

Date: _____

Section A - MSI Risk Assessment

This is a reassessment.

TASK		✓ CHW Assists	Identify hazards, injury prevention control measures, and instructions to CHW	✓ No issues
Personal Care	Bathing			
	Bed bath / sponge bath			
	Bath tub / shower			
	Skincare			
	Grooming eg. hair, shaving			
	Mouthcare			
	Toileting			
	Peri Care/Incontinence Prod.			
Patient Handling	Dressing/Changing			
	Assisted Walking			
	Repositioning in chair			
	Repositioning in bed			
	Use of lift equipment: floor lift or ceiling lift			
	Transfers From: To:			
	From: To:			
From: To:				

Signature: _____

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Date: _____

DOT			
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This is a reassessment.

TASK		<input checked="" type="checkbox"/> CHW Assists	Identify hazards, injury prevention control measures, and instructions to CHW	<input checked="" type="checkbox"/> No issues
Meals	Prepare meals <input type="checkbox"/> Assist eating			
	Assist client walking <input type="checkbox"/> Inside <input type="checkbox"/> Outside			
	Grocery Shopping			
	Adult Day Care			
Cleaning and Household Activities	Bed change			
	Laundry			
	Vacuuming			
	Check Fridge			
	<input type="checkbox"/> Bathroom cleaning / floor <input type="checkbox"/> Kitchen cleaning / floor			
	Other cleaning tasks			

Section C - Chemical Hazards

This is a reassessment.

Product Name – List products CHW will use in home	Indicate health hazard, injury prevention control measures, and instructions to CHW. Attach additional page if more space is required.	<input checked="" type="checkbox"/> No issues

Rubber Gloves Kitchen

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Bathroom

Section B – Assistive Devices

This is a reassessment.

EQUIPMENT	✓ If in Place	✓ If needed	Comments: does equipment need repair? Does equipment need to be installed? Who responsible? Implementation date? Who will follow up and when?	✓ No issues
Wheelchair(s)/Scooter(s): Manual/Powered				
WalkerAides: <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker:Standard/Wheels				
<input type="checkbox"/> Raised Toilet Seat/Rails <input type="checkbox"/> Commode				
<input type="checkbox"/> Hand-held Shower <input type="checkbox"/> Bath Mat				
Hospital Bed (circle) Manual / Electric With rails / without rails				
Transfer/Reposition Devices: Bath / Shower: <input type="checkbox"/> Bench or stool <input type="checkbox"/> Grab Bars				
Transfer: <input type="checkbox"/> Slide Sheet <input type="checkbox"/> Board <input type="checkbox"/> Belt <input type="checkbox"/> Pole(s) <input type="checkbox"/> Disc				
<input type="checkbox"/> Floor Lift <input type="checkbox"/> Ceiling Lift				
Other				

Section E – Violence and Working Alone

This is a reassessment.

VIOLENCE - Risks Client related <input type="checkbox"/> Non client related <input type="checkbox"/>	✓ present or history	Describe risks, injury prevention control measures, and instructions to CHW. Identify who the risks apply to.	✓ No issues
Aggression Against CHW <input type="checkbox"/> Physical <input type="checkbox"/> Verbal			
Aggression With / Against Objects			
Sexual Abuse			

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Date: _____

Other (state type)			
Pets:			
WORKING ALONE - Risks		Describe risks, injury prevention control measures, and instructions to CHW	<input checked="" type="checkbox"/> No issues
Isolated Workplace? <input type="checkbox"/> Yes <input type="checkbox"/> No Description: (i.e., remote, rural, limited communications, etc) <input type="checkbox"/> Location remote or rural <input type="checkbox"/> Location off the main roads, at a dead-end, or has limited daily traffic <input type="checkbox"/> Parking is more than one block away or in an underground garage <input type="checkbox"/> Limited or unreliable communications Contact Supervisor <input type="checkbox"/> No safe location from which to call for assistance. <input type="checkbox"/> Limited access by walking or bus (transportation); evening/night visits <input type="checkbox"/> Obstructions /entrapment areas that limit ability to get away safely (e.g. shrubs, fences, yard clutter, etc.)			
Community Crime Profile <input type="checkbox"/> Evidence of obvious criminal activity. Description			
Unauthorized visitors <input type="checkbox"/> Yes <input type="checkbox"/> No Name: Relationship:			
CHW is able to communicate with the supervisor or employer via (tick all that apply) <input type="checkbox"/> Telephone at client's home <input type="checkbox"/> Cell phone <input type="checkbox"/> Pay phone located @ _____ <input type="checkbox"/> Other (state):			

Section D – Biological Hazards and Infection Control

This is a reassessment.

