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| Site Assessment Form for Homeless Service Sites Date of Assessment: | | | | | | | | | |
| Name of facility | | | | Name of Observer: | | | | | |
| Address: | | | | N° people served per day: | | | Sq ft: | | |
| Type of facility: o Day shelter o 24/7 shelter o Supportive/Transitional housing  o Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Hours of operation: | | | | | |
| Ownership: o Public o Private o Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Participate in HMIS? Y / N | | | | Collect bed maps? Y / N | | | | | |
| Site POC: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name Position Phone # | | | | | | | | | |
| **Staff** | | | | | | | | | |
| # Permanent Staff on Site \_\_\_\_\_\_\_\_\_\_\_\_\_  # Volunteer/Temp Staff on Site: \_\_\_\_\_\_\_\_\_  Do staff rotate to other sites? Y / N | | | | Medical Services Available: Y / N  Clinician Type : | | | | | |
| **Facilities** | | | | | | | | | |
| Kitchen facilities? Y / N If yes: Cooking on site?: Y / N Meals delivered?: Y / N Meals are individually boxed? Y / N | | | | | | | | | |
| Is this facility used as a meal site where individuals come to eat (in addition to the clients who stay overnight)? Y / N | | | | | | | | | |
| # Showers: | | | | # Private Bathrooms \_\_\_\_\_\_\_ # Communal Bathrooms \_\_\_\_\_\_ | | | | | |
| # Total Beds: | | | | # Beds Filled Per Night (on average): | | | | | |
| # Beds filled on date of (circle one): Assessment, 1st Confirmed Case, Mass Testing, 1st Symptomatic Client: \_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| # Female Beds: | | # Male Beds: | | | | # Non-assigned Beds: | | | |
| # Individual Rooms: | # Double Rooms: | # Family rooms: | | | | # Dorm style rooms & capacity:  3-4 ppl\_\_\_\_\_\_\_\_ 8-10 ppl\_\_\_\_\_\_\_\_\_\_ 4-8 ppl\_\_\_\_\_\_\_\_ > 20 ppl\_\_\_\_\_\_\_\_\_\_ | | | |
| Are bed/mats assigned to one person? Y / N | | | | Are beds/mats stacked nightly? Y / N | | | | | |
| Distance between beds in sleeping area:  At least 3 Feet: Y / N  If no, distance between beds: | | | | Separation screens/barriers in congregate area? Y / N | | | | | |
| Bed linens provided? Y / N | | | | | |
| Are clients sleeping head-to-toe? Y / N | | | | How often linens changed/washed? | | | | | |
| **IPC Measures** | | | | | | | | | |
| IPC signage for COVID- 19posted (e.g. handwashing, hygiene posters)? | | | Y / N | | Do staff wear work clothes different from street clothes? | | | Y / N | |
| Aware of referral system in case of sick clients? (to hospital or to I&Q) | | | Y / N | | Staff routinely wear mask when interacting with clients? | | | Y / N | |
| Limited number of designated entry points (staff, visitors, clients)? | | | Y / N | | Staff routinely wear mask when onsite but not interacting with clients? | | | Y / N | |
| Handwashing points at facility entry? | | | Y / N | | Staff routinely wear glove when interacting with clients? | | | Y / N | |
| Are points of entry monitored by staff to ensure hand hygiene? | | | Y / N | | Availability of mask/cloth face coverings for clients? | | | Y / N | |
| Handwashing points available and functioning for staff & clients? | | | Y / N | | Routine use of mask/ cloth face coverings by clients? | | | Y / N | |
| **All** staff trained on hygiene measures & standard precautions? | | | Y / N | | Cleaning schedule in place for:  Kitchen  Bathrooms  Bedrooms | | | Y / N  Y / N  Y / N | |
| How frequently are common areas cleaned? | | | | |
| **Isolation Areas** | | | | | | | | | |
| Designated **symptomatic area(s) for suspected cases.**  # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Size\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Capacity \_\_\_\_\_\_\_\_\_\_\_ | | | | Designated **isolation area(s) for confirmed cases.**  # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Size\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Capacity \_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Can this be a long-term isolation area for mild cases? | | | Y / N | | **Appropriate staff trained on:**  Isolation Protocol  PPE Protocol  Reporting suspected or confirmed cases | | | | Y / N Y / N  Y / N |
| Do symptomatic areas or isolation areas have designated latrine? | | | Y / N | |

