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Environmental and Sensory Processing Awareness Checklist for Residential Programs

Site/Program: **Date:**

Agency Name: **Time:**

Address: **Season:**

Name of Reviewer 1:

Role of Reviewer 1: ❑ Nurse ❑ Residential Mgr/Staff ❑ Parent/Family Member
❑ MSC ❑ Administrator ❑ Other ______________
❑ OT/PT ❑ Direct Care

Name of Reviewer 2:

Role of Reviewer 2: ❑ Nurse ❑ Residential Mgr/Staff ❑ Parent/Family Member
❑ MSC ❑ Administrator ❑ Other ______________
❑ OT/PT ❑ Direct Care ❑ NA

Reason for Review:

Residence Type: ❑ IRA House ❑ IRA Apartment
❑ ICF ❑ Living with Parent/Family Member
❑ Own Home/Apt. ❑ Family Care ❑ Other ______________

Total number of individuals living on-site: ____________

Number of common rooms/areas used by individuals/staff: ____________

Number of bedrooms: ____________

Total number of respite beds: ____________ ❑ N/A

Are ResHab and/or DayHab offered at this site? ❑ Yes ❑ No

Age ranges of individuals (by number or percent):

0-5 yrs. __________ **6-12 yrs.** __________ **13-18 yrs.** __________ **19-21 yrs.** __________

22-30 yrs. __________ **31-40 yrs.** __________ **41-50 yrs.** __________ **51-60 yrs.** __________

61-70 yrs. __________ **71-80 yrs.** __________ **81+ yrs.** __________

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Diagnoses of Intellectual and Developmental Disabilities (I/DD) served at this location.
Please estimate using percentages.

_____ Mental Retardation/Developmental Delay
_____ Autism Spectrum
_____ Epilepsy/Childhood onset Seizure Disorder
_____ Cerebral Palsy
_____ Neurological Impairment (e.g.: Spina bifida)
_____ Learning Disability
_____ Sensory Impairment (e.g.: deaf, tactile defensive)
_____ Down Syndrome
_____ Other Genetic Syndrome (e.g.: Prader Willi, Rett)
_____ Undetermined
_____ Fetal Alcohol Syndrome/Toxic Substance Exposure
_____ Not diagnosed yet
_____ Other – please list:

____

____

____

____

Mental Health Diagnoses served at this location
Please estimate using percentages.

_____ Not applicable
_____ Anxiety/PTSD
_____ Bi-Polar Disorder
_____ Schizophrenia
_____ Personality Disorder
_____ Depression
_____ Obsessive Compulsive Disorder
_____ Other, specify: ____

____

____

Percentage of people with mental health diagnoses served at this location __________%

Chronic Medical Diagnoses served at this location
Please estimate using percentages.

_____ Not applicable
_____ Diabetes (Type I or II)
_____ Cancer
_____ Allergies (list below)
_____ Cardiovascular Disease
_____ Osteoporosis
_____ Arthritis (osteo or rheumatoid)
_____ Dementia – specify type: ______________________
_____ Other, specify: ____

____

____

____

Approximate % of people with chronic medical diagnoses served at this location _______%

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Types of Diagnosed Sensory Processing Issues and/or Sensory Impairments:

____

____

❑ None at this time

Approximate percentage of people with known sensory processing issues or impairments:

__________%

Primary Mobility at this location
Please estimate using percentages.

_____ Ambulatory _____ Cane/Crutches _____ Wheelchair

_____ Requires assistance _____ Walker _____ Other (describe below)

Mobility Concerns: ____

____

____

❑ None at this time

Approximate percentage of people with known mobility concerns: __________%

Other information to take into consideration: ____

____

____

____

Miscellaneous

Is there a designated place/area for staff and residents to smoke? ❑ Yes ❑ No

What type of shelter is provided in inclement weather for people who smoke? ❑ Yes ❑ No

Where are cigarette butts disposed of?

____

Is there outside lighting at night:
In parking areas ❑ Yes ❑ No
At the main entrance/exit ❑ Yes ❑ No
At alternated entrances/exits ❑ Yes ❑ No

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Environmental and Sensory Processing Awareness Checklist for Residential Programs

Name of Room/Area:

Approximate dimensions (height, width & length in feet)**:** ______________________________

Brief description of the physical components of the room/area (e.g.: number of windows, tables, chairs, floor space for movement, carpet):

Description of how the room/area is used (dynamics, busy times, etc.)**:**

Describe the "feel" of the room, e.g.: home-like, institutional, cold, etc.

