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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 sheltero 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 / NIf 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:KitchenBathrooms  Bedrooms | Y / NY / NY / 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 ProtocolPPE ProtocolReporting suspected or confirmed cases | Y / N Y / NY / 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 / NMask: 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 / NIf 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 / NDuration 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 Measureso Covid-19 screeningo Covid-19 suspect patient isolation | o WASHo Waste managemento Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Notes/follow-up plan:** |
| **Supplies/Infrastructure Support Provided** (provide details)**:** |