GENERIC NON CLINICAL (WORKPLACE) RISK ASSESSMENT

Complete this risk assessment template for risks identified as per RM11 Non Clinical Risk Assessment Procedural Guidelines.

GUIDE TO COMPLETING THE FORM

Current Position

Risk Description

- Identify the nature of a hazard/risk
- Identify and specify those at risk, i.e. staff members, service users, visitors/contractors/members of the public
- Identify the possible outcome of an incident, i.e. level of injury, loss of life, impact on service delivery

Current Controls

- Detail what controls / procedures are already in place to help reduce the identified risk i.e. fire safety training, DSE assessments, breakaway training

Current Risk Rating

- Assign a numeric score (1 – 5) to both the Consequence (C) and Likelihood (L) columns, using the Risk Matrix at the bottom of this form as a guide. Multiply the two scores together to give the overall Risk Rating (RR). eg (C) **3** x (L) **2** = (RR) **6**

Forecast

Further Action Required

- Note additional controls/measures/processes that if introduced would mitigate/minimise the risk currently presented

Target Date for Completing Further Action/Review Date Following Further Action Implementation

- Insert date for completing actions identified in the Further Action Required section and a suitable date for reviewing the action following completion of the Further Action, i.e. Target Date 31/07/2018 – Review Date 30/07/2019 (Note: Risks should be reviewed annually as a minimum)

Responsible Person

- Insert the name of the person responsible for the identified action

Predicted Residual Risk Rating

- Taking into account the new control measures assign a numeric score to the Likelihood column as in the Current Risk Rating section. The Consequence score will be unaffected and remain the same as in the Current Risk Rating Section. Multiply the two scores together to give the Predicted Residual Risk Rating. This should result in a lower overall Risk Rating than the Current Position score. At worst, the score may remain the same; however the Residual Risk rating should not be higher than the Current Risk rating, as this would indicate your actions have increased the level of risk.

Note – This process should be repeated for each individual identified risk. Press Tab on the keyboard at the end of each line to produce a new line for each risk as appropriate.

NEXT STEPS

1. Share your completed risk assessment with your Manager / Service Director / Director for approval.

2. Upon completion and approval of the form it must be logged in the originating department and the following implemented using the scoring method as detailed in RM11 the Risk Assessment Policy and Procedure.

Individual Risk Rating	Monitoring & Escalation Arrangements	Record & Review
1-6	Share, discuss, action and review at local team meeting	Retain and update risk assessment once approved by Director. It is your responsibility to review the assessment annually as a minimum. However, in the event of any changes that affect the identified risk, the risk assessment should be reviewed and updated as required and the details added to the Review section at the bottom of the form.
6-25	Share, discuss, action and review at appropriate local Health and Safety Group / Governance meeting or SMT. Agree escalation to directorate risk register • If risks are rated as high escalate to the Executive Director at the earliest opportunity • Risks rated at 10 or above will be considered for escalation to the Corporate Risk Register or BAF by the Executive Operational Sub Committee	• Retain and update risk assessment once approved by Director. • Forward risk assessment to epunft.risk@nhs.net for inclusion on the directorate or specialist risk register • If this is a maternity or pregnant worker risk assessment then it must be sent to epunft.HRsicknessdocuments@nhs.net • Any changes causing slippage or an adjustment to the 'current risk rating' must be communicated to the Performance Team to update the Risk Register. • Any risk assessment included on the risk register must be reviewed monthly as a minimum. Some risks dependent of severity will require more urgent monitoring.

3. The risk assessment must be updated, approved and communicated at the times identified in the assessment.

ACTION PLANNING

Areas for action must be detailed within the risk assessment. If there is a need for a more complex action plan this must be completed separately and the details of how & when the plan are to be monitored noted on the risk assessment form in the Further Action Required section.

RISK ASSESSMENT TITLE:	RAID services at Southend Hospital		
NAME & TITLE OF PERSON(s) COMPLETING ASSESSMENT:	[redacted] [redacted]	**DIRECTORATE:**	
WARD/ UNIT/TEAM:	RAID services in A&E Southend	**ASSESSMENT APPROVED BY :**	
SERVICE:	RAID	**SERVICE DIRECTOR APPROVAL:**	
DATE OF ASSESSMENT:	18.12.18 (initial assessment)	**If relevant, name of person being assessed:**	

Introduction:

This service operates out of Southend General University Hospital, Southend. They have a number of main areas of use. These include: MH Waiting room; MH Suite and office; Treatment room; Office; they also have use of the kitchen in the local area but this is not theirs alone. They undertake their work within the A&E cubicles, in the suite and also on the wards as required.

