

Risk Assessment Template

Risk assessment number	271038	Conducted by	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group Sarah Freeman, Associate Director of Nursing, unplanned Care Group Joanne Hilton, Assistant Chief Nurse, Quality and Workforce Judith Connor, Associate Director of Quality, Quality Governance Louise Horsley, Senior Quality Governance Lead, Quality Governance		Date	11/01/2022
Brief description of job/activity/objective being assessed		There is a risk of harm to patients, staff and visitors within planned and un-planned care due to the Trust's inability to maintain safe staffing levels as a result of the sustained Covid-19 pandemic; potentially resulting in, poor experiences of care, increased patient and staff dissatisfaction, complaints, incidents, increased sickness levels, claims, and a negative impact on the reputation and financial status of the Trust.				
Site	All Trust sites		Location	All ward areas and departments		
Step 1: Identify the hazards (Using bullet points write down here the potential hazards)						
<ol style="list-style-type: none"> 1. There is a risk that patients will receive care delivered by staff which falls below the standards expected by the Trust and its professional and regulatory bodies resulting in potential regulatory action. 2. There is a risk that the Trust cannot maintain safe staffing levels. 3. There is a risk that nursing staff and allied health professionals (AHPs) will be unable to meet their professional standards and responsibilities. 4. There is a risk that staff may perceive they are working outside of their scope of professional practice/competence. 5. There is a risk that existing staff are unable to support learning in practice. 6. There is a risk of increased staff absences due to the numerous impacts of the sustained Covid-19 pandemic. 7. There is a risk that staff and the organisation will become accustomed to working with unsafe staffing levels. 8. There is a financial, reputational and regulatory risk to the organisation if it cannot maintain the provision of a safe and effective service. 						

Source	Risk assessment	Category	Clinical Risk
Step 2: Decide who might be harmed and how (For each hazard you need to be clear about who might be harmed; it doesn't mean listing everyone by name, but rather identifying groups of people e.g. patients, nursing staff, porters, secretaries etc. and how they may be harmed)			
<p>1. There is a risk that patients will receive care delivered by staff which falls below the standards expected by the Trust and its professional and regulatory bodies resulting in potential regulatory action due to:</p> <ul style="list-style-type: none"> a. Provision of sub-optimal or delayed care and treatment resulting in poor patient experience b. Care and treatment delays leading to an increased risk of deterioration and increased harms. For example, human errors, falls and pressure ulcers c. Increased risk of delays in the prompt recognition and escalation of deterioration d. Delays or omissions in the administration of medications, including pain relieve and time critical medication e. Increasing delays in referral to treatment times (RTT) f. Increased length of stay due to delays in enacting discharge related tasks increasing the risk of complications, deconditioning and subsequent impact on effective patient flow <p>2. There is a risk that the Trust cannot maintain safe staffing levels due to:</p> <ul style="list-style-type: none"> a. The Trust being in an increasing vacancy deficit despite creative approaches to recruitment and retention and additional funding being made available by the Trust b. There already being a national nursing shortfall prior to the Covid-19 pandemic for which the organisation has a recruitment and retention work plan and a safe staffing plan in place; however, as a result of the pandemic there has been a worsening of this position c. Staff that have worked through the pandemic being fatigued and their resilience being reduced d. Staff being redeployed to unfamiliar wards or departments e. Risk of increasing staff absence as a result of Covid-19; either as a contact, confirmed case, or due to stress related sickness f. Nationally reduced availability of Lateral Flow Devices for staff testing to support early return to work in line with national guidance g. Employees being able to temporarily self-certify for 28 days raised from 7 days nationally h. Evidence of an increased length of absence documented on fit notes issued by health care professionals in relation to stress and anxiety i. Staff deciding not to be vaccinated. The deadline for staff to receive their 1st dose of a Covid Vaccination is 3rd February 2022 to be fully vaccinated by the deadline of 1st April 2022 (unless medically exempt) j. Occupational Health Assessments conducted when staff were shielding potentially not being reviewed which limits the scope of potential redeployment k. Matrons increasingly spending additional time reviewing safe staffing and rota-fill which is reducing the time spent on quality and safety oversight l. Reduction in fill rate of bank and agency staff m. Reluctance by some staff to obtain necessary training/FIT testing to be able to work in red areas n. Staff potentially being less able to manage challenging behavior of patients and relatives due to reduced staffing levels which increases the risk of harm to the patient, staff and other patients o. Changes being required to the configuration of wards during the prolonged Covid-19 pandemic p. Potential for increased length of stay due to delays in enacting discharge related tasks increasing risk of complications and impacting on effective 			

