Client Risk Assessment and Care Planning: A National Practice Module

Assessing client risk and writing person-centered care plans in home care.

Why this module matters. Most serious harms in home care, such as falls, medicine errors, and avoidable hospital stays, can be anticipated at assessment. A thorough assessment is the foundation of every safe care plan.

About this module

This module gives teams a shared, evidence-based approach to assessing client risk and writing person-centered care plans in home care. It draws on current federal rules and national guidance, and it ends with a checklist that agencies, clinicians, and families anywhere in the United States can adopt.

Item	Details
Who it is for	Agency owners, supervisors, nurses, and care coordinators
Format	10 units, case scenarios, a knowledge check, and a national checklist
Time	About 2 to 3 hours as training, or use single units as refreshers
How to use it	Supervisors and nurses use all units. Aides focus on Unit 6. Leaders use Unit 7 and the checklist.

Learning objectives

After completing this module, learners will be able to:

1. Explain why assessment drives safe care.
2. Describe the federal rules on assessment and care planning.
3. Assess the 13 core domains.
4. Assign consistent risk levels.
5. Write a person-centered care plan.
6. Reassess on schedule and when conditions change.
7. Track assessment quality.

Scope. Aides and family caregivers observe, support, and report. Clinical assessments, medication changes, and legal decisions belong to licensed professionals or qualified advisers. Follow your state rules and agency policies.

Unit 1. Why assessment drives safe care

A home care plan is only as good as the assessment behind it. A complete, person-centered assessment finds risks before they cause harm, matches services to need, and gives everyone the same picture of the client.

Fact	Figure	Source
Older adults who fall each year	More than 1 in 4	CDC, 2026
Medicare 30-day readmission rate	17.0 per 100 hospital stays (2020)	AHRQ HCUP
Older patients with a medication error or misunderstanding after discharge	81%	Ziaeian et al., 2012
Family caregivers with formal training in medical or nursing tasks	About 1 in 5	AARP and NAC, 2025

Each of these risks can be found at assessment: fall risk, recent hospital stays, medicine problems, and an unprepared caregiver.

Unit 2. The national rules

Rule or framework	What it requires	Applies to
Medicare home health assessment (42 CFR 484.55)	An initial assessment within 48 hours of referral or return home, and a comprehensive assessment, including OASIS data, within 5 days of start of care. Updated at set points and when the condition changes.	Medicare-certified home health agencies
Medicaid HCBS person-centered planning (42 CFR 441.301(c))	The service plan reflects the person's goals and preferences, is developed with the person and people they choose, and is reviewed at least every 12 months and when needs change. The 2024 Access Rule adds reporting on how often this happens on time.	Medicaid home and community-based services
Age-Friendly 4Ms	A national framework for older adults: What Matters, Medication, Mentation, and Mobility. CMS's Age Friendly Hospital measure asks hospitals to attest to these practices.	All settings, as best practice
CDC STEADI	Screen every older adult for fall risk yearly and after any fall.	All settings, as best practice
State licensing rules	Most states require an assessment and a written care plan before or at the start of service.	Licensed home care agencies

> **Even if you do not bill Medicare or Medicaid.** Private-pay home care agencies may not be bound by Medicare or Medicaid rules, but these standards are the national benchmark that clients, hospitals, and payers expect.

Unit 3. The core domains of a home care assessment

A complete assessment covers the whole person and the home. Use the domains below at intake, then update them at reassessment.

Domain	What to ask or observe	Common tools
What matters	Goals, routines, preferences, culture, language, and who makes decisions	Conversation; advance directive review
Health conditions	Diagnoses, recent hospital or ED visits, pain, sleep, vision, hearing	Records review; client and family report
Medicines	All prescriptions and over-the-counter products, who manages them, any problems	Brown-bag review; Beers Criteria (clinicians)
Mentation	Memory, confusion, mood, and signs of depression	Mini-Cog; PHQ-2 (clinicians or trained staff)
Mobility and falls	Walking, transfers, falls in the past year, fear of falling	STEADI three key questions; Timed Up and Go (clinicians)
Daily activities	Bathing, dressing, toileting, eating, transfers (ADLs); meals, shopping, money, transport (IADLs)	Katz ADL; Lawton IADL
Nutrition and swallowing	Weight change, appetite, chewing, coughing with meals, fluids	Weight history; clinician referral
Skin	Pressure areas, wounds, incontinence	Braden Scale (nurses)
Home safety	Hazards, stairs, bathroom, lighting, smoke alarms, oxygen, weapons, pets	Home safety checklist
Caregiver capacity	Who helps, how much, their health and stress, what they can safely do	Caregiver interview
Social needs	Housing, food, transportation, utilities, and personal safety	CMS Health-Related Social Needs screening questions
Abuse, neglect, and exploitation	Signs of harm, isolation, or financial misuse	Observation; mandated reporting
Emergency plan	Contacts, power-dependent equipment, evacuation needs	Emergency plan form

