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WHS Risk Assessment - CHS Staff COVID Vaccination Requirements

WHS Consultation Paper

CHS WHS Team

9 October 2023

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Risk Assessment - CHS Staff COVID Vaccination Requirements

COMPLETE RISK ASSESSMENT DETAILS

Group, Division, Branch, Work area/unit, physical location **or** National Standard Group: CHS Workforce – All Divisions		
Completed by:	Daniel Guthrie, Senior Director WHS Team – People & Culture	Date: 6 September 2023

Risk Category: ☒ PEOPLE ☒ CLINICAL ☐ PROPERTY AND SERVICES ☐ INFORMATION
☐ FINANCIAL ☐ BUSINESS SYSTEMS AND PROCESSES ☒ REPUTATION ☐ ENVIRONMENT

STEP 1. ESTABLISH THE CONTEXT

Context *(What are the circumstances in which you are operating? You should consider the background, the objective of your team/unit/division, the resources available, the information/data available, the political climate, who your stakeholders are):*

In October 2021, following a surge of SARS-Cov-2 COVID-19 (COVID) infections in Australia and globally, a Public Health Emergency (PHE) was declared in the Australian Capital Territory (ACT) by the Chief Health Officer (CHO), ACT Health Directorate.

The PHE required all CHS staff to meet mandatory COVID vaccination requirements to provide greater protection from COVID for patients, staff and visitors in healthcare setting.

The CHO subsequently removed the PHE in September 2022 and provided the following guidance to ACT employers:

> *' Employers need to consider whether they wish to implement their own vaccination requirements in their employment policy or **work health and safety settings.** '*

There have been considerable changes and improvements to the risk controls available to manage COVID since the start of the pandemic in 2020.

In accordance with the guidance from the CHO, the following two risks form the basis of this risk assessment and recommendations for proposed procedural settings for COVID vaccination requirements and for CHS staff and the risk management of unvaccinated staff.

RISK 1	The risk of increased harm to patients and staff caused by **the continuation of mandatory CHS staff COVID vaccination requirements**
	VERSUS
RISK 2	The risk of increased harm to patients and staff caused by **ceasing mandatory CHS staff COVID vaccination** and providing alternative options to demonstrate COVID protection and manage unvaccinated staff

STEP 2. IDENTIFY THE RISK

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RISK 1	The risk of increased harm to patients and staff **caused by the continuation of mandatory CHS staff COVID vaccination requirements**

Cause *(Why is it a risk?)* – Note – Further information is detailed in

- Exacerbation of ongoing staff shortages – mandatory vaccination requirements exacerbate the significant staff shortages that exist in the healthcare sector. This includes the ability for CHS to recruit and engage qualified, experienced and capable healthcare staff including prospective staff and existing CHS who do not have a compliant COVID vaccination status.
- Increased psychosocial risk exposures – e.g. to the existing workforce including fatigue and burnout caused by the flow on effects of staff shortages, to the displaced patient facing staff who are not vaccinated and remain on non-patient facing suitable duties since October 2021, and other issues including impacts on the personal autonomy of vaccine choices for staff.

Consequence *(What will happen if this risk eventuates?)*

- Increased staff sick leave, staff turnover, reduced staff morale and productivity, potential psychosocial injuries linked to fatigue and burnout, and risk of higher severity psychosocial injuries to unvaccinated CHS staff who have been on suitable duties since October 2021.
- Patient safety issues linked to staff shortages and psychosocial risks including impacts on the ability of CHS to provide a safe and reliable health service, and potential for more frequent adverse clinical outcomes e.g. linked to fatigue, patient supervision, staff ratios etc.

RISK 2	The risk of increased harm to patients and staff caused by **ceasing mandatory CHS staff COVID vaccination** and providing alternative options to demonstrate COVID protection and manage unvaccinated staff

Cause *(Why is it a risk?)*

- The presence of unvaccinated CHS staff in CHS workplaces potentially increases the transmission COVID to patients, staff and visitors in the CHS healthcare setting, and Exposure of patients, staff and visitors to severe COVID disease.