patient flow

- q. Inaccurate recording of staffing RAG ratings (completed for each shift) and the safe care acuity staffing tool (completed twice daily) which could create sub-optimal use of available staffing
- r. Staff not having all of the competencies required to work in the allocated specialty area resulting in potential harm to patients
- s. Occasionally there being no substantive staff on a shift as staff are pulled from elsewhere due to sickness gaps therefore they do not know the ward which impacts on the quality of care delivered and has the potential for future sickness absence
- t. It being increasingly difficult to source staff with specialist skills to cover gaps in specialist areas such as respiratory, chemotherapy administration, interventional radiology and renal dialysis potentially resulting in sub-optimal care delivery
- u. Late shifts and in week shifts being particularly problematic due to low fill rates
- v. Current mitigation with corporate nurses supporting not covering weekend or evening work due to current contractual hours/work patterns

3. There is a risk that nursing staff and allied health professionals (AHPs) will be unable to meet their professional standards and responsibilities due to:

- a. Requirement to work in new and unfamiliar environments
- b. Lack of time to undertake training or competency supervision with unfamiliar equipment or specialty specific knowledge resulting in increased risk of negative impacts on staff health and wellbeing
- c. Additional workload as a result of sickness/absence and demand for services
- d. Time pressures reducing the ability to maintain contemporaneous record keeping and complete entries effectively
- e. A lack of access to support mechanisms and relationships to escalate concerns and a reduction in team dynamics when working in unfamiliar areas

4. There is a risk that staff may perceive they are working outside of their scope of professional practice/competence due to:

- a. Perceived personal risk and accountability for human error and/or patient harm

5. There is a risk that existing staff are unable to support learning in practice due to:

- a. Demand of clinical workload
- b. Availability of supervisors, assessors, preceptors and mentors
- c. Suspension of non-critical mandatory training
- d. Suspension of routine appraisals

6. There is a risk of increased staff absences due to the numerous impacts of the sustained Covid-19 pandemic due to:

- a. Fluctuations in leadership
- b. Complacency leading to the inappropriate use of personal protective equipment introducing risks of transmission
- c. Reduced availability and staff compliance with lateral flow testing requirements and reporting
- d. The prolonged impact of the Covid-19 pandemic on staff health and wellbeing
- e. Staff being unable to take breaks as staffing levels reduced, the burden of working harder and faster for prolonged periods

- f. Staff working extra shifts which potentially leads to burn out
- g. Increased presenteeism
- h. Lived Covid-19 experiences resulting in post-traumatic stress disorder (PTSD)
- i. Being vaccine hesitant and potentially leaving the Trust
- j. Earlier decisions to retire and ultimately leave the NHS as a result of poor staff experience which may lead to increased staff turnover
- k. Occupational health reviews being delayed due to gaps in team capacity and workload resulting in longer periods off work

7. There is a risk that staff and the organisation will become accustomed to working with unsafe staffing levels due to:

- a. Accepting a reduced risk tolerance due to adapting to dynamic pandemic circumstances
- b. Not meeting planned staffing levels including within remote sites

8. There is a financial, reputational and regulatory risk to the organisation if the Trust cannot maintain the provision of a safe and effective service due to:

- a. New unfunded and established services, e.g. PPE hub, FIT testing, swabbing team and relatives line etc.
- b. Increases to the number of staff receiving sick pay and need to backfill
- c. Temporary 28 day self-certification in place extended from 7 days
- d. Indefinite full pay and no sickness policy management for staff off work with symptoms suggestive of long Covid impacting on the Trust's staffing budget
- e. Rising staffing costs
- f. The deadline for staff to receive their 1st dose of a Covid Vaccination being 3rd February 2022 to be fully vaccinated by the deadline of 1st April 2022 (unless medically exempt) which may leave a wider staffing gap
- g. Increase in complaints regarding the standards of care and treatment received and delays to planned elective procedures
- h. Poor patient experience and outcomes
- i. Increase in incidents and serious incidents causing harm
- j. Increase in litigation and claims against the Trust including for hospital acquired Covid-19
- k. The Trust unable to defend some litigation and claims due to the lack of contemporaneous record keeping and the quality and safety of care delivered being below expected standards due to short staffing
- l. Sickness monitoring and review meetings are delayed due to a combination of HR capacity restrictions and the ward sisters not getting office time which means staff may be off longer and/or feel unsupported
- m. Increase in staff grievances and time required to investigate
- n. Reputational/regulatory risk due to failing to provide a safe service
- o. Poor patient flow through AED and delays in flow through and out of AED, assessment units and wards impacts on the emergency care system
- p. Reputational risk from not being able to safely restart all services as delivered pre-pandemic
- q. Risk of regulatory, criminal and legal action as a result of any harm or sub-optimal care