Known difficulties/challenges of the room/area (list any efforts made to address them)**:**

Known difficulties/challenges of the furniture in the room/area (list any efforts made to address them)**:**

Accessibility

Adaptive Devices Used (e.g.: lifts, shower chair, commode):

Do the Adaptive Devices meet individuals' needs? ❑ Yes ❑ No. **If No, briefly explain.**

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Condition of Adaptive Devices:

Barriers in the environment affecting mobility (e.g.: width of doors, thresholds, doorknobs, clutter):

Usability

Is there personal space available for each person? ❑ Yes ❑ No ❑ N/A

Are there personal objects in the room/area for each person? ❑ Yes ❑ No ❑ N/A

Safety Considerations (e.g.: evacuation plans):

Are there rocking chairs or other furniture available for people who seek or engage in repetitive movements? ❑ Yes ❑ No ❑ N/A

If yes, does the use of this furniture appear to calm individuals? ❑ Yes ❑ No ❑ N/A

Are there smaller, quieter spaces for individuals to use when needed? ❑ Yes ❑ No ❑ N/A

Sensory Review - Visual

Use of contrasting colors for…

- **walls and floors?** ❑ Yes ❑ No ❑ N/A
- **handrails and walls?** ❑ Yes ❑ No ❑ N/A
- **designated areas?** ❑ Yes ❑ No ❑ N/A
- **toilets, sinks, tubs?** ❑ Yes ❑ No ❑ N/A
- **sofas, tables, chairs?** ❑ Yes ❑ No ❑ N/A
- **stairs & stairwells?** ❑ Yes ❑ No ❑ N/A

Is there visual cueing for mobility and way-finding? ❑ Yes ❑ No ❑ N/A

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Visual clutter – is there too much to look at? ❑ Yes ❑ No ❑ N/A

Are important signs and cues at eye-level for the individuals? ❑ Yes ❑ No ❑ N/A

Is there sufficient lighting at all entryways, stairwells and exits from this room/area at all times of the day (e.g.: overhead lights, motion sensors)?
❑ Yes ❑ No ❑ N/A

Is there task lighting at all times of the day (e.g.: lamps next to or near all tables and chairs)?
❑ Yes ❑ No ❑ N/A

List potential sources of glare (e.g.: windows, high gloss floors or painted surfaces):

List sources of shadows and/or extremes of light? (entering hallways from dark bedrooms at night)

Sensory Review - Auditory

Sources of background noise (heating and A/C systems, overhead paging, music, phones, door alarms, TV, stereo, refrigerators, other people):

Describe the acoustics of the room/area (e.g.: echoing, sounds carry across the room).

Are there soft materials in the room/area (carpets, tapestries, drapes, ceiling tiles)**?** If yes, please list below. ❑ Yes ❑ No ❑ N/A

Sensory Review - Tactile

Are there opportunities for all individuals to touch different surfaces and textures while in the room/area? If yes, please list below. ❑ Yes ❑ No ❑ N/A

How might the *types/textures* of the floor in this area impact mobility?

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What *types* and *textures* of foods are available to program participants?

Are there snacks/meals offered at this location? ❑ Yes ❑ No (if no, skip the next 5 questions)

Are there foods types or textures that most prefer over others? If yes, please list below.
❑ Yes ❑ No ❑ N/A

Are there program participants who spit out food, refuse specific food, or have a specific diet? ❑ Yes ❑ No ❑ N/A

If yes, are there common foods that are refused? ❑ Yes ❑ No ❑ N/A
Please list:

Are there common comfort foods? If yes, please list below.
❑ Yes ❑ No ❑ N/A

Are program participants likely to smell any foods cooking or baking prior to meal times?
❑ Yes ❑ No ❑ N/A

Sensory Review – Taste & Smell

What smells exist in this environment when individuals are using the room/area? Consider all sources of odors – food, cleaning products, plants, arts & crafts materials, etc. and list below:

Is aromatherapy incorporated into any activities? ❑ Yes ❑ No ❑ N/A
If yes, list the positive or negative effects on the individuals.

General

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What is the average temperature during the day in this room/area? __________ °F

Who monitors and adjusts the temperature if necessary? ______________________________

How are individuals assessed to determine if a room temperature change is necessary? And how often?

____

____

Are there plants and/or flowers in the room/area? ❑ Yes ❑ No ❑ N/A

Do any of the individuals or staff have allergies to pollen, mold, weeds, dust, pets, etc.?

❑ Yes How many staff? ________ How many individuals? ________
❑ No
❑ N/A

If yes, how is the room/area maintained to eliminate or minimize these allergens?

____

____

Is it common for an individual to have "challenging behaviors" or to become unable to function to his or her optimum ability in this room/area? If yes, please list below.