Consequence *(What will happen if this risk eventuates?)*

- Increased potential for negative clinical outcomes in CHS workplaces including:
- Increased transmission and infection involving patients, staff and visitors.
- Increased severity of disease, particularly for patients and staff who are vulnerable to COVID e.g. those aged 65 plus, immuno-suppressed etc.
- Increased staff sick leave, staff turnover, reduced staff morale and productivity, and potential psychosocial injuries linked to fatigue, burnout etc.
- Reduced ability to provide safe and reliable healthcare services e.g. inadequate patient supervision and staff ratios etc. leading to adverse clinical events.

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STEP 3. ANALYSE THE RISK			
Current controls * ** Note – some of the risk controls listed below are only active when COVID risks increase*	**Are these controls effective in reducing the risk?**		
1. Mandatory CHS staff COVID vaccination requirements for all staff and prospective staff since October 2021 as per *CHS Procedure 23/065 – Occupational Assessment, Screening and Vaccination.*	☐ ADEQUATE	☒ NEEDS IMPROVEMENT Other competing risks associated with mandatory vaccination requirements are of increasing concern e.g. psychosocial and patient safety risks due to related staff shortages, as described in STEP 4 below	☐ INADEQUATE
2. Improved clinical management of COVID patients. Some examples include: - Improved clinical treatment procedures, knowledge and protocols generally based on clinical research and learnings from the pandemic - Use of Medihoods – to contain and filter infectious air expired by COVID patients to reduce the likelihood of transmission to healthcare staff and surrounding patients and visitors. - Antivirals - The use of antivirals to reduce the consequences of the virus multiplying in infected patients COVID e.g. Paxlovid® (nirmatrelvir + ritonavir)	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
3. Establishment of appropriate procedures for the identification and management of COVID risks in CHS workplaces. Some examples include: - Admission Cohort COVID-19 Enhanced Patient Testing (ACCEPT) Program - CHECC Workforce Response Plan - Clinical Management of Adults with COVID-19	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE

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- COVID-19 Positive Paediatric Patients Management Guideline - COVID-19 Women Youth and Children Operations - De-isolation of COVID-19 patients within ACT Health facilities - Management of a COVID-19 Exposure in a Canberra Health Service Health Facility - Management of air purifiers - Management of COVID Positive Pregnant Women (>20 Weeks Gestation) - Mental Health COVID-19 Inpatient Operations - Personal Ventilation Hood Procedure - Post COVID recovery and rehabilitation model of care - CHS Staff Health and Wellbeing COVID-19 Response Strategy 2021 - CHS Supporting CHS Staff during the COVID-19 pandemic framework - COVID-19 Manager's Toolkit			
4. Mandatory CHS staff hand hygiene training - near 100% completed training and staff are highly experienced in use of PPE to reduce transmission risks in the community and at work.	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
5. Increased availability of hybrid working arrangements for CHS staff e.g. work from home or away from clinical areas e.g. non-patient facing staff - A significant proportion of staff now work from home or in other non-clinical FlexiSpace work locations - These arrangements reduce COVID exposure opportunities	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
6. Staff Fit testing of PPE masks – to ensure best PPE mask fit for staff to reduce transmission of COVID to and from staff and patients	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE

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7. Improved infrastructure to reduce the transmission of COVID in CHS workplaces. Examples include: - Physical separation barriers – e.g. installation of Perspex separation screens to reduce airborne transmission at client engagement points e.g reception, ward clerks etc. - Installation of hand sanitization stations / bottles at entry points to CHS facilities / wards / common areas, any stations are touchless activated - Ventilation/Air handling – HEPA filters and air handling unit filters changed more frequently compared to pre-COVID, and air exchange rates increased to increase air circulation - Touchless door release installed at several access points – e.g. push-button door release mechanisms replaced with hand wave devices to reduce touchpoints that can lead to increased COVID transmission risks	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
8. Improved operational management of COVID patients and staff including procedures enforced regarding: - Identification of COVID & suspected COVID patients on wards and other locations and segregation from non-infected persons as much as possible - Symptomatic and infected staff are not allowed to enter a health facility and must follow quarantine protocols to reduce chances of transmission	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
9. Use of the Rapid Assessment Testing (RAT) to provide a method to: - Ensure earlier detection of COVID infection in staff, patients and visitors at the earliest opportunity - Activate appropriate risk controls to reduce opportunities of transmission.	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE

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**** RISK CONTROLS ACTIVATED AT HIGHER RISK TIMES OF COVID ACTIVITY ****			
Below are examples of risk controls that are only activated in response to higher risk periods of COVID under the CHS COVID Risk Escalation Framework i.e. green, yellow, amber and red risk levels			
10. Escalating PPE requirements under for higher level COVID risks, for example: - All patient facing staff wearing N95/P2 - Eye protection e.g. googles, face shield, protective gowns - Non-patient facing staff in surgical masks.	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
11. Introduction of PPE for patients, and visitors to reduce transmission risks: - All visitors in surgical masks. - Patients in surgical masks where able. - PPE management as if all people on health facilities are COVID positive.	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
12. Completion of Check-in Screening tool for patients, staff, visitors and contractors - Requirement to complete ACT Health check-in online prior to entry to the workplace	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
13. Security specific risk controls: - Access control e.g. swipe access required to enter clinical areas to reduce opportunities for transmission - Screening booths operated by CHS Security check all staff/visitors to enforce check-in screening tool and restrict access as required e.g. patient visitor limits, lockdowns etc.	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
14. Social distancing in non-clinical areas – floor markings/room signage to indicate separation distance and room capacity e.g. lifts, meeting rooms, tea rooms, reception queuing	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE

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15. CHS COVID-19 Business Rules including Pandemic Safe Checklist (PSC) completed for all work areas. Examples include: - Social distancing with marked segregation in congregation point e.g. in queuing areas and congregation points where minimum distances of separation are marke e.g. maximum capacity for occupants in a defined space e.g. persons in a lift, staff in a meeting room etc. - Checks on availability of hand sanitisation facilities in work locations	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
16. Regular consultation and communication to CHS staff - to ensure current risks are known including mitigation strategies in place and required from staff e.g. updates from CEO and CHECC	☐ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
17. Restricted entry to CHS work areas – patient visitor limits or no visitor rules exclusion to reduce transmission potential during higher risk periods	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
18. CHS Covid Escalation Framework – details risk control measures under escalation of COVID activity from lower risk level GREEN to highest risk level of RED e.g. entry restrictions, use of higher risk control PPE N95 masks etc.	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
19. Online meeting format available for staff meetings and education sessions to reduce congregating and increase potential for transmission risks	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
20. Telehealth appointments available where possible for times of higher levels of COVID transmission to reduce one on one clinician/patient contact and potential transmission	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE

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21. Physical separation – furniture and work area layouts adjusted according to physical separation distances and maximum limit of persons in work area	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
22. Establishment of the COVID Health Emergency Coordination Centre (CHECC) – expert/Executive level representation and regular meetings - e.g. to coordinate develop consistent policy/procedure and communicating current risk controls and expectations to reduce risks involving staff, patients and visitors	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
23. Service reduction/stoppage as necessary, for example to reduce exposure opportunities for COVID: - only critical surgery available with elective surgery postponed - limited one to one contact e.g. outpatients by telehealth, health centres closed etc.	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE
24. Establishment of COVID testing centres: - To allow mass testing and pathology for COVID infection - Separate suspected COVID patients/members of the public into a high caution/risk controlled environment where there are strict infection control arrangements - CHS staff have full PPE and work area COVID risk designed to reduce physical distancing e.g. Garran centre - Drive thru testing to reduce physical distancing and minimal touch points	☒ ADEQUATE	☐ NEEDS IMPROVEMENT	☐ INADEQUATE

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STEP 4. EVALUATE THE RISK

Refer to the CHS Consequence and Likelihood rating tables – Appendix A

The assessed risk ratings for the two risks are summarised below.

Current Assessed Risk Ratings – Risk 1 vs Risk 2

RISK 1	The risk of increased harm to patients and staff **caused by the continuation of mandatory CHS staff COVID vaccination requirements**		
	Likelihood	**Consequence**	**RISK RATING**
	Possible	*Major*	**HIGH**
	This risk is: ☐ ACCEPTABLE ☒ **INTOLERABLE**		

VERSUS

RISK 2	The risk of increased harm to patients and staff caused by **ceasing mandatory CHS staff COVID vaccination** and providing alternative options to demonstrate COVID protection and manage unvaccinated staff		
	Likelihood	**Consequence**	**RISK RATING**
	Unlikely	*Major*	**MEDIUM**
	This risk is: ☒ **ACCEPTABLE** ☐ INTOLERABLE		

Section 18 of the *Work Health and Safety Act 2011* are the key sections relevant evaluate the risks, and in this case competing risks to determine appropriate actions to manage the risks to a level that is 'reasonably practicable'. The evaluation of the two risks under these sections of the legislation are detailed below.