Step 3:

Existing control measures

Processes in place:

- E-rostering established in all clinical areas
- Datix incident reporting and escalation where indicated
- Risk and safety huddles (daily Monday-Friday)
- Workforce and Quality Matron huddle/oversight (3 x daily, 7/7)
- Quality and Safety audit programme (weekly)
- Non-clinical staff re-deployment hub established
- Assessment of acuity and dependency (safe care) (2 x daily)
- Staffing RAG (planned V actual) completed each shift
- Staffing RAG produced shared with the SitRep 4 times per day and circulated to all Senior Trust managers
- Redeployment of staff to support safe minimum staffing levels on wards and within departments
- Bank staff and flexible workforce including the Responsive workforce team are used where possible to fill vacant shifts
- Agency staff are used if available to fill vacant posts
- Specialist agencies are used to try to fill shifts in areas of significant specialism (such as Renal dialysis & Chemotherapy)
- Opening hours of the vaccine hub reduced to 2 days per week to release staff
- Establishment reviews completed and agreed in line with national guidance with additional funding identified by the Trust to support a number of areas
- Risk assessments in place for all staff and informal wellbeing conversations taking place
- Routes for escalation of concerns, e.g. incident reporting, matrons
- Freedom to speak up guardians in place
- Senior nursing cover provided every weekend to support on-call if on-call manager is not a Senior nurse
- Where movement of staff is required into areas where they may not have all the competencies required to work in that specialty there is a professional understanding that should be a substantive nurse working on the ward. Where this isn't possible a Matron is available to provide support

