EACH - Risk Assessment/Hazard Analysis Form V1.2

Location:	The Treehouse, Milton and The Nook hospice buildings	**Assessment No:**	One	**Assessment Date:**	Updated 12.4.2022
Department:	Staff and volunteers from all departments working in and visiting hospice buildings	**Assessment Type**: (Delete as appropriate: Note 1)			
		Specific		***Generic***	

Activity/Process/ Rationale:	Working safely in the hospice buildings during COVID-19 pandemic

Assessor		**Line Manager Acceptance** (Note 2)	
Name:	H Warriner, C Norman, Nathan Musket, Mike Higgins, Melissa Lindsell Louise Gower	**Name:**	L Maynard C Roberts
Job Title:	Matrons and Service Managers	**Job Title:**	Assistant Directors
Signature:		**Signature:**	**Electronic**

Assessment Review (Note 2)							
Review Date:		**Name:**		**Job Title:**		**Signature:**	
Review Date:		**Name:**		**Job Title:**		**Signature:**	
Review Date:		**Name:**		**Job Title:**		**Signature:**	

Risk Rating = Likelihood x Consequence = Residual Risk (RR)

						Management Plan		
Hazard	**Who is at Risk?**	**Control Measures** (Existing controls)	**Risk Rating** (Note 3)	**Additional Controls** (Additional control is to be put in place and managed)	**RR Rating** (Note 4)	**Owner**	**Target Date**	**Comp Date**
Exposure to and spread of Covid-19 Coronavirus	All staff, volunteers, visitors and service users present in the hospice buildings	Pandemic Flu Policy and Infection Control Policy and Procedures available to all staff detailing & providing active links to information regarding routes of transmission and mitigation actions including infection control procedures.	3x4	**Asymptomatic testing remains in place** All care and facilities staff who are asymptomatic and work in the care area on a regular basis (including Administrators) complete lateral flow device (LFT) tests twice per week. The testing for hospices guidance below has not yet been updated so until it is updated EACH Care and Facilities Staff and those HR and Fundraising staff who are based in Milton hospice or Treehouse should follow national guidance : COVID-19: managing healthcare staff with symptoms of a respiratory infection - GOV.UK (www.gov.uk) Patient-facing care and facilities staff who have symptoms of a respiratory infection, and who have a high temperature or do not feel well enough to attend work, are required to take an lateral flow device (LFD) test as soon as they feel unwell. They are no longer required to take a PCR test. Staff who are close contacts of a case of COVID-19 no longer required to take a PCR test. All care and facilities staff (and those based in Milton and Treehouse who have received a positive COVID-19 test result, regardless of whether they	2x4			

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		Child and young person (CYP) specific RAHAs in place as required – documented in individual's electronic care records. Individual Risk assessment for any staff members in at risk groups including Black, Asian		have symptoms, are advised not to attend work for 5 days. They should follow: guidance for people with a positive COVID-19 test result And People with symptoms of a respiratory infection including COVID-19 - GOV.UK (www.gov.uk) The following specific advice for hospices is superseded until it is updated: Coronavirus (COVID-19) testing for hospices - GOV.UK (www.gov.uk) Individual risk assessments for any staff who may be at high risk of complications from respiratory infections such as flu or severe illness associated with covid 19 are undertaken when required by the individual and their line manager. Additional advice can be obtained from HR department and then via occupational health. • If a member of staff or volunteer becomes unwell with respiratory symptoms while in the workplace they will be sent home immediately and advised to seek a test				

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		and Minority Ethnic (BAME) staff.		• Managers to assess whether the staff member or volunteer can conduct their work from home • Managers to maintain regular contact with staff members during this time. • Managers to support staff to work from home where possible and ensure they are provided with appropriate equipment such as laptops, keyboards, mobile phones headsets. • Routine LFD testing (on admission) for resident (overnight) CYP and resident family members continues. • CYP and family members attending for day care session should be asked to complete a LFT before admission. • Family members attending briefly to drop off their CYP for short break care are not required to do a LFD test • Visitors and EACH non clinical staff should continue to undertake a LFT before entering the hospice building this will be reviewed on 31 May 2022. Care and facilities staff can return to work when they have had 2 consecutive negative LFD test results (taken at least 24 hours apart).				

