nova scotia health authority

Continuing Care
Safety Risk Assessment Tool

Client Name: _____

HCN: _____

DOB: _____

attach patient label if applicable

Client name:	HCN:

SECTION A: PRE-VISIT RISK ASSESSMENT (To be completed BEFORE first home visit.)		
Review the safety information collected during Intake before completing this section . Validate (do not repeat) the details.		
General Risk	To your knowledge, is there any reason a home visit may pose a risk to staff?	☐ **Yes** ☐ **No**
	If yes, please describe:	
	Comments and/or client's plan to mitigate risk:	
Animals/ Pets	Do you have any pets?	☐ **Yes** ☐ **No**
	If yes, pets must be secured in another room or crate or outside of the house during the staff visit.	☐ **Discussed** ☐ **N/A**
	Comments and/or client's plan to mitigate risk:	
Smoking	Do you or others smoke in your home?	☐ **Yes** ☐ **No**
	If yes, there must be no smoking in the home at least one hour prior to **and** during staff visits.	☐ **Discussed** ☐ **N/A**
	Comments:	
Substance Use	I am required to let you know that NSHA has a zero tolerance policy for substance use where staff are present. This means no one in the home can be under the influence of illegal substances, non-medicinal cannabis and/or alcohol during the home visit.	☐ **Discussed**
	Comments:	
Presence of Others	Are there others who live in your home? If yes, please list:	☐ **Yes** ☐ **No**
	We welcome you to involve others in your care and encourage you to have someone present. Will anyone else be present during the staff visit? If yes, please list:	☐ **Yes** ☐ **No**
	If yes, we respect your privacy and confidentiality. Are you comfortable discussing your care in the presence of this person(s)?	☐ **Yes** ☐ **No** ☐ **N/A**
	If yes, will anyone be present who is known to be potentially aggressive or violent? If so, we may require that person not be in the home when staff are present.	☐ **Yes** ☐ **No** ☐ **N/A** ☐ **Discussed**
	Comments:	

Client Name: _____

HCN: _____

DOB: _____

attach patient label if applicable

Client name: HCN:

Guns & Other Weapons	Do you have any guns or other weapons on the premises where staff will be visiting?	☐ **Yes** ☐ **No**
	If yes, are they locked/secured?	☐ **Yes** ☐ **No** ☐ **N/A**
	Please note that staff will not be able to enter the home unless they are secured.	☐ **Discussed** ☐ **N/A**
	Comments and/or client's plan to mitigate risk:	
Infectious Diseases	Does anyone living in your home have an infectious disease (such as measles, mumps, TB, chicken pox)?	☐ **Yes** ☐ **No**
	If yes, are you permitted to have visitors in your home?	☐ **Yes** ☐ **No** ☐ **N/A**
	Comments:	
	Have you ever been told you were MRSA or VRE Positive? If yes, please tell me more (i.e. any additional precautions that you or others need to take)?	☐ **Yes** ☐ **No**
	Comments:	
Infestation	Are there any issues with bugs or rodents in your home?	☐ **Yes** ☐ **No**
	If yes, please describe (Rats, Roaches, Bed bugs, Mice, Other):	
	Comments:	
Other Comments:		

Staff Name (print):			
Signature:		Date:	

Client Name: _____

HCN: _____

DOB: _____

attach patient label if applicable

Client name:	HCN:

SECTION B: IN-HOME RISK ASSESSMENT (To be completed DURING first home visit.)

Review Section A before making the first home visit.

Type of location:

☐ Single Family ☐ Apartment ☐ Assisted Living ☐ Other: _____

Hazards associated with getting to the client's home

- ☐ Lengthy walk to client's home (excessive distance)
- ☐ Poorly lit parking lot/street
- ☐ Parking lot poorly maintained
- ☐ Client's property poorly maintained and/or not routinely cleared in winter months
- ☐ City sidewalk not well maintained and/or not routinely cleared in winter months
- ☐ House is in isolation
- ☐ Home is located in an area that one might consider high-risk
- ☐ No cellular reception
- ☐ Other: _____
- ☐ None identified

Hazards inside the client's home

- ☐ Exits/doors are blocked
- ☐ Stairs poorly maintained, missing rails
- ☐ Trip hazards (floors are cracked, loose rugs, loose mats)
- ☐ Unsanitary environment
- ☐ Concern of contagious conditions and/or communicable disease
- ☐ Cluttered or cramped work area affecting ability to perform tasks safely
- ☐ Electrical appliances, other equipment required to perform tasks in poor working order
- ☐ Phone not available
- ☐ No power
- ☐ No running water
- ☐ Other: _____
- ☐ None identified

Multi-Tenant Dwellings Only

- ☐ Common stairs poorly maintained
- ☐ Poorly lit hallway / stairwell
- ☐ Common hallways are cluttered and full of debris
- ☐ Exits and emergency exits are not visible or marked
- ☐ Exits are blocked or non-functional
- ☐ Elevator is non-functional / requires excessive stair climbing
- ☐ A buzzer system is not available / difficulty notifying client and entering the building
- ☐ External door is locked during the day (cannot notify client or gain access to the building)
- ☐ Other: _____
- ☐ None identified

Stray Needles (Sharps)

- ☐ Stray / improperly disposed of used needles/sharps/lancets inside or outside the home
- ☐ None identified

Chemical

- ☐ Chemical hazards present (specify):
- ☐ None identified

Client Name: _____

HCN: _____

DOB: _____

attach patient label if applicable

Client name:	HCN:

SECTION B: IN-HOME RISK ASSESSMENT continued

Hazards related to client care

- ☐ Client may require more than a one-person assist to transfer or mobilize
- ☐ Client is unable to communicate their basic needs effectively
- ☐ Client presents with or has a recent history (in past week) of agitated or aggressive responsive behaviours
- ☐ Medical condition present requiring special precaution (specify):
- ☐ Equipment required to provide care is not available
- ☐ Equipment available is inadequate or in poor condition
- ☐ None Identified

Other Hazards

- ☐ Mold (visible or odour)
- ☐ Client has no emergency preparedness plan (e.g. in the event of extended power absence, flood, fire, etc.)
- ☐ Other: _____
- ☐ None Identified

General Comments about the Safety Risk Assessment

SECTION C (To be completed AFTER first home visit.)

Confirm that the information collected on this form is accurate by signing below.

☐ Results of risk assessment and plans to mitigate risks discussed with client and documented

Note: Significant Risks must be communicated to others in the Circle of Care who also make home visits as soon as reasonably possible.

☐ No Risks Identified

Staff Name (print):			
Signature:		Date:	