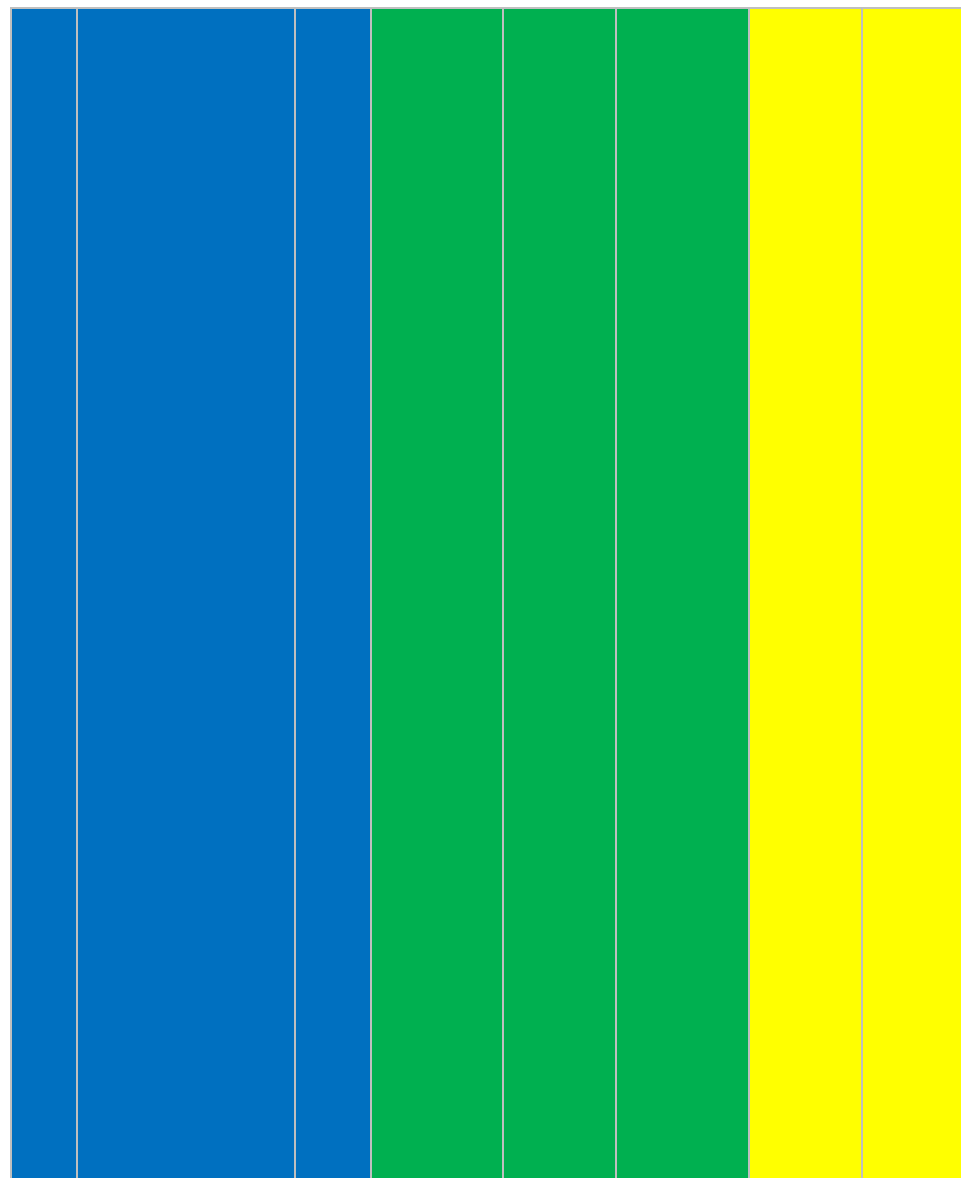
Risk matrix

Table 3 – Impact / Severity	Catastrophic	5	5	10	15	20	25
	Major	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Low	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5

- Good stock and supply of PPE available for staff from the hub
- Dedicated PPE hub and allocated staff in operation
- IPC oversight
- Dedicated swabbing team
- Policies and standard operating procedures in place
- Continuing participation in national audit programme
- Patient experience oversight
- Command Centre team including a Clinical Site Matron on duty 24/7 monitor the site using the Wall of Analytics which includes the Deteriorating patient tile
- Review and adoption of relevant National guidance including guidance from professional bodies where indicated
- National guidance and SOP in place requiring staff to complete and report bi-weekly lateral flow device results (6/1/22)
- Individual Risk and quality impact assessments
- Staff supported to work in other areas as per individual risk assessments
- Thrive - a community where everyone can learn, grow and reach their full potential. A place where staff feel heard, are always treated with dignity and respect and are trusted to do their job.
- Occupational Health Support and access to psychological services in place
- Weekly Wednesday bulletin circulated to signpost staff to health and wellbeing support and available services
- Senior nursing and quality oversight roles/senior leadership in place

Monitoring and review meetings:

- Safety Event Group (SEG) (weekly)
- Quality of Care Panel (QuOC) (weekly) with ADN and Senior nurse participation to support decision making
- Silver Clinical Reference Group (2 x weekly) with DADN or ADN participation to support decision making
- Gold Clinical Reference Group (3 x weekly) with ADN participation to support decision making
- Tactical silver Command call (3 x daily) with DADN or ADN participation to support decision making



<ul style="list-style-type: none"> Gold CRG (daily) attended by the Chief Nurse Exec Gold (daily) attended by the Chief Nurse 							
Risk rating taking into account existing controls							
Likelihood	5	X	Impact	4	=	Risk rating	20 (Extreme)
Rationale							
<p>The current control measures in place do not fully mitigate the risk due to sustained staffing shortages and the evolving and dynamic nature of the Covid-19 pandemic.</p> <p>Staff continue to feel anxious about staff shortages, staffing levels, potential redeployment and the ongoing physical and emotional impact of the sustained Covid-19 pandemic.</p> <p>There is a sustained and high level of stress amongst senior nursing/AHP staff faced with decision making regarding safe patient management, staffing, and the quality of care provided by the Trust.</p>							
Target risk rating							
Likelihood	3	X	Impact	4	=	Risk rating	12 (High)
Rationale							
Staffing pressures eased along with plateau of Covid-19 cases. Control measures identified prove effective in maintaining patient and staff safety, experience and health and well-being.							