Unit 4. Roles on the assessment team

Team member	Role in assessment and planning
Client	Shares goals, preferences, and history; agrees to the plan
Family or representative	Adds history and observations; describes what help they can give
Intake coordinator	Gathers referral information, payer details, and urgent needs before the first visit
Supervisor or nurse	Completes the assessment, assigns risk levels, writes and signs the plan
Aide	Follows the plan, observes daily, and reports changes
Primary care clinician	Confirms diagnoses and medicines, orders tests or therapy
Therapists, pharmacist, social worker	Assess specialized needs: mobility, home safety, medicines, benefits

Unit 5. Assessing memory, mood, and decision-making

Memory loss, depression, and delirium are common and often missed. Each changes what the client can safely do and who needs to be part of decisions.

Condition	What it looks like	What to do
Dementia	Gradual memory loss, trouble with familiar tasks, getting lost, repeating questions	Screen (for example, Mini-Cog); refer to the clinician; plan supervision and safety
Delirium	Sudden confusion that comes and goes, trouble paying attention, unusual sleepiness or agitation	Treat as urgent: report to the clinician the same day
Depression	Low mood, loss of interest, withdrawal, poor appetite, sleep changes	Screen (for example, PHQ-2); refer; check for safety concerns
Decision-making capacity	Difficulty understanding choices or their consequences	Clinician assesses; record the legal representative and any advance directive

> **Respect autonomy.** A diagnosis of dementia does not remove a person's right to be involved. Ask about preferences and include the person in every decision they can take part in.

Unit 6. Assessing the caregiver and social needs

About 63 million Americans provide ongoing care to a family member, and many are stretched thin. The plan fails if it depends on a caregiver who cannot sustain it.

Ask the caregiver	Why it matters
What do you help with now, and how many hours a week?	Shows the real gap that paid help must fill
What tasks are you unsure or uncomfortable doing?	Identifies training needs, such as transfers or medicines
How is your own health and stress?	Caregiver burnout often comes before a care crisis
Who can step in if you are sick or away?	Creates a backup plan
Do you have trouble paying for food, housing, transport, or utilities?	Social needs affect health and service use

CMS's Health-Related Social Needs screening covers five core needs: housing instability, food insecurity, transportation, utility help, and interpersonal safety. Connect positive screens to the Area Agency on Aging, 211, or a social worker.

Unit 7. Turning findings into a risk level

Assign a risk level for each domain and an overall level. The overall level sets how often supervisors check in and how quickly changes are reported.

Level	Typical findings	Response
Low	Stable health, independent or minimal help, safe home, strong support	Standard plan; reassess yearly and with any change
Moderate	One or two risks, such as a fall in the past year, several medicines, or mild memory loss	Targeted interventions; supervisor review within 30 days
High	Several risks, recent hospital stay, dementia with safety concerns, limited support, or unsafe home	Clinician involvement; frequent supervision; reassess within 14 days and after any event
Immediate	Danger to life or safety, abuse, or a medical emergency	Act now: 911, Adult Protective Services, or the clinician

> **Consistency.** Each agency should define its own levels and response times in policy, and apply them the same way for every client.

Unit 8. Writing the person-centered care plan

The care plan turns the assessment into daily actions. A good plan is specific enough that any aide could follow it on a first visit.

Part of the plan	Example
The person's goal, in their words	"I want to stay in my own home and get to church on Sundays."
Each risk and the action	Fall risk: walker within reach, night lights on, PT referral made
Tasks, frequency, and who does them	Shower assistance Monday, Wednesday, Friday by aide; medication reminders daily by family
What to report and to whom	New confusion, a fall, or refusal of food: call the nurse the same day
Emergency plan	Contacts, hospital preference, advance directive location
Review date	Every 12 months, or sooner when needs change

Write the plan in plain language. Share it with the client, family, and aides, and keep a signed copy.

Unit 9. Reassessment and change in condition

Needs change, often quickly. Reassess on schedule and whenever a trigger occurs.

Trigger	Action
Hospital stay or ED visit	Reassess before or at the first visit back
Fall, with or without injury	Reassess fall risk and update the plan
New diagnosis or medicine change	Review medicines, risks, and tasks
Change reported by an aide or family member	Supervisor follow-up within the time set by policy
Change in the caregiver's ability to help	Review hours and supports
Scheduled review	At least every 12 months, or as required by payer or state

Aides are often the first to notice change. Train them to use a simple early warning list: eating less, more tired, new pain, change in walking, new confusion, bowel or bladder changes, or skin changes.

