questions I have for the doctor:

SECTION 6

Family Communication Planner

One of the most common failure points in eldercare is fragmented family communication. This section helps you get everyone on the same page before having bigger conversations.

Family Members Involved

List the family members who should be involved in decisions about your parent's care. Include name, relationship, location, and how involved they currently are:

Roles & Responsibilities

Who is the primary point of contact for medical decisions?

Who handles or oversees his/her finances?

Who is geographically closest and most available for in-person help?

Are there disagreements in the family about his/her situation or what to do? Describe:

Conversation Planning

What do you need to communicate to other family members about what you observed?

What conversation do you need to have with your parent(s) directly? What are you most concerned about saying, and how will you approach it?

What is the plan for a family check-in — phone call, in-person meeting, email update?

SECTION 7

Home Safety Walkthrough

Use this section during or after your visit to do a systematic room-by-room safety check. Check what you observed, and note what needs attention.

Entryways & Exterior

☐ **Steps in good repair**	*Notes:* _____
☐ **Handrails sturdy and present**	*Notes:* _____
☐ **Adequate exterior lighting**	*Notes:* _____
☐ **Clear path to front door**	*Notes:* _____
☐ **No ice / wet surface hazards**	*Notes:* _____

Living & Common Areas

☐ **Clear walkways (no clutter)**	*Notes:* _____
☐ **Rugs secured / non-slip**	*Notes:* _____
☐ **Cords not crossing walking paths**	*Notes:* _____
☐ **Adequate lighting**	*Notes:* _____
☐ **Furniture stable (not used as grab support)**	*Notes:* _____
☐ **Phone accessible in main areas**	*Notes:* _____

Kitchen

☐ **Frequently used items at accessible height**	*Notes:* _____
☐ **No expired / spoiled food**	*Notes:* _____
☐ **Stove / oven in safe condition**	*Notes:* _____
☐ **Adequate lighting over work surfaces**	*Notes:* _____
☐ **No burn marks or signs of accidents**	*Notes:* _____

Bathroom

☐ **Grab bar in shower or tub**	*Notes:* _____
☐ **Grab bar near toilet**	*Notes:* _____
☐ **Non-slip mat in shower / tub**	*Notes:* _____
☐ **Non-slip rug on bathroom floor**	*Notes:* _____
☐ **Adequate lighting**	*Notes:* _____
☐ **Medications organized and accessible**	*Notes:* _____
☐ **Shower chair present if needed**	*Notes:* _____

Bedroom

☐ **Nightlight present**	*Notes:* _____
☐ **Path to bathroom clear at night**	*Notes:* _____
☐ **Phone accessible from bed**	*Notes:* _____
☐ **Bed at safe height (not too high or low)**	*Notes:* _____
☐ **No items on floor that could cause tripping**	*Notes:* _____
☐ **Medical alert device worn or accessible**	*Notes:* _____

Overall home safety concerns, what are the top 3 things that need to be addressed?

What modifications would make the biggest difference in his/her safety at home?

SECTION 8

Resources & What to Ask For

Use this section as a reference for the most common types of professional support and how to access them.

Key Professionals to Know

Occupational Therapist (OT): Specializes in evaluating a person's ability to perform daily activities safely and independently. Can conduct home safety evaluations, recommend modifications and adaptive equipment, and develop strategies for daily living challenges. Ask for a referral from the primary care physician.

Physical Therapist (PT): Specializes in movement, strength, balance, and pain. Can evaluate gait and fall risk, develop targeted exercise programs, and recommend assistive devices. A PT referral is appropriate whenever there are concerns about walking, balance, or fall history.

Certified Aging in Place Specialist (CAPS): A professional, often a contractor, designer, or occupational therapist, trained specifically in home modifications that allow older adults to remain safely at home as they age. CAPS-certified professionals can assess the home and recommend or implement modifications such as grab bars, ramps, wider doorways, and accessible bathrooms. To find a CAPS professional in your area, visit the National Association of Home Builders (NAHB) directory at https://www.nahb.org/nahb-community/nahb-directories/professionals-with-home-building-credentials-directory

Geriatric Care Manager (GCM): A healthcare professional (often a social worker or nurse) who specializes in coordinating care for older adults. Can assess the overall situation, identify gaps in care, coordinate with multiple providers, and help families navigate difficult decisions. Particularly helpful when family members are geographically dispersed.

Geriatrician: A physician who specializes in the care of older adults. If the primary care physician is not experienced with geriatric care, a referral to a geriatrician may be appropriate, particularly if there are concerns about cognition, polypharmacy, or complex medical needs.

Pharmacist: Pharmacists are an underused resource for medication review. Many pharmacies offer medication reconciliation services and can identify potentially dangerous drug interactions. This service is often available at no cost.

How to Access Support

- **Area Agency on Aging (AAA):** Every region of the US has an AAA that can connect you with local services, transportation, meals, home care, legal assistance, and more. Find yours at eldercare.acl.gov or call 1-800-677-1116.
- **Medicare:** Covers PT, OT, and home health services when medically necessary and ordered by a physician. Ask their doctor what may be covered given their specific situation.
- **Medicaid:** May cover additional services for those who qualify, including personal care aides and home modifications.
- **Home health agencies:** Can provide non-medical companion care, personal care (bathing, dressing), and homemaker services. Ask for referrals from the physician or local AAA.
- **PACE programs:** Program of All-Inclusive Care for the Elderly, for those who qualify, provides comprehensive medical and social services to help older adults remain at home.

Notes & Resources

Local contacts, agency names, phone numbers, and resources you want to follow up on:

You showed up. That matters.

The fact that you noticed something and took the time to document it, think it through, and build a plan puts you ahead of most families navigating this moment. You don't have to solve everything at once. You just have to take the next right step.

You have what you need. Now follow through.