MSK Private. Risk Assessment around staff providing physiotherapy assessment and treatment of MSK conditions to patients where social distancing measures are not able to be adhered with.

Details	MSK Private: Staff providing physiotherapy assessment and treatment to patients where social distancing measure are not possible to adhere with.	**Name (person completing RA)**	MSK Private Operations Manager
Market area	MSK Private	**Service/Site**	Physio London Canary Wharf
Date	15/06/20	**Review date**	01/07/20
Terms	Liklihood (L) x Consequence (C) = Initial risk rating (IR). Following additional controls (L) x (C) = Residual Risk (RR)		

Risk level	Low 1 – 3	Moderate 4 – 6	High 8 - 12	Extreme 15 - 25

Hazard (what could go wrong?)	Possible causes:	Existing controls	L	C	IR	Additional controls (gap analysis)	Date	RR	Accepted (Y/N)
Occupational exposure to COVID-19 in employees/ contractors providing MSK assessment and treatment where social distancing measures are not possible to adhere with, in order to provide effective clinical treatment. 1. Staff symptoms lead to isloation and 2 week period away from work 2. Staff symptoms lead to hospital admission on general ward 3. Staff symptoms lead to ICU admission 4. Staff symptoms lead to death Clinical exposure to Covid-19 in patinets/chaperones recieving MSK assessment and treatment where social distancing measures are not possible to	***Direct exposure*** – 1) Close proximity working with a patient (less than 2 meters) 2) Patient who coughs/ sneezes in the proximity of a clinician ***In-direct exposure*** - 1) clinician touches face after not following correct hand washing procedure	**Audit** Clinical space monthly audit Hand washing monthly audit Full IPC audit . **Staff learning, training and development** Mandatory training Infection prevention and control	3 2 1 1	2 3 4 5	6 6 4 5	**See controls and additional controls in place for Impact on the health and safety of staff and patients who have contact with individuals who may be contagious with COVID-19 (This includes the wearing of PPE for staff and mask for patients).** Advise clainicians in operations manual and re-induction to face to face treatment to	15/06/20	(2x2) 4 (1x3) 3 (1x4) 4 (1x5) 5	

adhere with to receive quality clinical treatment. 1. Patient symptoms lead to isloation and 2 week period away from work 2. Patient symptoms lead to hospital admission on general ward 3. Patient symptoms lead to ICU admission 4. Patient symptoms lead to death	2) Clinician touches surface and then face after not following cleaning procedure correctly	Infection control policy and procedure	3 2 1 1	2 3 4 5	6 6 4 5	maintain social distancing parameters for as much of the assessment/ treatment session as possible. Complete elements of assessment from 2 metre distance. Conduct treatment for advice and rehabilitation programmes from2 metre distance Advise clinicians in operations manual and re-induction to face to face work, where possible, choose assessment or manual therapy techniques to limit instances where the clinician is face to face with patient in close proximity. This would include using clinically reasoned interventions where the patient can be in postions of prone over supine/ lying the patient down in supine as opposed to long sitting/ where possible being side to side with patient.		2x2) 4 (1x3) 3 (1x4) 4 (1x5) 5	

Acupuncture Occupational exposure to COVID-19 in employees/ contractors performing acupuncture treatment in face to face clinical settings. Particular risks identified are exposure to body fluids e.g. patient vommitting as a post treatment reaction or blood spots from removal of needles or a staff sharps injury. 1) Staff symptoms lead to isloation and 2 week period away from work 2) Staff symptoms lead to hospital admission on general ward 3) Staff symptoms lead to ICU admission 4) Staff symptoms lead to death Clinical exposure to COVID-19 in patient/carers recieving acupuncture treatment in face to face clinical settings. 1) Staff symptoms lead to isloation and 2 week period away from work 2)Staff symptoms lead to hospital admission on general ward 3)Staff symptoms lead to ICU admission 4) Staff symptoms lead to death	***Direct exposure*** – 1) Close proximity working with a patient (less than 2 meters) 2) Patient who coughs/ sneezes in the proximity of a clinician 3) Patient has a reaction to treatment resulting in an vomitting episode 4)Patient has blood spots post treatment at needle site ***In-direct exposure*** - 1) clinician touches face after not following correct hand washing procedure 2) Clinician touches surface and then face	Acupuncture policy. Acupuncture audit completed around best practice. Acupuncture CPD IPC Policy IPC Audit AACP /CSP/ Physio First market updates Regular Sharps collects/ stoarge proceedure.	3 2 1 1 3 2 1 1	2 3 4 5 2 3 4 5	6 6 4 5 5 6 4 5	**See controls and additional controls in place for Impact on the health and safety of staff and patients who have contact with individuals who may be contagious with COVID-19** **(This includes PPE)** -Clear clinical discussion with patient about the possible side effects from acupuncture in current Covid-19 environement. Consent agreed and documented. -Have access to PPE "face visor" at clinic in case of scenario where patient feels nauseous during after treatment. This can be used as extra line of protection against splashback. -Spill kit in clinic in place.		2x2) 4 (2x2) 4 (1x4) 4 (1x5) 5 2x2) 4 (2x2) 4 (1x4) 4 (1x5) 5	