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				The first LFD test should only be taken 5 days after the day their symptoms started (or the day their first positive test was taken if they did not have symptoms); this is described as day 0. If both LFD tests results are negative, they may return to work immediately after the second negative LFD test result, provided they meet the criteria below: • the staff member feels well enough to work, and they do not have a high temperature. • if the staff member works with patients whose immune system means that they are at higher risk of serious illness despite vaccination, a risk assessment should be undertaken, and consideration should be given to redeployment until 10 days after their symptoms started (or the day their first positive test was taken if they did not have symptoms) • the staff member must continue to comply rigorously with all relevant infection control precautions and personal protective equipment (PPE) must be worn properly throughout the day				

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				The staff member should resume twice-weekly asymptomatic LFD testing when returning to work. If the day 5 LFD test is positive, they should continue to test daily until they have received two negative LFD test results, taken 24 hrs apart. If the staff member's LFD test result is positive on the 10th day, they should discuss this with their line manager who may undertake a risk assessment. If a staff member is tested with an LFD test within 90 days of a prior positive COVID-19 test and the result is positive, they should follow the advice for staff members who have received a positive test result for COVID-19 again, unless a clinical or risk assessment suggests that a re-infection is unlikely. **Staff members who are contacts of a confirmed case of COVID-19** People who live in the same household as someone with COVID-19 are at the highest risk of becoming infected because they are most likely to have prolonged close contact. People who stayed overnight in the household of someone with COVID-19 are also at high risk.				

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				Patient-facing healthcare staff who are identified as a close contact should continue with twice-weekly asymptomatic LFD testing. If you are a household or overnight contact of someone who has had a positive COVID-19 test result it can take up to 10 days for your infection to develop. It is possible to pass on COVID-19 to others, even if you have no symptoms. Staff who are identified as a household or overnight contact of someone who has had a positive COVID-19 test result should discuss ways to minimise risk of onwards transmission with their line manager. This may include considering: • redeployment to lower risk areas for patient-facing healthcare staff, especially if the member of staff works with patients whose immune system means that they are at higher risk of serious illness despite vaccination • working from home for non patient-facing healthcare staff • limiting close contact with other people especially in crowded, enclosed or poorly ventilated spaces				

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				Whilst they are attending work, staff must continue to comply rigorously with all relevant infection control precautions. If staff develop any symptoms during these 10 days, they should follow the advice for staff with symptoms of a respiratory infection, including COVID-19. **Triaging / screening for respiratory illness** • A record of visitors is maintained for emergency fire procedures. • Triage of all service users and their families is undertaken by clinical staff who are trained and competent in assessment prior to arrival in the care area or as soon as possible on arrival. • Service users will be cared for on a usual (standard) care pathway using standard infection control precautions (SICPs) or barrier nursed on a respiratory care pathway with additional Transmission based precautions (TBPs) in place. • Safe systems of work outlined in the hierarchy of controls, including elimination, substitution, engineering, administrative controls and PPE/RPE, are an integral part of IPC measures. Staff will continue to risk assess including an evaluation of the ventilation in the area, operational capacity, physical distancing and prevalence of				

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				infection / any new variants of concern.. Where an unacceptable risk of transmission remains following this risk assessment, it may be necessary to consider the use of respiratory protective equipment (RPE) in specific situations. COVID-19: infection prevention and control (IPC) - GOV.UK (www.gov.uk). This assessment is recorded in the CYP care record. **Occupational health and vaccination** Prompt recognition of cases of respiratory infection among health and care staff is essential to limit transmission. All staff should be vigilant for any signs of respiratory infection and should not come to work if they have respiratory symptoms and a high temperature. They should seek advice from their manager in the first instance. Who may seek further advice from IPC teams/occupational health department as per the local policy. Symptomatic staff should avoid contact with people both in the hospice and in the general community. Bank, agency, and locum staff should follow the same deployment advice as permanent staff.				

