Alberta Health Services

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 *(dd-Mon-yyyy)*

Discharging/ Transferring Unit/ Site/ Facility

Patient/Resident Name *(Last, First)*	
PHN/ULI	Date of Birth *(dd-Mon-yyyy)*
Discharging Unit and Facility Name	Unit Phone/Fax Number
Date of Request for Transfer *(dd-Mon-yyyy)*	Reason for Transfer Request
Contact Name *(person completing form)*	Phone Number

Outbreak status of discharging unit?

☐ N/A ☐ Open Outbreak

EI# *(if required/available):* _____ Date Outbreak opened *(dd-Mon-yyyy)* _____

Etiological/Agent type: _____

Attending/most responsible physician is aware pending discharge/transfer to a unit/site with an open outbreak with transfer restrictions?

☐ No ☐ Yes ☐ N/A *(receiving site not on outbreak)*

Informed consent obtained from patient/resident or guardian for discharge/transfer to unit/site with an open outbreak with transfer restrictions?

☐ No ☐ Yes ☐ N/A *(receiving site not on outbreak)* ☐ N/A *(unable to consent and no decision maker in place)*

Has client been identified as a close contact of a positive case?

☐ No ☐ Yes → Last exposure date *(dd-Mon-yyyy)* _____

Symptoms of outbreak illness in patient/resident ***(ONLY complete if patient is coming from an outbreak unit/site)***

Last swab collection date (if tested) *(dd-Mon-yyyy)* _____ Result _____

☐ No *(never symptomatic for outbreak illness)*

☐ Yes **If symptomatic at any point* → Onset date *(dd-Mon-yyyy)* _____

Resolved date *(dd-Mon-yyyy)* _____ Describe symptoms _____

For **confirmed influenza outbreaks** only (at sending or receiving site): Immunization and/or antiviral prophylaxis

Has the patient/resident received current season influenza vaccine?

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

☐ Client refuses vaccine

☐ Yes → Date of immunization *(dd-Mon-yyyy)* _____

Has the patient/resident commenced antiviral prophylaxis?

☐ No → For influenza outbreak at receiving site, provide first dose of antiviral before transfer.

☐ Yes → Start date *(dd-Mon-yyyy)* _____

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

Has patient/resident received a dose of COVID-19 vaccine between last September and now?

☐ Yes ⟶ Date of most recent dose *(dd-Mon-yyyy)* _____

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

☐ Client refuses vaccine

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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Receiving Unit/ Site/ Facility *(To be completed by or in collaboration with the receiving unit/site/facility)*

Facility Name

Floor/Unit | Room Number

Contact Name *(Person completing form)*

Phone number | Fax number

Receiving site/unit in agreement with patient/resident transfer/admission:

☐ No ☐ Yes

Patient/Resident is being admitted to outbreak unit:

☐ No *(outbreak information below not required)* ☐ Yes *(outbreak information required as listed below)*

Outbreak status of receiving unit?

☐ N/A ☐ Open Outbreak

EI# *(if required/available):* _____ Onset date *(dd-Mon-yyyy)* _____

Etiological/Agent type: _____

Accommodation Type:

☐ Private room ☐ Private room with shared bathroom ☐ Shared (semi-private) room

All outbreak control measures in place *(refer to page 4 for detailed assessment):*

☐ No ☐ Yes

Able to isolate/confine patient/resident to single room (if required) *(refer to page 4 for detailed assessment):*

☐ No ☐ Yes

Able to carry out enhanced cleaning of room for remainder of outbreak

☐ No ☐ Yes

Able to provide tray service to client in room *(if required):*

☐ No ☐ Yes

The following actions must be completed for confirmed influenza A or B outbreaks:

☐ Arrangements made to continue antiviral prophylaxis, as required.

☐ Review influenza vaccine status.

The following actions must be completed for confirmed COVID-19 outbreaks:

☐ Review COVID-19 vaccine status.

Transfer/Discharge Review *(To complete as per zone processes)*

Transfer/Discharge

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

☐ MOH Pre-Approval Criteria Met ☐ Approved ☐ NOT Approved

Name of Approver/Title _____ Date *(dd-Mon-yyyy)* _____

Outbreak Lead completing form *(if applicable)*

Name _____ Date *(dd-Mon-yyyy)* _____

Notes/Instructions: _____

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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 put on isolation with appropriate precautions.
    - Collect specimens as directed by MRHP or Public Health Outbreak Team
- Cancellation of high risk activities.
- Visitors should wear a mask in common areas on outbreak units.
- 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.