Has COVID-19 changed how practices should approach risk assessments?

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If someone had said to you mid-2019 that 'you should not be meeting friends, if your friends ask you to meet, you should say no. You should not meet family members who do not live in your home. You should not go shopping except for essentials like food and medicine. If you don't follow the rules the police will have the powers to enforce them, including through fines and dispersing gatherings', what would you have thought?

How things were pre COVID-19

Over the years, practice staff have become more familiar with the term risk assessment, and many are used to being asked on a regular basis for risk assessments for differing aspects of their work. Such requests have in the past perhaps proved more time-consuming than difficult as template examples have been available and proved helpful, with practices adapting and/or amending these to reflect their individual set ups. Often, these risk assessments will have continued to be 'suitable and sufficient' at the recommended annual review, perhaps just requiring an addition of some sort or a tweak here or there.

Generally, you need to do everything 'reasonably practicable' - balancing the level of risk against the measures needed to control the risk in terms of money, time or trouble. You are not expected to do what would be grossly disproportionate to the level of risk - nor would you be expected to create huge amounts of paperwork, but you would be expected to apply sensible measures to ensure risks are as low as they can be.

For example, it would be fair to say we now know much about standard infection control precautions (SICPs), and how to minimise the risks of blood-borne virus transmission in dentistry to both patients (effective decontamination) and staff (safe system of work, safe sharps handling and disposal, appropriate PPE and, for hepatitis B, the offer and take-up of the vaccination course).

An altogether different challenge

COVID-19 presented us with a then unknown and potentially serious virus. This caused understandable concern and put the UK into lockdown. Sadly, it followed that we lost many people to COVID-19, both in the UK and throughout the world.

The HSE writes: 'Your risk assessment should only include what you could reasonably be expected to know - you are not expected to anticipate unforeseeable risks.'[1]

So, the problem was (and to a degree still is) dealing with the unknown. Despite COVID-19 being with us for over two years now there continues to be unknowns (including new variants). During this time risk assessments have been required for the protection of staff, patients, visitors – indeed everyone!

An assessment too far?

We've had to consider those who were 'clinically extremely vulnerable' and 'clinically vulnerable' and take additional measures to minimise their risks. Occupational health departments/providers may have seemed appropriate for assessing staff at higher risk, but many of their services became overwhelmed and ultimately it often fell to individual employers to do the assessment. For individual staff we had to take into account:

1. Age: 70 and over
2. Sex: Males at higher risk
3. Those with underlying health conditions or co-morbidities
4. Ethnicity: BAME background, particularly those aged above 55 or with co-morbidities
5. Pregnancy: Particularly those over 28 weeks or with underlying health conditions
6. Disabilities identified which may have been the subject of reasonable adjustments.

Separately, we've also had to consider if staff (and patients) were living in a household with someone who came under a higher risk category.

If we think about all the additional aspects we have had to consider and deal with in this relatively short period of time, either for the first time, or in greater detail than we had to pre COVID-19 these include (and with risk implications):

- Not seeing patients!
- Remote consulting and prescribing
- Screening and triaging
- Avoidance (where possible) of AGPs
- Fit testing of staff for RPE (FFP2s/FFP3s)
- Ensuring adequate ventilation and calculating post AGP downtime (or fallow time)
- Ensuring patients and visitors wear face coverings (unless exempt)
- Ensuring one-way systems, social distancing and hand sanitation stations
- Increased cleaning and disinfection of surfaces and touchpoints
- The uncomfortable effects of enhanced PPE, especially during hot weather
- Suitable areas to don and doff
- Twice weekly lateral flow device testing
- COVID-19 vaccination.

Standard Operating Procedures – and help with risk assessing

Standard Operating Procedures have evolved throughout the two-year period and, at the time of writing, all four countries (England, Northern Ireland, Scotland, Wales) have opted for two pathways, respiratory and non-respiratory – with respiratory (if treatment cannot be deferred) requiring transmission-based precautions (TBPs) including post AGP downtime (or fallow time). The SOPs now include guidance to help with risk assessing.

So, do we think practices should change their approach to the risk assessment process?

A reasonable answer to this might be both no and yes! No, in that we can approach in the same way. Yes, in that we need to be prepared for quick change at short notice as further information becomes available and/or if other COVID-19 variants emerge.

Reference

1. Health and Safety Executive. What the law says on risk assessing. Available online at: www.hse.gov.uk/managing/delivering/do/profiling/the-law.htm (Accessed February 2022).

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