Unit 10. Measuring assessment quality

Measure	How to calculate
Assessments completed before or at the start of service	On time ÷ new clients
Care plans reviewed on schedule	Reviewed within 12 months ÷ active clients
Reassessment after hospital stay	Reassessed by first visit back ÷ clients with a hospital stay
Fall screening completed	Screened in 12 months ÷ clients 65+
Plans signed by the client or representative	Signed ÷ active plans

Case scenarios

Case 1. New client, age 81

A daughter calls to start four hours of help a day for her father, who lives alone after a recent hospital stay for pneumonia. She mentions he “seems foggy.”

- Which domains need the closest look?
- What risk level might apply, and why?

Discussion: Recent hospital stay, possible delirium or memory change, and living alone suggest high risk. Assess cognition, medicines, falls, and the emergency plan at the first visit, involve the clinician, and reassess within 14 days.

Case 2. Change reported by an aide

An aide notices a client has stopped eating breakfast and is sleeping more.

- What should happen next?
- Who updates the plan?

Discussion: The aide reports the same day. The supervisor or nurse follows up within policy timelines, contacts the clinician if needed, and updates the plan.

Knowledge check

1. How soon must a Medicare home health agency complete the comprehensive assessment? *(Within 5 days of start of care)*
2. How often must a Medicaid HCBS person-centered plan be reviewed at minimum? *(At least every 12 months, and when needs change)*
3. What are the 4Ms? *(What Matters, Medication, Mentation, Mobility)*
4. Name three triggers for reassessment. *(Hospital stay, fall, new medicine or diagnosis)*
5. Name five social needs to screen for. *(Housing, food, transportation, utilities, personal safety)*
6. Who is often first to notice a change in condition? *(The aide or family caregiver)*

National Client Risk Assessment and Care Planning Checklist

This checklist puts national guidance into one tool that agencies in any state can adopt at intake and reassessment. The “National basis” column shows where each item comes from. Adapt it to your state rules and policies.

Name or ID	Date	Completed by and role
Agency or organization	Reviewed by	Next review date

A. Before or at start of service

Action	National basis	Done	Notes
Initial contact and assessment scheduled before services begin	State licensing; 42 CFR 484.55	☐	
Client’s goals and preferences recorded in their words	42 CFR 441.301(c); 4Ms	☐	
Decision-maker and advance directive status recorded	Best practice	☐	
Language and communication needs recorded; interpreter arranged	Civil rights law; best practice	☐	

B. Assessment domains completed

Action	National basis	Done	Notes
Health conditions and recent hospital or ED visits	42 CFR 484.55	☐	
Medicines reviewed, including over-the-counter products	4Ms; CDC STEADI	☐	
Memory, confusion, and mood screened	4Ms	☐	
Fall risk screened with the three key questions	CDC STEADI	☐	
ADLs and IADLs assessed	Best practice	☐	
Nutrition, swallowing, and skin assessed	Best practice	☐	
Home safety assessed	Best practice	☐	
Caregiver capacity and stress assessed	ACL National Strategy	☐	
Social needs screened	CMS HRSN screening	☐	
Signs of abuse, neglect, or exploitation checked	State mandated reporting	☐	
Emergency plan completed	Best practice	☐	

C. Care plan

Action	National basis	Done	Notes
Risk level assigned for each domain and overall	Agency policy	☐	
Each risk linked to a specific action and owner	Best practice	☐	
Reporting instructions written for aides and family	Best practice	☐	
Plan written in plain language and shared	42 CFR 441.301(c)	☐	
Plan signed by client or representative	42 CFR 441.301(c); state rules	☐	

D. Reassessment

Action	National basis	Done	Notes
Scheduled review at least every 12 months	42 CFR 441.301(c)	☐	
Reassessment after hospital stay, fall, or major change	42 CFR 484.55; CDC STEADI	☐	
Aide-reported changes followed up within policy timelines	Best practice	☐	
Assessment quality measures reviewed quarterly	Best practice	☐	

Completed by: signature	Printed name and title	Date
Reviewed by: signature	Printed name and title	Date

Sources and further reading

CMS: Ensuring Access Final Rule, HCBS quality measure reporting (medicaid.gov)

McCarter & English: CMS Age Friendly Hospital measure (4Ms) (mccarter.com)

CDC STEADI Pocket Guide (cdc.gov)

CDC: Facts About Older Adult Falls (cdc.gov)

AHRQ HCUP Statistical Brief 304 (hcup-us.ahrq.gov)

Ziaeian et al., 2012: Medication reconciliation after discharge (pmc.ncbi.nlm.nih.gov)

AARP: Caregiving in the US 2025 (aarp.org)

INTERACT Stop and Watch Early Warning Tool (secure.in.gov)

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