This is an overarching work place risk assessment for the Southend site and covers, as far as possible, the known risks and hazards that the staff may experience.

There may be a risk to the health and safety to staff, service users and members of the general public who visit the building in the following areas. Please note that these are not in order of risk rating:

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		C	**L**	**RR**					**C**	**L**	**RRR**
violence and aggression Who: staff, contractors, patients and other NHS workers Impact: major injury,	Staff receive relevant training via the mandatory training requirements for clinical staff There is security in and around the A&E area There is CCTV in and around the A&E area Service users are assessed when either in cubicles or in the MH Suite for their tendencies. There is restricted access to most of the areas where Raid work, however there is not strict control over the keypad access arrangements and most are "on the latch" during the day				There is a major upgrade system for security panic alarm systems. This is rolling out over the next 2-3 years. This is under the manager-ship of the LSMS for Southend Hospital. To link in with the LSMS to establish when this will take place for RAID services			[redacted]			

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<u>Security</u> Who: staff, patients and other 3rd parties Impact: damage, injury, loss of reputation, complaints claims and litigation	The only key in use is that of the drug cupboard (no drugs currently in use at present time). Staff have access to various agreed areas only on the SUH site. This is either by means of their ID swipe card or via key pad system.										
	There is no panic alarm system in place for the MH suite. There has been recent incident where staff member was injured.				There is a major 3 year project for SUH to roll out a trust wide/site wide panic alarm system. MH Suite will be included in this, but no dates as yet set on which phase this will be on. Manager to liaise with SUH LSMS further.			[redacted]			

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	A number of the key pad systems were found to be on the latch or the door not closing properly to the kitchen door.				Task to be raised by the manager to have the door re-set. Manager to remind staff that the door must be locked at all times (kitchen has knives as well as other items for self harm or weaponry) – Sharp knives have now been removed to the staff kitchen, accessible only via swipe cards.			[redacted]			
<u>Consideration for Ligature Risks/ hazards in the unit</u> Who: service user who are expressing or feeling thoughts of suicidal ideation Impact: death or injury	The shower room in the MH suite has recently been upgraded (2018) to ligature reduced design facilities. However, this cannot currently be used as the drains do not work and flood the area.				Task has been raised with SUH estates, but this needs chasing until completion.			[redacted]			

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	The MH suite has multiple anchor points especially along the long wall where sockets and light fittings are. Also there are a number of protruding self-closers (paediatric access, main and office doors) and hinges such as those on the shower room door				Plan being drawn up to box in the wall to cover over all of these items on the wall of the MH suite. To consult with SUH and seek guidance on improved closers To discuss with team to assess if the risk is sufficient to warrant this and advise. Of note is that there has not been any incident in the past anecdotally to suggest this is a problem.			[redacted]			

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	Patients do not access all the areas, and when in MH Suite they are under observation. Patients begin to be assessed in triage, their physical health needs are met first, continuing in to MH suite.				Staff need to ensure that they identify those patients clearly that are at risk of attempts to ligature. To raise at team meeting to ensure staff are fully apprised of the concerns and share this risk assessment. Sectioned patients from Rochford are escorted and they usually tie in with RAID staff when on site, but this does not happen every time. This needs to be promoted. A separate assessment is not considered required for this service.			[redacted]			
	There is however unsupervised access to the general corridors and toilets within the A&E department, these have not been considered for ligature reduced fitments. These are outside EPUT control.				The toilet (in general space) is out of control due to damage previously caused. This need to be repaired and refurbished to reduce the risk. Task to chase up repairs			[redacted]			

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<u>Consideration for Fire risks within the Service area</u> Who: Anyone in the service area Impact: injuries sustained	For the most part everything related to the management and control of fire is via SUH. This includes Emergency lighting, alarms, FFE, call systems and detectors maintenance and management etc										
	Fire Officer for SUH comes to the team to deliver face to face fire training and awareness sessions. Due to attend on 21.12.18 Staff undertake the trusts OLM e learning fire training. Staff are aware of the fire procedures and evacuation processes for the hospital				Manager to ensure compliance via monthly supervision. Note that this has recently been updated to include this feature.			[redacted]			