Section 18 – What is *reasonably practicable* in ensuring health and safety

18 - Reasonably practicable *- in relation to a duty to ensure health and safety, means that which is, or was at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters including—*

(a) the likelihood of the hazard or the risk concerned occurring; and

(b) the degree of harm that might result from the hazard or the risk; and

(c) what the person concerned knows, or ought reasonably to know, about—

(i) the hazard or the risk; and
(ii) ways of eliminating or minimising the risk; and

(d) the availability and suitability of ways to eliminate or minimise the risk; and

(e) after assessing the extent of the risk and the available ways of eliminating or minimising the risk—the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk.

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Assessment under S.18 - *WHS Act – What is 'reasonably practicable' in ensuring WHS*

To determine what is 'reasonably practicable', RISK 1 and RISK 2 were assessed collectively as competing risks that required prioritising and consideration in respect of appropriate risk control actions under S.18 of the *Act*.

Overall, in summary it was determined that the following risk control actions are 'reasonably practicable' and recommended in respect of the management of RISK 1 and RISK 2:

- That CHS should cease mandatory vaccination requirements for staff vaccination
- That *CHS Procedure 23/065 – Occupational Assessment, Screening and Vaccination* should be reviewed and updated to include alternative options to demonstrate protection from COVID in addition to vaccination and the risk management of unvaccinated employees as per Attachment 1.

The rationale and key reasons to support these recommended actions are detailed below:

1. The current assessed risk ratings are 'HIGH' for RISK 1 compared to 'MEDIUM' for RISK 2 supporting prioritised action for RISK 1. With the implementation of the recommended actions both RISK 1 and RISK 2 are projected to have risk rating of 'MEDIUM'.

2. While it is recognised that COVID vaccination is the single most effective risk control for COVID, mandatory COVID vaccination is no longer a proportionate risk control measure to impose on CHS staff, and should be ceased as a procedural setting by CHS for the following key reasons:

- As indicated by the *Australian Technical Advisory Group on Immunisation* (ATAGI) in their most recent guidance (see Attachment 2).
  - COVID vaccine is less effective compared to earlier in the pandemic, providing good protection for several months and then waning over time.
  - Much of the population is already well protected from COVID by the high level of hybrid immunity gained from vaccination and/or previous infection
  - The current recommendations for COVID vaccination to reduce population risks are now focussed on the 65+ age group and 'at risk individuals'
- The level of protection provided from COVID from a vaccinated staff member who is compliant with the current CHS vaccination procedure, will largely, not be dissimilar to that of an unvaccinated person. This is based on the fact that the majority of the population have been infected, that a compliant staff member's last vaccination could have been as long ago as 2021 and the ATAGI guidance above i.e. waning protection and population immunity.

3. Compared to earlier in the pandemic when mandatory vaccination was a critical and highly effective risk control in the healthcare setting, there have been significant improvements in the risk controls available to reduce the likelihood and consequences of COVID overall in the health setting as described in STEP 3 of this risk assessment.

4. ATAGI have not included COVID vaccination as a recommended vaccination for healthcare workers in their published guidance for this specific occupational group, noting that influenza vaccination is listed as being recommended for healthcare staff.

5. There are competing risks and impacts associated with mandatory COVID vaccination that impact both staff safety and patient safety, and in particular, psychosocial risks and flow on effects as described below:

   - Increasing psychosocial risks including those related to the exacerbation of staff shortages cause by:

     - The reduced recruitment pool available to CHS in respect of qualified, experienced and capable staff not able to be employed because of their non-vaccination status. And also the displacement of 34 current CHS patient facing staff who are not COVID vaccinated, and remain on non-patient facing suitable duties.

     - The projected increases in healthcare staff shortages in the future and the reduced competitive advantage of CHS when countries such as the UK, Italy and the US have in place non-mandatory vaccination requirements

     - The risk of high severity psychosocial risks impacts to 34 current CHS patient facing staff who are not COVID vaccinated, and who continue to remain on non-patient facing suitable duties since October 2021.

