

Client Health Record #
 Client Surname
 Given Name
 Date of Birth
 Gender
 MFRN
 PHIN
 Address

Community Health Services
SAFETY ASSESSMENT FORM TOOL (SAFT)
HAZARD IDENTIFICATION

Section 1. Working Alone/Violence/Physical Hazards Assessment (continued)		
Section 1.c. Abusive and Violent Behaviour – Client		
A. CURRENT violence or aggression? <input type="checkbox"/> No Evidence	Has the client been observed? <input type="checkbox"/> Threatening violence (threatened physical harm) <input type="checkbox"/> Attempting/actual violence <input type="checkbox"/> Being aggressive to property (hitting, kicking, throwing, burning, or breaking objects) <input type="checkbox"/> Being aggressive to person (yelling at, swearing at, or insulting someone) <input type="checkbox"/> Other – specify: _____	If one of more boxes are checked in this section (excluding no evidence), activate an alert. Follow your program process and complete SVP.
B. PAST ACTIVE violence or aggression? <input type="checkbox"/> No Evidence	<input type="checkbox"/> Previous alert found on client’s record that remained activated at discharge/transfer? <input type="checkbox"/> Alert deactivated at last discharge/transfer (history must be shared with staff) <input type="checkbox"/> Past violence/aggression reported by key informant Name and relationship of informant: _____ (Question to ask family/friend “do you have any knowledge of the client having any history of violent or aggressive behaviour towards caregivers?”) <input type="checkbox"/> Past violence/aggression reported at clinical handoff <input type="checkbox"/> Other – specify: _____	If one of more boxes (excluding deactivated alert and no evidence) are checked in this section, activate an alert. Follow your program process and complete SVP.
C. Current RISK FACTORS for violence or aggression. <input type="checkbox"/> No Evidence	Is the client displaying any of the following factors that would affect the provision of care: (check all that apply) <input type="checkbox"/> Confusion/Disorientation <input type="checkbox"/> Agitated/Impulsive <input type="checkbox"/> Angry/Irritable <input type="checkbox"/> Paranoid/Suspicious <input type="checkbox"/> Substance intoxication/Withdrawal <input type="checkbox"/> Other – specify: _____	If two or more boxes are checked (excluding no evidence) in this section, activate an alert. Follow your program process and complete SVP.
Alert Status on Initial Screening/Repeat Screening <input type="checkbox"/> Not required on Initial Screening <input type="checkbox"/> Not required on Repeat Screening <input type="checkbox"/> Activated on Initial Screening <input type="checkbox"/> Activated on Repeat Screening		Possibility of <input type="checkbox"/> Physical Aggression <input type="checkbox"/> Verbal Aggression <input type="checkbox"/> Sexual Aggression/Inappropriate <input type="checkbox"/> Resistive/Refusal of Care <input type="checkbox"/> Disruptive to others <input type="checkbox"/> Other, specify: _____
Alert Deactivated <input type="checkbox"/> Deactivated during period of care provision <input type="checkbox"/> Deactivated at Discharge or Transfer		
Behaviour Triggers		
<input type="checkbox"/> Physical need: hunger/thirst/bowel/bladder/body temperature <input type="checkbox"/> Pain <input type="checkbox"/> Complicating/New medical condition (e.g. Urinary Tract Infection/UTI) <input type="checkbox"/> Memory/cognitive impairment <input type="checkbox"/> Medication/Anesthetic related (reaction or adherence) <input type="checkbox"/> Fear/Anxiety/Confusion/Frustration/Separation anxiety <input type="checkbox"/> Lack of control/Lack of decision making <input type="checkbox"/> Time of day _____	<input type="checkbox"/> Unknown <input type="checkbox"/> Substance use/withdrawal (ETOH, drugs, solvent, nicotine) <input type="checkbox"/> Barriers (communication, language, hearing loss, glasses) <input type="checkbox"/> Unmet emotional need _____ <input type="checkbox"/> Environment (temperature, noise, lights) _____ <input type="checkbox"/> Reacts to specific gender of care provider _____ <input type="checkbox"/> Reacts to care provider(s) characteristics _____ <input type="checkbox"/> Reacts to persons of specific ethnicity _____ <input type="checkbox"/> Other person _____ <input type="checkbox"/> Other, specify _____	
Section 1.d. Abusive and Violent Behaviour – Person of Interest <i>A person of interest may include but is not limited to family member, caregiver, friend, or neighbor.</i>		
Name: _____ <input type="checkbox"/> Resides with Client <input type="checkbox"/> Has a key		Relation to Client: _____ Type: <input type="checkbox"/> Physical <input type="checkbox"/> Verbal <input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> No abusive or violent behavior concerns with POI		



