*This checklist helps teams to plan, seek approval for, and document visits during the COVID-19 pandemic. It is to be completed in the ODB for* ***EVERY*** *non-essential visit or one-time (not re-occurring) essential visit at Christian Horizons’ support location or essential overnight visit outside of support location.*

*For re-occurring essential visits or visits with designated visitors, this checklist is to be completed and approved* ***ONCE****, in advance of the first visit, and documentation of subsequent visits is to be recorded in support notes.*

*If the ODB is down, complete this checklist on paper or in the electronic MS Word form and then update the ODB when it is live.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
| **Name of Person Supported** |  | **Visit Start Date** |  | **Start Time** |  | **Visit End Date** |  | **End Time** |
| [ ]  Drive-by [ ]  Outdoor (e.g. porch, backyard) [ ]  Indoor [ ]  Essential Visits |  |  |
| **Visit at Support Location** (Complete Section A below) |  | **Designated Visit Area at Support Location** |
| [ ]  Essential Overnight Visits |  |  |
| **Visit Outside of Support Location** (Complete Section B below) |  | **Place of Visit Outside of Support Location (including address)** |
|  |
| **Person-Specific Requirements** (Please note any requirements or requests specific to the person using services or visitors for planning purposes and to ensure the visit meets the given expectations) |

1. **Non-Essential and Essential Visit at Support Location**

**Pre-visit:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | [ ]  Non-Essential [ ]  Designated [ ]  Essential |  | [ ]  Yes [ ]  No |
| **Visitor Name** |  | **Type of Visitors** |  | **Passed Active Screening** |
|  |  | [ ]  Non-Essential [ ]  Designated [ ]  Essential |  | [ ]  Yes [ ]  No |
| **Visitor Name** (If Applicable) |  | **Type of Visitors** |  | **Passed Active Screening** |
| [ ]  Yes [ ]  No |  |  |  |  |
| **For Essential Visits:** Will they be recurring/frequent? |  | **Specify Purpose of Essential Visits** |  | **Frequency of Essential Visits** (e.g., Each Tues morning, 3rd Mon of each month at 1:00 PM, etc.) |
|  |
| **Name of Employee(s) supporting the visit** |

[ ]  Visitors have been made aware of the guidelines and the details of the visit (including schedule, expectations around active screening, PPE, physical distancing and no physical contact).

[ ]  Visitors have been made aware Visitors have been made aware that any gifts for their loved one will be gratefully received in advance of the visit in order to be sanitized

**During visit:**

[ ]  Employee remained within eyesight of the visit to ensure expectations are followed.

[ ]  Employee ensured that the environment was as welcoming and gracious as possible given the expectations.

**Post-visit:**

[ ]  Employee confirmed that the visit progressed as planned.

If the visit did not go as planned, please note the issues/concerns and contact the Program Manager/Team Leader immediately.

Please note any concerns expressed by the visitor, person using services, or others in the home, or any comments about the visit in general:

1. **Essential Overnight Visit (Outside of Support Location)**

**Pre-visit:**

[ ]  Visitors have received **COVID-19 Visiting Guide for Families and Friends** and have been made aware of MCCSS guidelines for Essential Overnight Visits (including practicing respiratory etiquette, hand hygiene, physical distancing, avoiding crowded places and interactions with multiple people, using masks and sanitizing when in public, following enhanced precautions 14-days upon returning from overnight visits).

[ ]  Visitors are encouraged to support their loved one to trace contacts using the **Where I’ve Been Timeline** in the event of possible COVID-19 exposure.

[ ]  Employees have confirmed that both the person and their family member(s) or friend(s) have been actively screened for signs and symptoms of COVID-19 using Christian Horizons active screening protocol before an overnight visit commences.

**Post-visit:**

Please note any updates or issues/concerns that have arisen regarding the visit:

[ ]  The person returning home following an overnight visit was actively screened for signs and symptoms of COVID-19 before entry and supported to get tested, if wished.

[ ]  The Person returning home from overnight visit is being supported to follow the 14-days of enhanced precautions.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Completed by (Employee)** |  | **Reviewed By (Supervisor)** |  | **Original Plan Reviewed By (Area Manager)** |
|  |  |  |  |  |
| **Date**  |  | **Date** |  | **Date** |