❑ Yes ❑ No ❑ N/A

____

____

Are there specific times of day or tasks in which individuals exhibit patterns of "challenging behavior?" If yes, please list below. ❑ Yes ❑ No ❑ N/A

____

____

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Environmental and Sensory Processing Awareness Checklist for Residential Programs

Bedroom:

Approximate dimensions (height, width & length in feet)**:** ______________________________

Brief description of the physical components of the room/area (e.g.: number of windows, tables, chairs, floor space for movement, carpet):

Description of how the room/area is used:

Describe the "feel" of the room, e.g.: home-like, institutional, cold, etc.

Known difficulties/challenges of the room/area (list any efforts made to address them)**:**

Accessibility

Adaptive Devices Used (e.g.: lifts):

Do the Adaptive Devices meet individuals' needs? ❑ Yes ❑ No. **If No, briefly explain.**

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Condition of Adaptive Devices: ______________________________

____

____

Barriers in the environment affecting mobility (e.g.: width of doors, thresholds, doorknobs, clutter): ______________________________

____

____

____

Usability

How many people share this bedroom? ________

Is there personal space available for each person? ❑ Yes ❑ No ❑ N/A

Are there personal objects in the room/area for each person? ❑ Yes ❑ No ❑ N/A

Are personal objects accessible for each person? ❑ Yes ❑ No ❑ N/A

Safety Considerations (e.g.: evacuation plans, windows): ______________________________

____

____

Is other furniture available for the individuals to sit/relax in? ❑ Yes ❑ No ❑ N/A

If yes, does the use of this furniture appear to calm individuals? ❑ Yes ❑ No ❑ N/A

Are there smaller, quieter spaces for individuals to use when needed? ❑ Yes ❑ No ❑ N/A

Sensory Review - Visual

Use of contrasting colors for…

walls and floors?	❑ Yes	❑ No	❑ N/A
handrails and walls?	❑ Yes	❑ No	❑ N/A
bed/furniture and floor?	❑ Yes	❑ No	❑ N/A
closet door and wall?	❑ Yes	❑ No	❑ N/A
room door and wall?	❑ Yes	❑ No	❑ N/A
light switch and wall?	❑ Yes	❑ No	❑ N/A

Is there visual cueing for mobility and way-finding? ❑ Yes ❑ No ❑ N/A

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Visual clutter – is there too much to look at? ❑ Yes ❑ No ❑ N/A

Are important signs and cues at eye-level for the individuals? ❑ Yes ❑ No ❑ N/A

Is there sufficient lighting at entryways and exits from this bedroom at all times of the day (e.g.: overhead lights, motion sensors)?
❑ Yes ❑ No ❑ N/A

Is there task lighting at all times of the day (e.g.: lamps next to or near bed/chair)?
❑ Yes ❑ No ❑ N/A

List sources of shadows, glare or extremes of light ____

____

____

Sensory Review - Auditory

Sources of background noise (heating and A/C systems, thin walls, music, phones, door alarms, TV, stereo, other people):

____

____

Describe the acoustics of the room/area (e.g.: echoing, sounds carry across the room).

____

____

Are there soft materials in the room/area to help absorb sound (carpets, tapestries, drapes, ceiling tiles)**?** If yes, please list below. ❑ Yes ❑ No ❑ N/A

____

____

Sensory Review - Tactile

Are there opportunities for all individuals to touch different surfaces and textures while in the room/area? If yes, please list below. ❑ Yes ❑ No ❑ N/A

____

____

How might the *types/textures* of the floor in this area impact mobility? __________________

____

____

____

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General

What is the average temperature during the day in this room/area? __________ °**F**

Who monitors and adjusts the temperature if necessary? ______________________________

How are individuals assessed to determine if a room temperature change is necessary? And how often?

____

____

____

Are there plants and/or flowers in the room/area? ❑ Yes ❑ No ❑ N/A

Do any of the individuals or staff have allergies to pollen, mold, weeds, dust, pets, etc.?

❑ Yes How many staff? ________ How many individuals? ________
❑ No
❑ N/A

If yes, how is the room/area maintained to eliminate or minimize these allergens?

____

____

Is it common for an individual to have "challenging behaviors" or to become unable to function to his or her optimum ability in this room/area? If yes, please list below.

❑ Yes ❑ No ❑ N/A

____

____

Are there specific times of day or tasks in which individuals exhibit patterns of "challenging behavior?" If yes, please list below. ❑ Yes ❑ No ❑ N/A

____

____

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Environmental and Sensory Processing Awareness Checklist for Residential Programs

Kitchen:

Approximate dimensions (height, width & length in feet)**:** ______________________________

Do individuals eat in the kitchen or is there a separate dining area?