Infectious diseases resources identification: <input type="checkbox"/> Client <input type="checkbox"/> Other household member <input type="checkbox"/> No Issues Describe the disease:		
CHW exposure risk identification	Preventive control measures	Additional instructions to CHW
Airborne pathogens: <input type="checkbox"/> infectious client sneezing/coughing <input type="checkbox"/> disrupted dust/animal waste Blood and body fluids <input type="checkbox"/> sharps in the home <input type="checkbox"/> catheter care <input type="checkbox"/> handling biohazardous waste <input type="checkbox"/> handling contaminated laundry/bedding <input type="checkbox"/> handling of Other Potentially Infectious Materials (OPIMs) <input checked="" type="checkbox"/> presence of cytotoxic drugs <input type="checkbox"/> Food Safe: cross contamination in food prep <input type="checkbox"/> Pet waste:	<input type="checkbox"/> Needless system; using safety engineered devices <input type="checkbox"/> Use designated sharp container <input type="checkbox"/> Compliance with Universal Precaution <input type="checkbox"/> Hygiene practice <input type="checkbox"/> Hand washing technique <input type="checkbox"/> Use double gloves where appropriate Use PPE, including: <input type="checkbox"/> gloves <input type="checkbox"/> nitrile gloves <input type="checkbox"/> gowns <input type="checkbox"/> mask or respirator <input type="checkbox"/> goggles <input type="checkbox"/> face shields <input type="checkbox"/> shoe covers <input type="checkbox"/> Other controls, specify:	<input type="checkbox"/> Required safe work procedures. Specify: <input type="checkbox"/> Training and education required. Specify: <input type="checkbox"/> Other instructions:

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Date: _____

<input type="checkbox"/> Vermin (e.g.: rodents, insects)		
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SECTION F - General Hazards

This is a reassessment.

GENERAL HAZARDS – check all that apply	For any ✓: describe hazard, injury prevention control measures, and instructions to CHW	✓ No Issues
Road access: <input type="checkbox"/> affected by weather <input type="checkbox"/> poor repair		
Exterior: <input type="checkbox"/> cluttered entrance <input type="checkbox"/> poor repair <input type="checkbox"/> trip/slip hazards <input type="checkbox"/> address not visible <input type="checkbox"/> poor lighting <input type="checkbox"/> not covered from weather (i.e. snow) / no salt available <input type="checkbox"/> stairwell access only <input type="checkbox"/> unsafe ramp/steps/walking surface <input type="checkbox"/> exit doors / evacuation paths inaccessible / unmarked <input type="checkbox"/> key or lockbox unavailable		
Interior: <input type="checkbox"/> floors slippery <input type="checkbox"/> floors uneven <input type="checkbox"/> trip hazards <input type="checkbox"/> poor lighting <input type="checkbox"/> elevator in poor repair		
Stairs: <input type="checkbox"/> no or unsafe handrails <input type="checkbox"/> low ceiling <input type="checkbox"/> narrow / steep <input type="checkbox"/> obstacles / trip hazards <input type="checkbox"/> other		
Air Quality: <input type="checkbox"/> poor ventilation <input type="checkbox"/> smell / odor <input type="checkbox"/> scents or dust <input type="checkbox"/> smokers in the home <input type="checkbox"/> obvious presence of moulds, or other allergens		
Electrical Hazards: (list locations/appliances affected) → <input type="checkbox"/> appliances broken or in need of repair <input type="checkbox"/> electrical cords are frayed <input type="checkbox"/> electrical sockets are overloaded		
Oxygen Equipment: <input type="checkbox"/> concentrator <input type="checkbox"/> oxygen tank walker <input type="checkbox"/> liquid oxygen <input type="checkbox"/> equipment not stored safely <input type="checkbox"/> no signs posted <input type="checkbox"/> poor repair		
Fire Safety: <input type="checkbox"/> exits inaccessible (clutter/blocked) <input type="checkbox"/> oxygen in use <input type="checkbox"/> electrical hazards <input type="checkbox"/> smoker in home <i>smoke detectors</i> <input type="checkbox"/> none <input type="checkbox"/> non-functional <i>fire extinguisher</i> <input type="checkbox"/> none <input type="checkbox"/> non-functional <input type="checkbox"/> inaccessible		
Firearms:		

Signature: _____

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Date: _____

<input type="checkbox"/> firearms in the home If ✓ above: <input type="checkbox"/> ammunition not stored separately <input type="checkbox"/> not secured/stored safely <input type="checkbox"/> history of violence in home (see section E)		
Other:		

Is Client aware of the CHW's obligation to refuse unsafe work? Yes No