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| **Employees at Higher Risk - Risk Assessment Documentation sheet** | | | | | | | |
| Name |  | | | | Known as |  | |
| Manager |  | | | | DOB |  | |
| Job Role |  | | | | Work Area |  | |
| Fully vaccinated: (2 doses of vaccination) | | **Yes** | | **No** | Directorate |  | |
| **Hazards** | | **Control Measures and Actions Agreed** | | | | | **Tick** |
| **1) Employees whose immune system means they are at higher risk**   * Down’s syndrome * Certain types of cancer of have received treatment for certain types of cancer * Sickle cell disease * Certain conditions affecting their blood * Chronic kidney disease (CKD) stage 4-5 * Severe liver disease * An organ transplant * Certain autoimmune or inflammatory conditions (such as rheumatoid arthritis or inflammatory bowel disease) * HIV or AIDS who have a weakened immune system * Inherited or acquired conditions affecting their immune system * Rare neurological conditions: multiple sclerosis, motor neurone disease, Huntington’s disease or myasthenia gravis | | For staff employed in a non-patient facing role | | | | | |
| The employee has been appropriately advised of IPC guidance. The occupational risk of exposure to COVID-19 has been mitigated so far as reasonably practicable. | | | | |  |
| No further action required | | | | |  |
| Actions agreed below | | | | |  |
| For staff employed in a patient facing role | | | | |  |
| The employee has been appropriately advised of IPC guidance. The occupational risk of exposure to COVID-19 has been mitigated so far as reasonably practicable.  Staff whose role requires them to work in patient facing roles must explore additional measures, balancing risk with the needs and wants of the employee:   * Discuss/explore re-deployment opportunities to a lower risk area (non patient facing role) if the risks cannot be tolerated. | | | | |  |
| No further action required, notes of discussion/conversation below | | | | |  |
| Actions agreed below | | | | |  |
| **Notes and actions agreed with employee**  (once work area agreed document any further actions that may be needed in support of this control measure) | | | | | |
|  | | | | | |
| Completed by:  (please print name) | | | Signature:  Date: | | | | |
| **Any changes to individual health or workforce requirements will require a regular review of the risks and actions required to mitigate those risks** | | | | | | | |

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