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				Systems are in place to ensure that country-specific vaccination and testing policies are in place as advised by occupational health/public health teams. The vaccination status of staff may be considered when making staffing decisions for cohort areas. Regardless of whether staff have had and recovered from or have received vaccination for a specific respiratory pathogen they must continue to follow the infection control precautions, including PPE, as outlined in this document: Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 - GOV.UK (www.gov.uk) **Universal masking** • Universal masking is practiced throughout the hospices and offices linked to hospice buildings (with exception of central services building Milton which is considered a separate building as it has its own entrance). • Any respiratory symptomatic or confirmed positive (covid or other contagious respiratory illness such as RSV) service users must be cared for using TBPs on a respiratory care pathway with clear				

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				barrier nursing arrangements in place. One additional designated care space, following risk assessment, may be provided. Local arrangements are in place to identify specific and individual care environment for that service user (e.g. bedroom, bedroom and play room, bedroom and sensory room etc). These specific arrangements are communicated and handed over at least daily during shift handovers and/or Daily Care Planning meetings. • Facilities and housekeeping arrangements must match with either standard care or respiratory care pathway processes as required. **Wearing of scrubs** • Staff working in care areas should wear scrubs • Facilities staff may wear their uniform (as appropriate) • Staff have been provided with designated changing facilities including showering facilities • Clean scrubs are worn for each shift and laundered on site. • As covid secure and non secure areas are no longer mandated gowns are not required to be worn over scrubs when leaving the care area				

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				Maintaining physical distancing • All care and volunteer staff must maintain social/physical distancing of 2 metres where possible (unless providing clinical or personal care and wearing PPE). • The face to face delivery of activities, meetings and training is individually risk assessed and may continue to be delivered via virtual platforms. • Any end of life care, urgent short break care and symptom management work continues face to face. • Wellbeing activities and events are individually risk assessed including number of attendees, ability to social distance and ability to ventilate venue to decide if they should be held face to face or virtually. • Face to face arranged visits, meetings and training must be essential for EACH business and / or clinical purposes. • If not rostered to be on site, staff who are hybrid workers can work from home. Staff who are required to work in the hospice buildings due to the requirements of their role, should continue to do so following the procedures outlined to ensure safe practice. • Maximum number of staff permitted in each office displayed. • Desks are positioned for staff to work back-to-back or side-to-side (rather than face-to-face).				

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				• Managers to consider work schedules including start and finish times and shift patterns to stagger the number of staff working in the building, where possible. • Arrangements for staff to pre book a desk space using the online calendar are in place • Living safely with respiratory infections, including COVID-19 - GOV.UK (www.gov.uk). • Guidance on health and safety at work - HSE • Reducing the spread of respiratory infections, including COVID-19, in the workplace - GOV.UK (www.gov.uk) **Personal Protective Equipment (PPE)** • 4-6 weeks Stock of PPE maintained at all sites with centralised overflow store in Milton. • Staff to wear appropriate PPE as per PHE NHSE IPAC guidance • Current PPE requirements displayed within hospice buildings at key locations for staff to review. • EACH clinical equipment is cleaned before and after use. • Training in IPC measures are provided to all staff, including the correct use of PPE (including a face fit test if wearing a filtering face				

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				piece (FFP3), respirator, and the correct technique for putting on and removing (donning / doffing) safely. • Mouth-to-mouth resuscitation - bag valve masks are available for resuscitation for CYP in the care environment. When resuscitation is required to be given to an adult, parent, visitor or staff, the first aider must follow the advice below and use a cover for the mouth to prevent the physical contact with another person https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/covid-community/ • FFP3masks and long sleeve gowns are available alongside the resuscitation equipment should these be necessary. • Staff to report any problems with their skin as per usual practice via their line manager having followed all the advice in the infection control SOP. https://www.hse.gov.uk/skin/professional/health-surveillance.htm • Sessional use of PPE other than IIR masks should not be encouraged. Where necessary this should be risk assessed taking into account the CYP assessed health needs, the environment and the context of care delivery to others.				