Brief description of the physical components of the room/area (e.g.: number of windows, tables, chairs, floor space for movement, appliances, counter space):

Description of how the kitchen is used (meals, crafts, meetings, etc)**:**

Describe the "feel" of the room, e.g.: home-like, institutional, diner, etc.

Known difficulties/challenges of the room/area (list any efforts made to address them)**:**

Accessibility

Adaptive Devices Used (e.g.: lifts):

Do the Adaptive Devices meet individuals' needs? ❑ Yes ❑ No. **If No, briefly explain.**

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Condition of Adaptive Devices: ________________________________

____

____

Barriers in the environment affecting mobility (e.g.: width of doors, thresholds, doorknobs, clutter): ________________________________

____

____

____

Usability

How many people living in the home cook and/or use the appliances safely? ________

Are all individuals able to cook or use appliances if they so choose (are these items accessible)**?** ❑ Yes ❑ No ❑ N/A

Safety Considerations (e.g.: evacuation plans, windows, fire extinguishers): ________________________________

____

____

Is the kitchen a gathering place for people to socialize? ❑ Yes ❑ No ❑ N/A

If yes, is there enough room for everyone to socialize? ❑ Yes ❑ No ❑ N/A

Sensory Review - Visual

Use of contrasting colors for…

walls and floors? ❑ Yes ❑ No ❑ N/A

handrails and walls? ❑ Yes ❑ No ❑ N/A

furniture and floor? ❑ Yes ❑ No ❑ N/A

cabinets and wall? ❑ Yes ❑ No ❑ N/A

appliances and cabinets? ❑ Yes ❑ No ❑ N/A

light switch and wall? ❑ Yes ❑ No ❑ N/A

Is there visual cueing for mobility and way-finding? ❑ Yes ❑ No ❑ N/A

Visual clutter – is there too much to look at? ❑ Yes ❑ No ❑ N/A

Are important signs and cues at eye-level for the individuals? ❑ Yes ❑ No ❑ N/A

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Is there sufficient lighting at entryways and exits from the kitchen at all times of the day (e.g.: overhead lights, motion sensors)?

❑ Yes ❑ No ❑ N/A

Is there task lighting at all times of the day (e.g.: lamps next to or near appliances, sink, table)? ❑ Yes ❑ No ❑ N/A

List sources of shadows, glare or extremes of light

____

____

____

Sensory Review - Auditory

Sources of background noise (heating and A/C systems, music, phones, door alarms, TV, dishwasher, other people):

____

____

Describe the acoustics of the room/area (e.g.: echoing, sounds carry across the room).

____

____

Are there soft materials in the room/area to help absorb sound (carpets, table cloths, chair covers, drapes, ceiling tiles)**?** If yes, please list below. ❑ Yes ❑ No ❑ N/A

____

____

Sensory Review - Tactile

Are there safe opportunities for all individuals to touch different surfaces and textures while in the room/area? If yes, please list below. ❑ Yes ❑ No ❑ N/A

____

____

How might the *types/textures* of the floor in this area impact mobility?

____

____

____

____

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General

What is the average temperature during the day in this room/area? __________ **°F**

Who monitors and adjusts the temperature if necessary? ______________________________

How are individuals assessed to determine if a room temperature change is necessary? And how often?

____

____

____

Are there plants and/or flowers in the room/area? ❑ Yes ❑ No ❑ N/A

Do any of the individuals or staff have allergies to pollen, mold, weeds, dust, pets, etc.?

❑ Yes How many staff? ________ How many individuals? ________
❑ No
❑ N/A

If yes, how is the room/area maintained to eliminate or minimize these allergens?

____

____

Is it common for an individual to have "challenging behaviors" or to become unable to function to his or her optimum ability in this room/area? If yes, please list below.

❑ Yes ❑ No ❑ N/A

____

____

Are there specific times of day or tasks in which individuals exhibit patterns of "challenging behavior?" If yes, please list below. ❑ Yes ❑ No ❑ N/A

____

____

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Environmental and Sensory Processing Awareness Checklist for Residential Programs

Bathroom:

Approximate dimensions (height, width & length in feet)**:** ______________________________

Brief description of the physical components of the bathroom (e.g.: windows, tiles, handles on sink, toilet and tub, space for movement):

Description of how the bathroom is used (other than than the obvious)**:**

Describe the "feel" of the room, e.g.: home-like, institutional, cold, etc.

