

## Risk Assessment Worksheet

- Refer to Risk Assessment Matrix before completing form
- Discharging/Transferring site completes page 1 and 2
- Receiving Unit/Site/Facility completes page 3 and 4 (*this can be done by phone or fax in collaboration with the discharging site*)

Zone		Date of Request <i>(dd-Mon-yyyy)</i>	
<b>Discharging/ Transferring Unit/ Site/ Facility</b>			
Patient/Resident Name <i>(Last, First)</i>			
PHN/ULI		Date of Birth <i>(dd-Mon-yyyy)</i>	
Discharging Unit and Facility Name		Unit Phone/Fax Number	
Date of Request for Transfer <i>(dd-Mon-yyyy)</i>		Reason for Transfer Request	
Contact Name <i>(person completing form)</i>		Phone Number	
Outbreak status of discharging unit? <input type="checkbox"/> N/A <span style="margin-left: 200px;"><input type="checkbox"/> Open Outbreak</span> EI# <i>(if required/available):</i> _____ Date Outbreak opened <i>(dd-Mon-yyyy)</i> _____ Etiological/Agent type: _____			
Attending/most responsible physician is aware pending discharge/transfer to a unit/site with an open outbreak with transfer restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A <i>(receiving site not on outbreak)</i>			
Informed consent obtained from patient/resident or guardian for discharge/transfer to unit/site with an open outbreak with transfer restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A <i>(receiving site not on outbreak)</i> <input type="checkbox"/> N/A <i>(unable to consent and no decision maker in place)</i>			
Has client been identified as a close contact of a positive case? <input type="checkbox"/> No <input type="checkbox"/> Yes → Last exposure date <i>(dd-Mon-yyyy)</i> _____			
Symptoms of outbreak illness in patient/resident ( <b>ONLY complete if patient is coming from an outbreak unit/site</b> ) Last swab collection date (if tested) <i>(dd-Mon-yyyy)</i> _____ Result _____ <input type="checkbox"/> No <i>(never symptomatic for outbreak illness)</i> <input type="checkbox"/> Yes <i>*If symptomatic at any point</i> → Onset date <i>(dd-Mon-yyyy)</i> _____ Resolved date <i>(dd-Mon-yyyy)</i> _____ Describe symptoms _____			
For <b>confirmed influenza outbreaks</b> only (at sending or receiving site): Immunization and/or antiviral prophylaxis Has the patient/resident received current season influenza vaccine? <input type="checkbox"/> No → Offer and provide vaccine for patient/resident prior to discharge. Indicate if client refuses. <input type="checkbox"/> Client refuses vaccine <input type="checkbox"/> Yes → Date of immunization <i>(dd-Mon-yyyy)</i> _____ Has the patient/resident commenced antiviral prophylaxis? <input type="checkbox"/> No → For influenza outbreak at receiving site, provide first dose of antiviral before transfer. <input type="checkbox"/> Yes → Start date <i>(dd-Mon-yyyy)</i> _____			

## Risk Assessment Worksheet

For **confirmed COVID-19 outbreaks** only (at sending or receiving site): Immunization

Has the patient/resident received all recommended doses of vaccine?

No → Offer and provide one dose of vaccine for patient/resident prior to discharge. Indicate if client refuses.

Client refuses vaccine

Yes → Date of most recent dose (*dd-Mon-yyyy*) \_\_\_\_\_

Related comorbidities (*e.g., cardiovascular, renal disease, respiratory, immunocompromised, pregnancy*):

**Cognition and compliance with recommended hygiene** (*Choose One*)

Independent and compliant

Compliant but requires prompting (*needs to be monitored*)

Non-compliant, mobile

Non-compliant, mobile with assistance (*walker, wheelchair, personal assistance*)

Non-mobile (*bed-ridden*)

Notes/Instructions:

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## Risk Assessment Worksheet