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				• Single use PPE in the hospice is located on a trolley in appropriate areas close to the point of use on entering the care areas and outside service user bedrooms. • Single use PPE should be changed immediately after each service user and/or after completing a procedure or task • Where a staff member has been issued with reusable PPE such as face shields and visors, these should be decontaminated after each use following manufacturers guidance. • Gloves should be worn when there is exposure to blood and/or other body fluids and changed immediately after each service user. • Plastic aprons should be worn when providing direct care within 2 metres of respiratory care pathway and changed between service users. • Full body gowns or fluid repellent coveralls should be worn when there is a risk of extensive splashing of blood and/or body fluids and / or when undertaking aerosol generating procedures for children on a respiratory care pathway and should be changed between service users. • Eye or face protection should be worn during aerosol generating procedures following a risk assessment and should not be touched when worn. • Fluid resistant surgical masks should be worn all of the time in all locations in the hospice buildings				

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				Monitoring of IPC practices – guidance updated as required • Standard infection prevention and control processes are practiced at all times to minimise the risk of contact, droplet and aerosol transmission this includes universal masking. IPC guidance regularly reviewed. • Update on changes to national guidance shared via service level agreement with IPC named professionals. • Monitoring of IPC practices occurs dynamically on a daily basis by locality leadership team and daily care planning processes. • H&S environment walk rounds to include PPE use and storage, handwashing and social distancing practice. https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/updates-to-the-infection-prevention-and-control-guidance-for-covid-19 **Hand hygiene** • Guidance on hand hygiene, respiratory and cough hygiene, for all care staff can be found here. 20200520_COVID-19_Infection prevention control_Best practice handrub-1 (2).pdf (publishing.service.gov.uk)				

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				https://www.nhs.uk/conditions/emollients/ • Gel sanitisers available in all areas where washing facilities are not readily available. • Staff to be encouraged to protect their skin by applying emollient cream regularly. • Additional hand hygiene stations (alcohol-based hand rub) and signage in place to ensure good hygiene practices in staff, patients and visitors. • Quarterly hand hygiene audits completed. **Visitors** • Essential visits to the hospices are permitted. • All visitors must be triaged and confirm that they are fit to enter the hospice by an EACH member of staff BEFORE entering the hospices. • Visitors will need to undertake a LFT (after risk assessment) before entering the building. (this policy will be reviewed on 31 May 2022) • Visits to the hospice are in accordance with the Visitor Policy. • Family visitors including siblings are risk assessed on an individual basis and according to the context of their visit. • Family members (or those important to a CYP) who are resident or visiting are required to wear face coverings in all communal care areas but these are not needed in CYP bedroom or designated area for care.				

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				• All external visitors are required to wear a face covering/mask. • Visitors are advised ahead of time of the infection prevention and control arrangements in place prior to entering the hospice building, including bringing a face covering (family members only) or that a face mask will be provided for their use. • If a visitor is unable to wear a face covering or face mask they should be advised to make this known before their visit. • Arrangements for visitors attending meeting rooms at The Nook, The Treehouse and Milton Central services (e.g. recruitment interview) must comply with the arrangements described above. • Arrangements for visitors wishing to access the hospice care areas as part of fundraising or clinical training should follow the Visitors policy. In addition, when entering the clinical care area the visitor must wear a surgical mask at all times and comply with IPC arrangements. • In general there should be no more than 5 visitors (including one member of staff to escort them) for fundraising purposes. • Family members are not required to wear face covering in family accommodation and may be asked to wear one if staff enter the rooms **Areas in the hospices are no longer designated as covid secure and in-secure**				

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				• ALL hospice care areas must follow standard infection control pathway with universal masking. • Fluid resistant surgical masks (or face coverings for family members) are worn in all environments. **Ensure work areas ventilated** • All staff are required to ensure their work spaces are adequately ventilated. Ventilation reduces how much virus is in the air and therefore reduces the risk from aerosol transmission in that area. Staff can improve natural ventilation by fully or partially opening windows, air vents and doors. **Don't prop fire doors open.** It is important not to close windows or doors completely when people are using or occupying a naturally ventilated area. This can result in very low levels of ventilation. Airing rooms as frequently as you can improves ventilation. Open all the doors and windows fully to maximise the ventilation in a room. It may be better to do this when the room is unoccupied. • Large fans should not be used in the hospice building in areas where there is more than one person present • Hand held fans for symptom management of CYP may be used **Use of hospice building for staff training**				