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	Gangways are generally clear although there is a dumping ground outside the office area (SUH equipment items)				Manager to request clearance of this area.			[redacted]			
<u>Consideration for the control and management of medicines</u> Who: ? Impact: loss /theft of equipment. Destruction of medication due to poor storage	There is a plan in development to have some medications held in the office area. Medication cannot be stored until all staff have Honorary Contracts with SUH so that local policy and protocols are used. This is with SUH HR.				Need to have procedures in place that cover the arrangements and security aspects Honorary contracts need to be in place with SUH so that they can operate under their policy and procedural guidelines.			[redacted]			
	There is a medications cupboard in place with key (not in use as yet).				Thermometer needs to be provided in the room. Once in place daily monitoring needs to be commenced.			[redacted]			

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<u>Induction, Training and Supervision of staff</u> Who: staff Impact:	Staff competencies are managed via the training tracker. The manager undertakes monthly supervision of staff. Welfare concerns are shared via the supervision process. The manager is available if staff with to raise any concerns. All new inductees receive induction to the Trust, their environment and the team				To review the new paperwork for supervision that included mandatory training, CPD and DSE amendments. To share with the team at next meeting. All alerts and learning is shared at team meetings.			[redacted]			

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Consideration for staff completing their Display Screen Equipment self assessment Who: staff Impact: RSI, muscular skeletal issues	It was clear that staff had not completed their DSE assessments. Some staff had additional equipment such as foot stool in place.				All staff to complete their DSE assessments and also to review the OLM fit for work elements. Together with their manager to action where ever possible the items required and also promote a clutter free office environment.			All staff / [redacted]			
	The long worktop is broken on the left hand side and has been "chocked up" at one end.				Manager required to raise a task for suitable repairs and adjustments to the worktop to be affected.			[redacted]			
Consideration for Manual Handling risks Who: staff and patients Impact: possible injury due to poor manual handling methods etc.	It was advised that there are very few tasks where manual handling is an issue for the team										

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Consideration for First Aid requirements	The general rule of thumb is that staff self-administer. For greater injuries they would seek A&E staff assistance. The team does have a named responsible person, but there is not cover for 24/7. All qualified nurses are deemed as responsible persons. Management of the first aid boxes is under SUH control										
Consideration for Incident reporting	All staff are aware of how to report an incident				Enhanced Datix training to be afforded to staff who sign off incidents.			[redacted]			

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<u>Consideration for the environmental office allocation and work areas</u> Who: staff Impact: cramped working conditions leading to poor ergonomic practices refer to DSE	The administration office used is extremely cramped. There is a degree of clutter in the room. There are 2 hard drive set ups and most staff also work off of a laptop. There is another office that staff could work in when undertaking assessments etc.				It was suggested that the "alcove area" just outside the office door is partitioned off and this will afford additional much needed office space. This will also reduce the clutter in the corridor area.						
	The blinds in the office do not work properly. This is a problem in the summer particularly as the office is very hot and airless. There is no air con system in this area.				Raise a task with Estates to repair/replace the broken blinds			[redacted]			

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	The windows are crittall in design and to cut down the draught tissues have been placed in the window apertures. This is not terribly successful. Very cold in winter months.				Manager to make contact with Estates regarding potential for window replacements. (other adjacent windows have been replaced with double glazed ones).						
	Maintenance and management of the building regarding such aspects as PPM's portable appliance testing etc are under the control of the SUH estates team.										

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	There are a number of car parks on site. Staff have to pay as they go when working on the SUH site. Some Doctors have allocated parking. Staff do not have permits to park in the SUH car parks free of charge.										