   - Flow on impacts related to staff shortages as described above including:

     - Increased staff sick leave, higher staff turnover, reduced staff morale and productivity, potential psychosocial injuries linked to fatigue and burnout,

     - Reduced capacity to provide a safe and reliable health service, and potential for more frequent and significant adverse clinical outcomes e.g. linked to fatigue, patient supervision, staff ratios etc.

   - Respect for the personal autonomy of CHS staff in their vaccination choices - noting that while extremely rare, there can be adverse outcomes from COVID vaccination, and the personal choices of CHS staff and prospective staff need to be genuinely respected given the current lower level of threat posed by COVID.

6. While vaccination is still strongly encouraged, the alternative options to demonstrate protection from COVID in addition to vaccination, and risk management of unvaccinated employees as proposed in Attachment 1 are considered ‘reasonably practicable’ in the context of the findings of this risk assessment.

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STEP 5. TREAT THE RISK - RECOMMENDATIONS		
RISK TREATMENT ACTION PLAN		
Possible Risk Treatment Actions/Strategies	**Action Owner**	**Estimated completion date**
1. That this Risk Assessment and recommendations be circulated for consultation to all relevant stakeholders including CHS HSRs, Unions, and CHS Executive – requesting feedback in a consultation period of two weeks	Senior Director, WHS	
2. That subject to feedback provided during consultation as described in Recommendation 1 - Action be taken to review *CHS Procedure 23/065 – Occupational Assessment, Screening and Vaccination* including: • Removal of mandatory staff COVID vaccination requirements for current and prospective CHS staff. • Updating evidentiary requirements for demonstrating protection from COVID to include vaccination and alternative options as detailed in Attachment 1 • Allowing a risk assessment to be conducted where staff do not provide evidence of protection from COVID as detailed in Attachment 1.	ADON, Nursing & Midwifery and Patient Support Services	

Projected Target Risk Ratings *- i.e. expected after implementation of recommendations*

RISK 1	The risk of increased harm to patients and staff **caused by the continuation of mandatory CHS staff COVID vaccination requirements**		
	Likelihood	**Consequence**	**RISK RATING**
	Unlikely	*Major*	**MEDIUM**
	This risk is: ☒ **ACCEPTABLE** ☐ INTOLERABLE		

VERSUS

RISK 2	The risk of increased harm to patients and staff caused by **ceasing mandatory CHS staff COVID vaccination** and providing alternative options to demonstrate COVID protection and manage unvaccinated staff		
	Likelihood	**Consequence**	**RISK RATING**
	Unlikely	*Major*	**MEDIUM**
	This risk is: ☒ **ACCEPTABLE** ☐ INTOLERABLE		

Attachment 1 - Alternative CHS procedural settings for staff vaccination & managing unvaccinated staff

Under current *CHS Procedure 23/065 – Occupational Assessment, Screening and Vaccination* CHS staff are required to provide evidence of COVID vaccination.

The requirements below have been developed by CHS Infectious Diseases Specialists to:

1. Provide additional options for CHS staff and prospective staff to demonstrate protection from COVID
2. Provide guidance to enable the risk management via Managers of CHS staff and prospective staff who are unable to demonstrate protection from COVID from vaccination or as specified in 1. above

1. Additional options to demonstrate protection from COVID - CHS Procedure 23/065

The purpose of the inclusion of COVID vaccination in the *CHS Procedure 23/065 – Occupational Assessment, Screening and Vaccination* is to ensure that:

- The risk of infection and associated severe diseases associated with COVID infection in staff, students and volunteers within the healthcare system is minimised
- The risk of transmission of COVID from staff, students and volunteers to patients and healthcare consumers within the healthcare system is minimised

Vaccination is considered the single most effective risk control measure to minimise the risk of infection and transmission of COVID. Detailed below are the options and associated evidentiary requirements to enable CHS staff and prospective staff to demonstrate a level of protection from COVID under *CHS Procedure 23/065 – Occupational Assessment, Screening and Vaccination*

Evidence of protection from COVID can be provided by 1 of the following 3 options:

1. Primary course and booster immunisation in accordance with ATAGI advice (September 2023) i.e.:
   - A 2-dose primary course for those without risk factors for severe COVID-19
   - A 3-dose primary course for those with 'at risk' factors for severe disease (see ATAGI guidance)
   - A booster dose using a bivalent vaccine for all people aged over 65 years and/or with risk factors for severe disease (6 months or longer following last COVID-19 vaccine dose or proven infection)