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| **Client Screening** | | | | | | | |
| Are all clients screened for COVID-19 symptoms? | | | Y / N | Do clients receive temperature screening? | | | Y / N |
| If yes, how frequently are clients screened forsymptoms?  Daily: Y / N Other: | | | | If yes, how frequently do clients receive temperature screen?  Daily: Y / N Other: | | | |
| What is the screening process?  Is there a screening form? | | | | Does screener use:  Gloves: Y / N Face Shield: Y / N  Mask: Y / N Barrier/partition: Y / N  Other PPE: | | | |
| Who conducts client screening? | | | |
| **Actions taken for symptomatic clients** | | | | | | | |
| Provided with a surgical mask?  If so, how often do you provide them with a new mask? | | | Y / N | Relocated to a designated isolation area? | | | Y / N |
| Referred to a healthcare provider/facility?  If so, where? | | | Y / N | Do you call your supervisor to inform about a symptomatic client? | | | Y / N |
| **Actions taken for clients with confirmed COVID-19** | | | | | | |  |
| Isolated on site? | | | Y / N | Referred elsewhere for isolation?  If so, where: | | | Y / N |
| **Staff Screening** | | | | | | | |
| Are staff screened for symptoms before starting each shift? | | | Y / N | Who conducts staff screening? | | | |
| Do staff receive temperature screening before starting each shift? | | | Y / N | Does screener use:  Gloves: Y / N Face Shield: Y / N  Mask: Y / N Barrier/partition: Y / N  Other PPE: | | | |
| What is the screening process?  Is there a screening form? | | | |
| **Actions taken for symptomatic staff/volunteers** | | | | | | | |
| Provided a surgical mask? | | | Y / N | Are symptomatic staff allowed to continue working? | | | Y / N |
| Do you call a supervisor to inform about an ill staff with COVID-19 like symptoms? | | | Y / N | Referred to healthcare provider/facility?  If so, where? | | | Y / N |
| Any other actions taken when staff/volunteers symptomatic? | | | | | | | |
| **Reporting Cases to Health Authorities Provide Details:** | | | | | | | |
| Process in place to report **suspected** cases of COVID-19 among: | | Staff Y / N | | |  | | |
| Clients Y / N | | |  | | |
| Process in place to report **confirmed** cases of COVID-19 among: | | Staff Y / N | | |  | | |
| Staff Y / N | | |  | | |
| **Confirmed Cases** | | | | | | | |
| **Staff**  Total # Confirmed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of first confirmed case:\_\_\_\_\_\_\_\_\_\_\_  Date of last confirmed case: \_\_\_\_\_\_\_\_\_\_\_  Were all cases reported to health dept.? Y / N  If no, # reported\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Clients**  Total # Confirmed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of first confirmed case:\_\_\_\_\_\_\_\_\_\_\_  Date of last confirmed case: \_\_\_\_\_\_\_\_\_\_\_  Were all cases reported health dept.? Y / N  If no, # reported\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **PPE and Supplies** | | | | | | | |
| [Duration](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html) of current stock of supplies:  Masks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Gloves \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Eye shield or Goggles\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cloth face coverings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Hand-sanitizer available for all the rooms in the facility? Y / N  Duration of current supply of hand sanitizer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Where do you obtain PPE and other supplies from? | | | | |
| Who wears PPE in your facility? | | | | |
| **Cleaning Process** | | | | | | | |
| Is the cleaning process contracted out?  To whom? | | | Y / N | Do cleaning staff wear:  Gloves: Y / N Mask: Y / N  Other PPE: | | | |
| Are appropriate cleaning practices in use? (Frequency, showers cleaned after use, effective products, beds denominated) | | | Y / N | Did the cleaning staff receive COVID-19 IPC training? | | Y / N | |
| **Training Provided:** o IPC Measures o Covid-19 screening o Covid-19 suspect patient isolation | o WASH o Waste management o Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Notes/follow-up plan:** | | | |
| **Supplies/Infrastructure Support Provided** (provide details)**:** | | | |