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Consideration for the correct IT and software for the service. Who : patient and staff and external referral and reference agencies such as doctors Impact: slower service delivery, inferior systems that do not interact with 3rd parties	Currently staff load patient information up onto Mobius. There is no linkage to system one, therefore the feedback and clinical linkage with GPs is poor. The RAID service "piggyback" on the SUH server, there is not always a good connection to this and there are numerous breakages in service. Simon can you elaborate on the current processes				Suggestion made to install system one for the TEAM/service to promote better linkage with GP services Consider a dedicated server to be installed that will improve service connectivity and reduce failure. Investigation into the scoping for these developments to take place. Of note is a recent SI recommendation that suggested System one should be installed, the action had been turned green as if in place and this is not correct. Manager to ensure this is resolved. New staff joining the service are provided with laptops. These laptops need to be setup to access the SUH secure wifi and then EPUT servers. This has been addressed in the past but problems continue to occur with new staff. Laptops are provided that have not been setup to access the relevant services.			[redacted] Who will this be			

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Consideration for Control of Substances Hazardous to Health Who: staff /patients may be affected by chemicals Impact: burns, scolds, irritation and allergic reaction	The team do not have exposure to chemicals in their work arrangements. Usual detergents are in use, but these are assessed by SUH.										
	There is a detergent system in the kitchen area – it doesn't seem to work but there is no knowledge of what it is for.				Given that it is in a kitchen area, need to make contact with facilities to understand any risks etc that are associated.			[redacted]			
Occupational Health	Staff are aware of how to access occupational health and the well being services should there be need.										

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Team Meetings	There are regular team meetings. These are formal and recorded. Staff also have an opportunity to raise any issues at the team meeting.				To ensure that all health and safety considerations are included in the agenda. To include CAS alerts and any cascade information from the HSSC, sub groups as relevant to the team			[redacted]			
Smoking Who : staff / 3rd parties Impact: reduced staff safety and potential for incident/injury	There are smokers in the team, however they are aware of the no smoking rules on site and they have to take themselves off site to smoke.				It was unknown what staff do in the night time hours. Manager to clarify and add to current arrangements			[redacted]			

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<u>Work related stress</u> Who: staff and co-workers Impact: mental health concerns	Staff are all aware of the issue of work related stress. Staff are able to recognise the signs and symptoms of stress within themselves and with their co-workers. There is a suitable supervision process in action that assists staff to raise any concerns that they may have. The psychologist delivers monthly sessions in reflective practice Staff are able to either refer or self refer to occupational health if required.										

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		C	**L**	**RR**					**C**	**L**	**RRR**
<u>Sharps / needlestick concerns</u> Who: staff Impact: injury sustained due to puncture due to sharp	There are sharps bins in the relevant rooms. Staff are aware of the sharps policy and procedure.										
<u>Waste disposal</u> Who: staff and 3rd party contacts Impact: information breach Fire loading Infection via bodily fluids	For household waste this is dealt with by SUH. There are green shredding bins for use for confidential waste, this is also dealt with by SUH As is the clinical waste stream										
<u>Potential for Drug related issues</u> Who: Staff or 3rd party Impact: injury to staff by 3rd party, medicines management constraints	Where patients are concerned this concern is managed via the assessment and observation interactions										

CURRENT POSITION					FORECAST						
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		C	**L**	**RR**					**C**	**L**	**RRR**
	Where staff are concerned, if a concern is raised this is dealt with via supervision, welfare engagement and HR systems in place within the Trust										
	For medicines management concerns please reference the section above.										
<u>Slip, trips and falls</u> Who: staff and 3rd parties Impact: injury to staff or 3rd parties; damage to trust property											
<u>Site Rules</u>											

CURRENT POSITION					FORECAST						
RISK DESCRIPTION • Identify the task hazard / risk • Identify who may be affected • What is the possible outcome / impact?	**CURRENT CONTROLS** What current controls are in place to mitigate the risk?	**CURRENT RISK RATING** (Consequence x Likelihood)			**FURTHER ACTION REQUIRED** • What additional controls / measures can be introduced? • What actions will be taken to further mitigate the risk?	**TARGET DATE FOR COMPLETING FURTHER ACTION** (DD/MM/YY)	**REVIEW DATE FOLLOWING FURTHER ACTION IMPLEMENTATION** (DD/MM/YY)	**RESPONSIBLE PERSON**	**PREDICTED RESIDUAL RISK RATING** (Consequence x Likelihood) *Note: Consequence score remains as in the Current Risk Rating column*		
		C	L	RR					C	L	RRR
	<u>Lockdown procedure</u> is not known by the RAID service. The service currently work as instructed if this takes place.										
<u>Absconsions</u> Who : patient Impact: potential for injury or serious harm Loss of reputation/litigation and investigation	There is some occasional abscond incidents. Descriptions of patients are taken and if abscond occurs the team work collaboratively with the A&E service and police as required. All patients are informal when in the MH suite, unless brought in under police control. Where there is abscond from the suite, there is a protocol in place to report to the police.				Consider if photography of patients is a viable option for those with known abscond tendencies or practices. *Note: only 13% of patients in the RAID Southend services go on to be sectioned and admitted to the ward .13% of patients are admitted informally – no section. A much smaller percentage are sectioned.*			[redacted]			