Risk = Table 2 - Likelihood x Table 3 - Impact		1	2	3	4	5	
		Extremely Unlikely	Unlikely	Possible	Likely	Almost Certain	
		Table 2 – Likelihood / Probability					

Table 2 – Likelihood / Probability				
1	Extremely Unlikely	Less than 20%	Once every two years or more	Rare / Low
2	Unlikely	20% to 39%	Once a year	Unlikely / Low to Medium
3	Possible	40% to 59%	Once a Month	Possible / Medium
4	Likely	60% to 79%	Once a Week	Likely / Medium to High
5	Almost Certain	80% or more	Once a Day or more	Almost Certain / High

Table 3 – Impact / Severity			
1	Negligible	No / Minor Injury / Minimal loss / No time off work	Low
2	Low	Minor Injury / Some loss / 7 or Less days off / Some Damage	Low to Medium
3	Moderate	Injury / 7 or more days off / Damage / Loss / RIDDOR Incident	Medium
4	Major	Long term injury / irreversible injury / serious damage or loss / RIDDOR Incident	Medium to High
5	Catastrophic	One or more fatalities / irreversible injury / substantial damage or loss / RIDDOR Incident	High

Step 5: Risk reduction action plan <i>(Please list here what additional control measures are needed to reduce the risk to an acceptable level. You only need to complete this section when additional control measures are required)</i>				
Risk assessment number		Brief description		Date
Additional control measures required to reduce the risk to the lowest possible level:			Action owner/designation	Timescale
Continuing participation in recruitment initiatives, including overseas.			Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Work focused on recruitment and retention.			Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Development of Senior Nurse Quality Oversight Team.			Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	January 2022
Ensure continued provision of visible, senior nurse leadership to provide ongoing support so that staff feel safe to raise concerns and discuss issues that are concerning them.			Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Continual review of workforce resourcing in line with ward reconfiguration, emerging and updated National agreed standards and Covid 19 guidance.			Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Review and complete the Covid 19 risk assessment tool to ensure reasonable adjustments are in place and appropriate.			Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On- going
Ensure all frontline staff has received their Covid 19 vaccination to ensure the conditions of deployment regulations that take effect from 1 April 2022 are met.			Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Review safer nursing budgets and workforce establishments as part of the 6 month and annual review process.			Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne	On-going

	Hilton, Assistant Chief Nurse, Quality and Workforce	
Ensure workforce requirements are reviewed and meetings increased in line with changing demand and staffing position.	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Ensure staff health and wellbeing remains a priority and that staff are encouraged to take days off and approved annual leave.	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Support staff flexible working pattern requests wherever possible.	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Ensure appropriate fit testing and training has been completed.	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Review and monitoring of workforce data sickness and absence rates and actively managing to support staff return to work.	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Ensure changing national guidance, updates and SOPs are communicated in a timely way.	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Establishment of redeployment hub to support deployment of non-clinical staff.	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	January 2022
Support staff to raise and escalate concerns about quality of care or ward / service reconfigurations.	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Continue to encourage staff to report near misses and incidents to promote safe environments and a learning culture.	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce	On - going
Review opportunities to redeploy Clinical Nurse Specialists and Research	Adele Hartley-Spencer, Associate Director of Nursing,	On - going

nursing workforce.	Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce							
Encourage workforce to practice self-care, participate in wellbeing initiatives and access the resources available, promoted and provides by the Trust.	Adele Hartley-Spencer, Associate Director of Nursing, Planned Care Group and Sarah Freeman, Associate Director of Nursing, unplanned Care Group and Joanne Hilton, Assistant Chief Nurse, Quality and Workforce						On - going	
Residual risk								
Anticipated residual risk rating (Re-score your assessment based on the proposed additional control measures being implemented. This proposed / anticipated residual risk score will provide an indication of the potential / anticipated risk reduction that is likely)						Date added to risk register*		
						Date submitted to Risk.Assessments@bthft.nhs.uk		
						Date initial review required		
Likelihood	3	X	Impact	4	=	Residual risk rating	12 (High)	
Decision to accept residual risk								
Designation							Name	

Risk reduction action guide							
Risk Rating			Action Level	*Risk register	Action time scale	Remedial Action Owner	Decision to Accept Risk
Green	Low	1 to 3	Observations	No	12 months or more	Ward / Department Manager	Ward / Departmental Management
Yellow	Moderate	4 to 6	Recommendations / Continuous Improvement	Yes	6 to 12 months	Care Group / Department Manager	Departmental Management
Orange	High	8 to 12	Further Additional Controls / Process, Task, Activity Review / Escalation	Yes	2 weeks to 6 months	Divisional Manager	Divisional Management
Red	Extreme	15 to 25	Major Review / Escalation / Prohibit	Yes	Immediate to 2 weeks	Executive Director	Executive Director via IG&R /Board