   OR

2. Previous infection with SARS-CoV-2 as demonstrated by documentation* of detection of SARS-CoV-2 RNA by a Medical Pathology Laboratory using nucleic acid amplification (also known as a "PCR" test)

   OR

3. Previous infection without immunisation against SARS-CoV-2 as demonstrated by documentation* of detection of SARS-CoV-2 antibody in the blood by a Medical Pathology Laboratory (Note: this evidence should ONLY be used if either of the above evidence if not available)

* *Documentation includes a hard copy or electronic report from a Medical Pathology Laboratory. Reports are accessible for participating Australians via MyHealth record (https://www.digitalhealth.gov.au/initiatives-and-programs/my-health-record), for patients and clients of Canberra Health Services, including ACT Pathology, via MyDHR (https://www.mydhr.act.gov.au/mychart/Authentication/Login) or on request directly from the testing laboratory. Note that SMS notifications are not acceptable.*

2. Risk management of Category A CHS staff, students and volunteers who are unable to provide evidence of protection against COVID

Prior to commencement of employment staff, students and volunteers who are unable to provide evidence of protection against COVID must have an agreed risk management plan in place with their manager based on a risk assessment.

The risk management plan may follow a general template which is acknowledged by both the staff member/student/volunteer and their line manager, with the following recommendations in relation to work arrangements, the staff member must:

- Not provide direct care for patients with known COVID who are assessed according to IPCU procedures as infectious. "Direct care" is defined as within the same isolation or treatment room as the patient or within 3 meters of the patient if being managed in an open environment
- Not work on or attend a dedicated CHS COVID ward or attend a CHS ward which has been declared by CHS as under COVID outbreak conditions
- Demonstrate training and competency in hand hygiene, standard and transmission based precautions, and fit testing/checking of P2/N95 masks
- Remain aware of and compliant with all CHS COVID procedures and policies relevant to the work that they are undertaking
- Notify their manager immediately if they have a known medium or high risk COVID exposure (occupational or non-occupational) as soon as possible to determine appropriate post-exposure controls
- Not attend CHS workplaces if they have symptoms of an acute respiratory illness, according to the exclusion criteria outlined in the relevant CHS policies and procedures
- In the event of an acute respiratory illness, undertake COVID testing using either a single COVID ("PCR" test) or two COVID rapid antigen tests (RATs) performed at least 24 hours apart prior to returning to work.
- Immediately upon becoming aware of COVID infection to their manager and follow all current return to work procedures post-infection
- Wear surgical or P2/N95 mask and eye protection for personal protection, in addition to routine standard and transmission-based precautions, when working:
    - In areas where there may be increased risk of exposure to unknown cases of COVID e.g. Emergency Departments; Walk in Centres
    - With patients with Acute Respiratory Infections (ARIs) where COVID has not yet been excluded. In these situations these staff are to wear surgical or P2/N95 mask and eye protection for personal protection in addition to routine standard and transmission-based precautions, particularly during times of increased community incidence of COVID
- Not work in areas where there are highly vulnerable patients with risk factors for severe COVID, including hematology and oncology; transplant wards/clinics; and NICU. And are required to:

- Remain aware that early pre-emptive antiviral therapy reduces the risk of severe disease and hospitalisation following infection with COVID-19
- Acknowledge that changes in the properties of the COVID virus (i.e. transmissibility; virulence) may require modification of the risk management plan in place and their cooperation in this process
- Participate in a 3 yearly review to identify if any changes in individual circumstances, and/or contemporary recommendations which may change risk management approach and their risk management plan

In addition where staff and students who may have sub-optimal response to COVID Immunisation due to severe Immunocompromise are identified the following actions are to be taken to best manage risks:

- Staff and students with severe immunocompromise, are strongly recommended to discuss their individual vaccine requirements with their GP and/or Specialist
- CHS will provide access for staff and students with severe immunocompromise to specialist Infection Prevention and Control and/or Infectious Diseases advice as required to discuss individual risk mitigation based on the type/level of immunocompromise and other co-morbidities. Risk mitigation strategies based on individual circumstances may include:
  - Avoiding working directly with COVID patients, on COVID wards or in a ward/work areas where CHS has declared a COVID outbreak
  - Working in areas where there may be increased risk of exposure to unknown cases of COVID, use of surgical or P2/N95 masks and eye protection for personal protection, in addition to routine standard and transmission-based precautions, and strict compliance with CHS declared periods of amber and red precautions e.g. at times of increased community incidence of COVID
  - Being given access to rapid testing and a pre-emptive treatment plan
  - Provided with confidential advocacy with their line manager, to ensure the staff or student is appropriately placed in the work environment based on risk assessment