CURRENT POSITION					FORECAST						
RISK DESCRIPTION • Identify the task hazard / risk • Identify who may be affected • What is the possible outcome / impact?	**CURRENT CONTROLS** What current controls are in place to mitigate the risk?	**CURRENT RISK RATING** (Consequence x Likelihood)			**FURTHER ACTION REQUIRED** • What additional controls / measures can be introduced? • What actions will be taken to further mitigate the risk?	**TARGET DATE FOR COMPLETING FURTHER ACTION** (DD/MM/YY)	**REVIEW DATE FOLLOWING FURTHER ACTION IMPLEMENTATION** (DD/MM/YY)	**RESPONSIBLE PERSON**	**PREDICTED RESIDUAL RISK RATING** (Consequence x Likelihood) *Note: Consequence score remains as in the Current Risk Rating column*		
		C	**L**	**RR**					**C**	**L**	**RRR**
Anything else you come up with……..											

RISK ASSESSMENT REVIEW DETAILS

Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	
Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	
Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	
Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	
Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	
Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	

RISK MATRIX

Likelihood	Consequence (defined by hazard) 1	2	3	4	5
1	Low	Low	Low	Medium	Medium
2	Low	Medium	Medium	Medium	High
3	Low	Medium	Medium	High	High
4	Medium	Medium	High	High	Extreme
5	Medium	High	High	Extreme	Extreme

RISK IMPACT SCORES

The potential impact of risks can vary significantly and it is necessary to have a robust standard of scoring. Impact of risks should be assessed according to the grid below, which is adapted from "*A Risk Matrix for Risk Managers*" (NPSA 2008).

Domains	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
	Negligible (No Harm)	**Minor (Low Harm)**	**Moderate (Moderate Harm)**	**Major (Severe Harm)**	**Catastrophic (Death / Catastrophic)**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no / minimal intervention or treatment. No time off work Incident resulting in a bruise / graze Delay in routine transport for a patient An event which impacts on more than 1 patient / member of staff	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days Physical attack such as pushing, shoving, or pinching, causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident Physical attack causing moderate injury Self-harm requiring medical attention Grade 2 or 3 pressure ulcer Healthcare - acquired infection (HCAI)	Major injury leading to long-term incapacity / disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Physical attack resulting in serious injury Grade 4 pressure ulcer Long term HCAI Slip / trip / fall resulting in injury such as dislocation / fracture / blow to the	Incident leading to death Homicide committed by a mental health patient Multiple permanent injuries or irreversible health effects Rape / serious sexual assault Incident leading to paralysis Incident leading to a long term mental health problem An event which impacts on more than 100 patients /staff

		(no time off work required) An event which impacts on more than 10 patients / staff	Vehicle carrying patient involved in a road traffic accident Slip / trip / fall resulting in injury such as a sprain An event which impacts on more than 20 patients /staff	head Loss of a limb Post-traumatic stress disorder An event which impacts on more than 50 patients /staff	
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss less than 0.1 per cent of budget Claim less than £100,000	Loss of 0.1–0.25 per cent of budget Claim(s) between £100,000 and £250,000	Loss of 0.25–1.0 per cent of budget Claim(s) between £250,000 and £1 million	Uncertain delivery of key objective/Loss of 1.0–3.0 per cent of budget Claim(s) between £1m and £3m Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >3 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£3 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of more than 1 day Minor impact on environment	Loss/interruption of more than 1 week Moderate impact on environment	Loss/interruption of more than 1 month Major impact on environment	Loss/interruption of more than 3 months Catastrophic impact on environment