<b>Receiving Unit/ Site/ Facility</b> <i>(To be completed by or in collaboration with the receiving unit/site/facility)</i>	
Facility Name	
Floor/Unit	Room Number
Contact Name <i>(Person completing form)</i>	
Phone number	Fax number
Receiving site/unit in agreement with patient/resident transfer/admission: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Patient/Resident is being admitted to outbreak unit: <input type="checkbox"/> No <i>(outbreak information below not required)</i> <input type="checkbox"/> Yes <i>(outbreak information required as listed below)</i>	
Outbreak status of receiving unit? <input type="checkbox"/> N/A <input type="checkbox"/> Open Outbreak EI# <i>(if required/available)</i> : _____ Onset date <i>(dd-Mon-yyyy)</i> _____ Etiological/Agent type: _____ Accommodation Type: <input type="checkbox"/> Private room <input type="checkbox"/> Private room with shared bathroom <input type="checkbox"/> Shared (semi-private) room	
All outbreak control measures in place <i>(refer to page 4 for detailed assessment)</i> : <input type="checkbox"/> No <input type="checkbox"/> Yes	
Able to isolate/confine patient/resident to single room <i>(if required)</i> <i>(refer to page 4 for detailed assessment)</i> : <input type="checkbox"/> No <input type="checkbox"/> Yes	
Able to carry out enhanced cleaning of room for remainder of outbreak <input type="checkbox"/> No <input type="checkbox"/> Yes	
Able to provide tray service to client in room <i>(if required)</i> : <input type="checkbox"/> No <input type="checkbox"/> Yes	
The following actions must be completed for confirmed influenza A or B outbreaks: <input type="checkbox"/> Arrangements made to continue antiviral prophylaxis, as required. <input type="checkbox"/> Review influenza vaccine status.	
The following actions must be completed for confirmed COVID-19 outbreaks: <input type="checkbox"/> Review COVID-19 vaccine status.	
<b>Transfer/Discharge Review</b> <i>(To complete as per zone processes)</i>	
<b>Transfer/Discharge</b> If all applicable measures/actions included in this form are answered "yes", transfer is pre-approved by MOH. Note: All North Zone RAW Required must go to MOH/MOH designate for approval NZOutbreakCDTeam@ahs.ca <input type="checkbox"/> MOH Pre-Approval Criteria Met <input type="checkbox"/> Approved <input type="checkbox"/> NOT Approved	
Name of Approver/Title _____	Date <i>(dd-Mon-yyyy)</i> _____
<b>Outbreak Lead completing form</b> <i>(if applicable)</i>	
Name _____	Date <i>(dd-Mon-yyyy)</i> _____
Notes/Instructions: _____ _____ _____	

## Risk Assessment Worksheet

### Outbreak Control Measures are in place

- Following directions from Public Health for cohorting.
- Care is provided to symptomatic residents last.
- Consistent use of continuous masking and eye protection is in place for all healthcare workers and staff.
- All staff are trained on appropriate use of PPE with ongoing monitoring and audits.
- All staff are trained on proper hand hygiene with ongoing monitoring and audits.
- Ongoing resident screening for symptoms.
- Any symptomatic residents are swabbed and put on isolation with appropriate precautions.
- Cancellation of high risk activities.
- Visitors are continuously masked while in the facility.
- For influenza outbreaks only:
  - Non-Immunized staff are following the antiviral prophylaxis recommendations
  - Access to antiviral prophylaxis is in place for residents

### Ability to Isolate/Confine Symptomatic Resident During the Isolation Period

#### Symptomatic Resident will be placed in:

a private room

**OR**

temporary isolation room

**OR**

semi private with shared bathroom **AND** the following are in place:

- There is a physical barrier (curtain) in the room and there is 6 feet of separation.
- Bathroom will be cleaned and disinfected after each use by new admission.
- Room will be cleaned last and high touch areas done a minimum of twice per day.
- Clean and dirty linen will be separated for both residents. All AHS guidelines for “isolation without walls” will be in place

#### Additional mitigating factors for symptomatic residents with dementia will be applied on an as needed basis including:

- Staffing to assist with symptomatic resident during waking hours to ensure compliance with isolation and to:
  - keep resident occupied and in room as much as possible;
  - provide added hand hygiene;
  - provide additional high touch cleaning following symptomatic resident when outside of room;
  - facilitate physical distancing between symptomatic resident and others when outside room;
  - provide meaningful distractions, cognitive, social stimulation and calming strategies as needed.
- Resident will wear PPE as able with 1:1 staff support with activities and adjustment to site.
- 1:1 staffing

#### Symptomatic resident being admitted to a secure dementia unit, the following additional requirements will be applied:

- Additional symptomatic resident hand hygiene will be provided.
- Additional disinfection of high touch areas will occur.
- Fire doors will be closed to create mini units within each unit, where possible.
- Staff to assist with physical distancing and additional activities.
- Staggered meal service or physical distancing during meals.
- Point of care risk assessment completed when indicated.