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Section 1.e. Hazards Inside Client's Home/Apartment

- Exits/doors are blocked
- Stairs poorly maintained, missing or unsafe railing
- Floors are cracked, loose rugs/mats, worn flooring, torn carpets
- Cluttered work area affecting ability to perform tasks safely
- Cramped (lack of space) work area affecting ability to perform tasks safely
- Access to work area restricted or blocked
- Electrical appliances, other equipment required to perform tasks in poor working order
- Weapons inside the home, visible and not safely stored (i.e. guns not in a locked gun cabinet or knives that are not meant for food preparation)
- Phone not available
- Other – specify: _____

No hazards inside the client's home/apartment

Section 1.f. Multi-Tenant Dwellings Only (only complete if applicable)

- 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
- The elevator is non-functional/requires excessive stair climbing
- A 'buzzer' system is not available/difficulty notifying client and entering building
- The external door is locked during the day (cannot notify client or gain access to building)
- There are no security cameras or a security guard on site/assistance not available in an emergency
- Phone on site not available to staff/cannot call for help in an emergency
- Other – specify: _____

No hazards within the multi-tenant dwelling

Section 2. Other Hazards

Section 2.a. Animals in the Home/Site

No animals within the home/site

- Animals in the home/site Specify type, breed (if known), number and name(s) of: _____
- Service Animal
- Evidence of current aggression by animal(s) Past evidence of aggression by animal(s) Frequency/Type: _____
- Client's functional status impacts ability to secure animal(s)
- Client will not follow WRHA Operational Procedure – Animals in Clients Environment/Homes
- Issues related to fecal/urine elimination
- Equipment (lift or other)/client care activity could compromise staff/client safety during provision of care if animals are roaming

Risk Level: specify risk level based on information above

- Low:** service animal/pet, animal(s) contained in an enclosed space and not able to come into contact with staff, or animal(s) moves freely inside home with no negative behavioural history but remains in other areas of the environment – no staff contact

No SVP required. All staff to be notified of the presence of animals, type/breed, number and name(s). Provide client with Client Expectation Sheet.

- Medium:** (animal(s) move freely inside home with no negative behavioural history that MAY come into contact with staff. SVP required.
- High:** (animal(s) move freely inside environment and have negative behavioural history that MAY come into contact with staff. SVP required.

Note: Excluding Service Animals, every effort must be made and documented to contain or secure all low, medium and high risk animals/pets.

Reference: 3.8 of Operational Procedure: Animals/Pets in Client's Environment/Home

Section 2.b. Stray Needles (Sharps) in the Home/Site

No stray needles (sharps) in the home/site

- Stray/improperly disposed used needles/sharps/lancets in the home/site

Section 2.c. Infestation in the Home/Site

No infestation in the home/site

- Evidence of an infestation in the home/site Specify: mice rats cockroaches bed bugs other _____

Unless PPE required, No SVP required. Notify staff in comments section of task sheet and refer to Standard/Safe Work Procedure

Section 2.d. Mould in the Home/Site

Evidence of mould in the home/site based on observation in care area

No mould in the home/site

- Assessment performed
 - Small (1 - 3 patches less than 1 m²) Moderate (3 or more patches between 1 m² and 3 m²) Extensive (larger than 3 m²)
 - No risk (mould contained) No SVP required. Notify staff in comments section of task sheet and refer to Standard/Safe Work Procedure
 - Mould may be airborne. SVP required

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Section 2.e. Asbestos in the Home/Site Evidence of asbestos in the home/site **No asbestos in the home/site**
 Assessment performed
 No risk (asbestos contained) No SVP required. Notify staff in comments section of task sheet and refer to Standard/Safe Work Procedure
 Asbestos may be airborne. SVP required