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Likelihood and Consequence Tables

Consequence table

Category of risk	Consequence/outcome				
	Insignificant	Minor	Moderate	Major	Catastrophic
People	Injuries or ailments not requiring first aid treatment and/or psychological impact not requiring treatment from a health professional	Minor injury or First Aid Treatment required and/or psychological impact resulting in reduced ability to perform tasks	Serious injury causing hospitalisation or medium-term reversible disability (e.g. broken bone) or multiple medical treatment cases and/or psychological impact resulting in reduced ability to perform tasks and likely to require ongoing support (e.g. from a health professional)	Life threatening injury (e.g., loss of limb/s) or multiple serious injuries causing hospitalisation and/or permanent disability and/or psychological injury resulting in reduced ability to perform tasks requiring significant psychological treatment	Death or multiple people have life threatening injuries and/or permanent disability/ies and/or psychological injury resulting in inability to perform tasks requiring ongoing significant psychological treatment.
Clinical	• No injury • No review required • No increased level of care	Minor injury requiring: • Review and evaluation • Additional observations • First aid treatment	Temporary loss of function (sensory, motor, physiological or intellectual) unrelated to the natural course of the underlying illness and differing from the expected outcome of patient management.	• Permanent loss of function (sensory, motor, physiological or intellectual) unrelated to the natural course of the underlying illness and differing from the expected outcome of patient management.	• Patient death unrelated to the natural course of the underlying illness and differing from the immediate expected outcome of patient management. • All national sentinel events.
Property and Services	• Minimal or no destruction or damage to property • No loss of service • Event that may have resulted in the disruption of services but did not on this occasion.	• Destruction or damage to property requiring some unbudgeted expenditure • Closure or disruption of a service for less than 4 hours- managed by alternative routine procedures. • Reduced efficiency or disruption of some aspects of an essential service.	• Destruction or damage to property requiring minor unbudgeted expenditure • Disruption to one service or department for 4 to 24 hours - managed by alternative routine procedures • Cancellation of appointments or admissions for number of patients. • Cancellation of surgery or procedure more than twice for one patient.	• Destruction or damage to property requiring major unbudgeted expenditure • Major damage to one or more services or departments affecting the whole facility – unable to be managed by alternative routine procedures. • Service evacuation causing disruption of greater than 24 hours, e.g. Fire/ flood requiring evacuation of staff and patients/clients (no injury); or Bomb threat procedure activation, potential bomb identified, partial or full evacuation required (+/- injury).	• Destruction or damage to property requiring significant unbudgeted expenditure • Loss of an essential service resulting in shut down of a service unit or facility. • Disaster plan activation.
Financial	Less than $5K.	Less than $50K.	Less than $500K.	Less than $1M (Note: Less than $5M for infrastructure related costs.)	Greater than $1M. (Note: Greater than $5M for infrastructure related costs)
Information	Interruption to ICT systems, records and data access less than ½ day and/or system breach to business administration system with no personal or classified information stored	Interruption to ICT systems, records and data access less ½ - 1 day and/or system breach to business administration system with some identifiable information but not client threatening (data access not known)	Significant interruption (but not permanent loss) to ICT systems, records and data access 1-7 days and/or system breach to business administration system but not client threatening (data access not known)	Complete, permanent loss of some records and / or data, or loss of access to ICT systems and/or data for more than 7 days and/or systems breach to business administration system with identifiable/classified information stored but not client welfare threatening.	Complete, permanent loss of/or inability to recover/reconstruct all records and data and/or total loss of confidence in data/record integrity and/or systems breach to Government or business critical systems with client and/or business welfare threatened.
Business Process and Systems	Minor errors in systems or processes requiring corrective action, or minor delay without impact on overall schedule and/or insignificant impact on business outcomes and strategic objectives and/or negligible disruption to services or non-essential subsidiary services	Services do not fully meet needs and/or minor impact on business outcomes and strategic objectives and/or non-essential or subsidiary services experience minor disruptions.	One or more key accountability requirements not met and/or inconvenient but not client welfare threatening and/or moderate impact on business outcomes and strategic objectives and/or a number of objectives not met, minor or subsidiary services impaired.	Significant impact on business and/or strategic objectives and/or strategies not consistent with Government's agenda and/or trends show service is degraded and/or key service delivery impaired.	Strategic business outcomes processes fail, control infrastructure failure, critical business objectives not met. Unable to deliver necessary critical services.
Compliance/ Regulation	Non-compliance with CHS policy and procedures which are not legislated or regulated.	Numerous instances of non-compliance with CHS policy and procedures which are not legislated or regulated.	Non-compliance with CHS policy and procedures which require self-reporting to the appropriate regulator and immediate rectification.	Restriction of business operations by regulator due to non-compliance with relevant guidelines and/or significant non-compliance with CHS policy and procedures which threaten business delivery.	Operations shut down by regulator for failing to comply with relevant guidelines/legislation and/or significant non-compliance with CHS procedures which could result in failure to provide business outcomes and service delivery.
Reputation	Internal review and/or minor dissatisfaction across a small number of demographic groups or stakeholders.	Scrutiny required by internal committees or internal audit to prevent escalation and/or moderate dissatisfaction across a small number of demographic groups or several stakeholders.	Local media scrutiny (less than 1 week) and/or scrutiny required by external committees or ACT Auditor General's Office or inquest etc and/or dissatisfaction across a few demographic groups or multiple stakeholders.	Intense public, political and national media scrutiny (less than1 week) e.g. front-page headlines, TV stories and/or Minister/Chief Minister involvement and/or dissatisfaction across a large range of demographic groups and stakeholders.	Adverse finding/s from Assembly inquiry or Commission of inquiry or sustained adverse international media and/or loss of public confidence in Govt or Public Service forcing changes to the machinery of Govt
Environment	Limited effect to something of low significance and/or effects are limited to a small area with rapid recovery	Transient, minor effects and/or minor effects to environment and/or disturbance of native vegetation or waterways.	Moderate, short term harm to environment and/or disturbance of native vegetation or waterways.	Significant medium-term harm to environment and/or disturbance of native vegetation or waterways	Long term harm to the environment and/or widespread and/or severe impact or disturbance of native vegetation or waterways