Known difficulties/challenges of the room/area (list any efforts made to address them)**:**

Accessibility

Adaptive Devices Used (e.g.: lifts, tubs):

Do the Adaptive Devices meet individuals' needs? ❑ Yes ❑ No. **If No, briefly explain.**

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Condition of Adaptive Devices: ______________________________

____

____

Barriers in the environment affecting mobility/use of bathroom (e.g.: width of doors, thresholds, doorknobs, clutter): ______________________________

____

____

____

Usability

How many people share this bathroom? ________

Is there personal space available for each person? ❑ Yes ❑ No ❑ N/A

Are there personal objects in the bathroom for each person? ❑ Yes ❑ No ❑ N/A

Are personal objects accessible for each person? ❑ Yes ❑ No ❑ N/A

Safety Considerations (e.g.: evacuation plans, grab bars, non-slip surfaces): ______________________________

____

____

Sensory Review - Visual

Use of contrasting colors for…

- **walls and floors?** ❑ Yes ❑ No ❑ N/A
- **handrails and walls?** ❑ Yes ❑ No ❑ N/A
- **toilet and floor?** ❑ Yes ❑ No ❑ N/A
- **sink and wall?** ❑ Yes ❑ No ❑ N/A
- **bathtub and floor?** ❑ Yes ❑ No ❑ N/A
- **light switch and wall?** ❑ Yes ❑ No ❑ N/A

Is there visual cueing for mobility and way-finding? ❑ Yes ❑ No ❑ N/A

Visual clutter – is there too much to look at? ❑ Yes ❑ No ❑ N/A

Are important signs and cues at eye-level for the individuals? ❑ Yes ❑ No ❑ N/A

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Is there sufficient lighting at entryway/exit from this bathroom at all times of the day (e.g.: overhead lights, motion sensors)**?**

❑ Yes ❑ No ❑ N/A

Is there task lighting at all times of the day (e.g.: sink, tub, vanity)?

❑ Yes ❑ No ❑ N/A

List sources of shadows, glare or extremes of light

____

____

____

Sensory Review - Auditory

Sources of background noise (heating and A/C systems, thin walls, music, phones, door alarms, TV, stereo, other people):

____

____

Describe the acoustics of the room/area (e.g.: echoing)

____

____

Are there soft materials in the room/area to help absorb sound (carpets, drapes, ceiling tiles)**?** If yes, please list below. ❑ Yes ❑ No ❑ N/A

____

____

Sensory Review - Tactile

Are there safe opportunities for all individuals to touch different surfaces and textures while in the room/area? If yes, please list below. ❑ Yes ❑ No ❑ N/A

____

____

How might the *type/texture* of the floor in this area impact mobility?

____

____

____

____

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General

What is the average temperature during the day in this room/area? __________ °F

Who monitors and adjusts the temperature if necessary? ______________________________

How are individuals assessed to determine if a room temperature change is necessary? And how often?

____

____

____

Are there plants and/or flowers in the room/area? ❑ Yes ❑ No ❑ N/A

Do any of the individuals or staff have allergies to pollen, mold, weeds, dust, pets, etc.?

❑ Yes How many staff? ________ How many individuals? ________
❑ No
❑ N/A

If yes, how is the room/area maintained to eliminate or minimize these allergens?

____

____

Is it common for an individual to have "challenging behaviors" or to become unable to function to his or her optimum ability in this room/area? If yes, please list below.

❑ Yes ❑ No ❑ N/A

____

____

Are there specific times of day or tasks in which individuals exhibit patterns of "challenging behavior?" If yes, please list below. ❑ Yes ❑ No ❑ N/A

____

____

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Residential Program Environmental Recommendations

Review **each item** of this form. How does **each item** impact the participants' ability to function, interact with others, and/or learn in this specific room/area? If there is an impact, it should be considered when making any recommendations below.

Site/Program: **Date:**

*Repeat this process for all rooms/areas, entrances and hallways.

STRENGHTS of Site/Program:

Specific Sensory Processing Recommendations

Specific Physical Plant Recommendations (short and long-term based on priorities and budget)**:**

Other Recommendations

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RESPA Checklists to be completed: ❑ Individual ❑ Day Program

This evaluation should be reviewed for follow-up in:
❑ 1-month ❑ 3-months ❑ 6-months ❑ 1-year ❑ Other ______________________

Follow-up/Update on Progress

Date: ________________________

Reviewer's Name: **Role:**

Describe how the recommendations from the original Review have been addressed.

Additional follow-up is needed: ❑ Yes ❑ No

This evaluation should be reviewed again for follow-up in:
❑ 1-month ❑ 3-months ❑ 6-months ❑ 1-year ❑ Other ______________________

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