Section 2.f. Smoke-Free Home/Site (includes smoking and Aboriginal healing ceremonies) **No smoke in the home/site**
 Specify type/origin of smoke: _____
 WRHA Smoke-Free Policy is followed. No SVP required. Notify staff in comments section of task sheet and refer to Standard/Safe Work Procedures
 Client/Household member(s) use sacred tobacco/medicine in the home/site. No SVP required, if compliant with WRHA Smoke-Free policy. Notify staff in comments section of task sheet (The client burns sacred tobacco/medicine to do Indigenous healing ceremonies; the scent can linger and has, at times, been mistaken for the smell of marijuana, but it is not). Refer to Standard/Safe Work Procedures
 Does not follow the WRHA Smoke-Free Policy. 1st report 2nd report 3rd report

Section 2.g. Chemical Hazards **No chemical hazards in the home/site**
 Chemical Hazards – specify type: _____

Section 2.h. Hazardous Medication (Cytotoxic and Non-Cytotoxic) in the Home/Site **No hazardous medications**
 Client is prescribed hazardous medication (cytotoxic and non-cytotoxic). SVP required

Section 2i. Biological Hazard **No biological hazards in the home/site**
 Possible exposure to occupational/communicable disease (e.g. tuberculosis, mumps, chicken pox, measles, shingles) parasites (scabies, lice)
 Ensure appropriate notifications (Occupational Health, Infection Prevention and Control, Public Health, etc.)

Section 3. Musculoskeletal Injury Prevention/Ergonomics
 Ergonomic hazards for Manual Materials Handling (laundry, food prep, housekeeping) and Safe Client Handling (HCA, wound care, etc.) can be dealt with through specific processes and recommendations. Should either of those services be required, please refer to their specific assessment processes and address the applicable hazards accordingly through safe work procedures and monitoring/enforcement of those safe work procedures by the supervisor.

Section 4. Completion and Communication Details
 If severe hazard(s) are identified that cannot be managed immediately, the SVP might not be the best option and alternative ways for providing care to the client should be considered while a SVP is being developed.
 Contact WRHA Occupational and Environmental Safety & Health (OESH) or Department of Families Safety and Health Unit (SHU) regarding any questions, concerns, or if assistance is needed regarding the identification of hazards, completion of the SAFT, and the development of the SVP.

SAFT Completed by: _____ Date: _____ Phone: _____
PRINTED NAME, TITLE and DESIGNATION D D M M M Y Y Y D D M M M Y Y Y

SVP Required: No Yes Completed: _____
D D M M M Y Y Y D D M M M Y Y Y

Recipient	Date	Recipient	Date
	D D M M M Y Y Y		D D M M M Y Y Y
WRHA Home Care Case Coordinator – Hospital		Department of Families	
WRHA Home Care Case Coordinator – Community/Centralized		Children's Special Services/Family Support Worker	
WRHA Home Care Resource Coordinator/Scheduling Unit		Child Development Worker	
WRHA Home Care Nursing Resource Coordinator		Direct Service Worker (DSW)	
WRHA Direct Service Staff (HCA, HSW, RA, ISW, Allied Health)		Supported Living/Community Services Worker	
WRHA Home Care Visiting Nurses		Employment and Income Assistance Case Coordinators	
WRHA Healthy Aging Resource Team		Employment and Income Assistance Investigators	
WRHA Public Health Nurse		Vocational Rehabilitation Counselor	
WRHA Family First Home Visitor		Childcare Coordinator	
WRHA Midwife		Other: specify	
WRHA Community Mental Health Worker		Community Therapy Services (CTS)	
WRHA Community Mental Health Access Coordinator		Home Care Back-up Agency : specify	
WRHA Community Mental Health Proctor/Support Worker		Long Term Care: specify	
WRHA Community Facilitator		Other: specify	
WRHA Geriatric Program Assessment Team (GPAT)		Other: specify	
WRHA Geriatric Mental Health Team (GMHT)		Other: specify	
WRHA Day Hospital		Other: specify	
WRHA Adult Day Program		Other: specify	
WRHA Palliative Care Coordinator		Other: specify	