Likelihood of Risk Event Occurring

Descriptor	Probability of occurrence	Indicative Frequency (Expected to occur)
Almost certain	Occurs more frequently than 1 in 10 tasks.	Is expected to occur in most circumstances.
Likely	1 in 10 – 100	Will probably occur
Possible	1 in 100 – 1,000	Might occur at some time in the future
Unlikely	1 in 1,000 – 10,000	Could occur but doubtful
Rare	1 in 10,000 – 100,000	May occur but only in exceptional circumstances

Risk Matrix

The risk matrix is used for determining the risk rating or level of risk and is derived from the Consequence and Likelihood Tables, providing a qualitative outcome.

			Consequence →				
			Insignificant	Minor	Moderate	Major	Catastrophic
			1	2	3	4	5
Likelihood ↑	5	Almost Certain	Medium	High	High	Extreme	Extreme
	4	Likely	Medium	Medium	High	High	Extreme
	3	Possible	Low	Medium	Medium	High	Extreme
	2	Unlikely	Low	Medium	Medium	High	High
↑	1	Rare	Low	Low	Medium	Medium	High

Risk Rating / Priority	Priority and Authority for Action	Escalation Time Frame	Action Plan submission
Extreme	**Intolerable** **Escalate verbally to Chief Executive Officer** Implement a detailed risk treatment action plan to reduce the risk rating	**Within 24 hours**	**1 month or sooner through CPR**
High	**Intolerable** **Escalate to Corporate Plan Review (CPR) Committee and Executive Director** Implement a detailed risk treatment action plan to reduce the risk rating	**Within 7-14 days**	**2 months or sooner**
Medium	**Tolerable** **Escalate to Divisional Senior management** Implement a risk treatment action plan	**4 weeks**	**3 months or sooner**
Low	**Acceptable** **Escalate to Program manager** Manage through existing processes and procedures. Requires periodic monitoring	**8 weeks**	**3-6 months or sooner**