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				• Any training must be essential for business or clinical purposes. • Arrangements for training in meeting rooms and training rooms in the hospices must meet infection control guidance with universal masking in place. • Where possible training should be delivered using virtual means unless there is no alternative. Practical training attendees are less likely to remain static, more likely to touch surfaces or equipment, less likely to comply with 2m distancing and the duration of the study session needs to be taken into account. Longer sessions (e.g. all day) will attract greater risk. **Housekeeping and facilities staff** **Cleaning** • Safe management of the care environment, healthcare linen and blood and body fluids should be managed according to IPAC guidance March 2022 • Cleaning schedules are delivered according to the designated care pathway (standard or respiratory) required by the service user. As a minimum, twice daily cleaning, with the second clean focussing on high frequency touch points such as door handles, light switches are				

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				cleaned at least twice daily and disinfected as required, using appropriate cleaning products and methods, should be deployed. • A discharge clean must be done when a child is discharged home following any form of stay at the hospices. • A clinical clean will be undertaken following resolution of symptoms and removal of precautions for children cared for using the respiratory care pathway guidance. • Care staff to ensure they clean office equipment with relevant products when they start and finish working such as computer, desk top etc, door handles, light switches. • Managers to do checks to ensure that the necessary cleaning procedures are being followed. • Microfibre cloths or paper roll and microfibre mop heads are used to clean all hard surfaces, floors, chairs, door handles and sanitary fittings, using: A combined detergent disinfectant solution at a dilution of 1,000 parts per million available chlorine or a household detergent followed by disinfection (1000 ppm av.cl.). • Manufacturer's instructions are followed for dilution, application and contact times for all detergents and disinfectants. • (Hospice Tristel Fuse & Tristel jet, chlorine release tablets) • Clinell or other wipes are available in every office.				

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				PPE for facilities staff • Housekeeping and facilities staff use single use and reusable PPE that has been allocated to them according to relevant policies and procedures. • Gloves, aprons, fluid resistant surgical masks are worn as SCIPs when cleaning for service users on a standard care pathway. • Scrubs / uniform is worn with single use PPE (gloves, gowns, masks, eye protection) when undertaking discharge and clinical cleaning for example when there is known specified infection including respiratory care pathway service users or on CYP discharge.				

Notes to Accompany Risk Assessment:

1. If using a Generic risk assessment, the assessors and Line Managers are to satisfy themselves that the assessment is valid for the activity/process and that all significant hazards have been identified and assessed.

2. Line Managers are to note that they are held responsible for the contents of the risk assessment and they are signing to indicate that they consider the risks to be acceptable.

3. Likelihood Score (L) x Consequence Score (C)

a. What is the likelihood of the consequence occurring?

Likelihood Score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Descriptor Frequency How often might it or does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/,possibly frequently

Consequence Scores (Severity)

b. Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence Score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domain	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of staff service users, or others (physical or psychological harm).	Minor injury requiring no/minimal intervention or treatment. No time off work	Minor injury which is self resolving or requires minor intervention and/or Results in >3 days off work	Moderate injury requiring intervention and/or HSE/**RIDDOR** reportable incident Results in >4 days off work	Major injury and long-term incapacity/disability Results in > 6 months off work	Death Multiple, permanent injuries/health effects

4. Risk Rating Score - Likelihood x Consequence (L x C) = Example 3 x 2 = 6 (Moderate Risk)

Likelihood Score / Consequence Score		**1**	**2**	**3**	**4**	**5**
		Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
5	**Catastrophic**	5	10	15	20	25
4	**Major**	4	8	12	16	20
3	**Moderate**	3	6	9	12	15
2	**Minor**	2	4	6	8	10
1	**Insignificant**	1	2	3	4	5

a. When recording the Risk Rating ensure that both the Likelihood and Consequence scores are included. Record the residual Risk Rating to demonstrate that the risk has been reduced to an acceptable level.

b. A risk score of **8 or above** is to be added to the EACH Risk Register.

	Low Risk	Maintain control measures and review if there are any changes.
	Medium Risk	Improve control measures if reasonably practicable to do so.
	High Risk	Review control measures and consider alternative ways of working.
	Extreme Risk	Improve control measures and **do not proceed**. Conducting work at this level of risk is to be approved by Senior Management.

5. Risk Assessments are to be reviewed:

- At least annually.
- If there is reason to doubt the effectiveness of the assessment.
- Following an accident or near miss.
- Following significant changes to the activity, process, procedure or Line Management.
- Following the introduction of more vulnerable personnel.
- If using a **Generic** Assessment - prior to use.