	after not following cleaning procedure correctly								
Womens Health Occupational exposure to COVID-19 in employees/ contractors performing womens health assessment and treatment in face to face clinical setting. Including vaginal examination (VE). 1. Staff symptoms lead to isloation and 2 week period away from work 2. Staff symptoms lead to hospital admission on general ward 3. Staff symptoms lead to ICU admission 4. Staff symptoms lead to death Clinical exposure to COVID-19 in patients recieving womens health assessment and treatment in face to face clinical setting. Including vaginal examination (VE). 1. Staff symptoms lead to isloation and 2 week period away from work 2. Staff symptoms lead to hospital admission on general ward 3. Staff symptoms lead to ICU admission 4. Staff symptoms lead to death	***Direct exposure*** **–** 1) Close proximity working with a patient (less than 2 meters) 2) Patient undergoes internal examiniation ***In-direct exposure*** **-** 1) clinician touches face after not following correct hand washing procedure 2) Clinician touches surface and then face after not following cleaning 3) Clinician touches unclear piece of equipment and then face, after not following cleaning	Use of PPE to complete VE examinations (normal practice). Disposal of clinical waste into correct bin Consent Womens Health consent to treatment Clinical space monthly audit Hand washing monthly audit Full IPC audit - weekly Staff learning, training and development on womens health. Mandatory training Infection prevention and control	3 2 1 1 3 2 1 1	2 3 4 5 2 3 4 5	6 6 4 5 6 6 4 5	**See controls and additional controls in place for Impact on the health and safety of staff and patients who have contact with individuals who may be contagious with COVID-19** **(This includes the wearing of PPE).** **-No additional controls advised by specialist membership body in addition to CSP guidance.** https://pogp.csp.org.uk/		2x2) 4 (1x3) 3 (1x4) 4 (1x5) 5 2x2) 4 (1x3) 3 (1x4) 4 (1x5) 5	

Risk assessment

Risk Assessment Action Plan			
RA Action 1			
Title	Action details		Action description
Manintain social distancing during face to face appointments where possible	Start date	17/6/2020	• In training for return to practice, ensure Operations manaual is reviewed. • Advice to maintain social distancing parameters for as much of the assessment/ treatment session as possible. Complete elements of assessment from 2 metre distance. Conduct treatment for advice and rehabilitation programmes from 2 metre distance.
	Due date	1/7/2020	
	Lead	Operations Manager	
RA Action 2			
Title	Action details		Action description
Consider assessment and treatment techniques to minimise face to face exposure within 2 metre distance.	Start date	17/6/2020	• **See controls and additional controls in place for Impact on the health and saftey of Clinical staff who have contact with patients who may be contagious with COVID-19 (This includes PPE).** • Advise clinicians in operations manual and re-induction to face to face work, where possible, choose assessment or manual therapy techniques to limit instances where the clinician is face to face with patient in close proximity. This would include using clinically reasoned interventions where the patient can be in postions of prone over supine/ lying the patient down in supine as opposed to long sitting/ where possible being side to side with patient.
	Due date	1/7/2020	
	Lead	Operations Manager	
RA Action 3			
Title	Action details		Action description
Have clinical access to face visor as protection from bodily fuids.	Start date	17/06/2020	• Face visor ordered by facilities manager. • Face visor to be stored in clinical room. • Add to H&S officers audit check list to ensure visor is in clinical room.
	Due date	2/7/2020	
	Lead	Health and safety officer	

RA Action 4			
Title	Action details		Action description
Clear clinical discussion with patient about the possible side effects from acupuncture in current Covid-19 environement. Consent agreed and documented	Start date	17/06/2020	• Review operations manual to include Clear clinical discussion with patient about the possible side effects (dizziness/vommitting) from acupuncture in current Covid-19 environement. Consent agreed and documented.
	Due date	2/7/2020	
	Lead	Chris Hall	
	Due date		
	Lead		

Consequence score (table 1)

Choose the most appropriate domain for the identified risk from the left hand side of the table, then work through the columns in the 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
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**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	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	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	Major injury leading to long term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

			An event which impacts on a small number of patients	Mismanagement of patient care with long-term effects	
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		Breech of statutory legislation	Single breech in statutory duty Challenging external	Enforcement action Multiple breeches in statutory duty	Multiple breeches in statutory duty Prosecution

		Reduced performance rating if unresolved	recommendations/ improvement notice	Improvement notices Low performance rating Critical report	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	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 Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 percent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million Finance including claims
Service/business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility

Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

Likelihood score (table 2)

What is the likelihood of the consequence occurring? The frequency score is appropriate in most circumstances and is easier to identify. It should be used whenever possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/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 ocassionally	Will probably happen/recur, but it is not a persisting issue/circumstances	Will undoubtedly happen/recur, possibly frequently

Risk scoring (table 3) = consequence x likelihood (C x L) matrix

	Likelihood				
Consequence	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 Negligible	1	2	3	4	5

Risk grading (table 4) - when grading risk, the scores obtained from the risk matrix are assigned the following grades:

1-3	Low risk	
4-6	Moderate risk	Ensure your line manager is aware of any moderate risks
8-12	High risk	EMT must be made aware of risks graded 8 or above via the designated market director for the service in which you work.
15-25	Extreme risk	

- Ensure that all risks are included within the appropriate risk register and escalated where applicable. The EMT must have sight of any risk that is graded high or extreme (graded above 8 up to 25).
- All risk assessments should be available in the area(s) that they were intended and accessible to all staff. A copy should also be sent to governance: clinicalgovernance@vhg.co.uk to be reviewed by the Governance, Quality and Risk Committee (GQRC) each month.

Instructions for use

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use table 2 to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
4. Calculate the risk score (table 3) by multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score)
5. Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.
6. For calculating the risk colours on the risk analysis scores you can use these RGB codes:

	R	G	B
	175	175	25
	255	225	25
	245	145	25
	235	55	45

References

A risk matrix for risk managers – NHS NPSA: https://www.neas.nhs.uk/media/118673/foi.16.170_-_risk_matrix_for_risk_managers_v91.pdf