Risk Assessment for visitor access to IPU

1.	**Name of Patient Being Visited including EMIS Number**	
	Name and phone number of visitor	

2. COVID RISK

	Categories	**Yes**	**No**
A **B**	Do you have any of the following symptoms? Temperature, loss of taste and or smell, sore throat, persistent cough? Have you been told to self -isolate by Test and Trace system? If so, you will be not be able to visit.		
C	Do you live with someone who has tested positive for COVID 19 in the last ten days? If so, we ask that you wear your mask for the whole visit to reduce the risk of transmission.		
D	Have you travelled from abroad and followed government guidelines? If no, you must adhere to these prior to visiting.		
E	Have you provided an LFT test completed at least 30 minutes ago that is showing a negative result?		

3. Timings and Duration of Visits (to be agreed in advance)

	Timings agreed, 10am to 2pm or 4pm to 8pm, max of 4 hours		

4. Protecting Visitor

	Rationale for protecting visitor from risk of infection explained		

5. Supply of Personal Protective Equipment (PPE)

	Hospice agrees to supply appropriate PPE to the visitor (apron, gloves and surgical mask)		

6. Use and Disposal of PPE

	Explanation given on the use and disposal of PPE		

7. Visitor Agrees to Abide by the following requirements

a	To bring only small number of personal effects such as purse/wallet, keys and mobile phone into the hospice		
b	Wash hands and forearms before entering the IPU and on leaving, have temperature checked		
c	Don and doff PPE as advised by staff and wear protective equipment, including a mask, as advised by staff		
d	Minimise time spent within 2 meters of loved one		
e	Remain at the bedside for the duration of your visit. If you need anything, please call for one of the nursing team using the call bell		

Form Completed By:		I understand I am entering a health care setting that is providing care for COVID positive patients and I understand the potential risk this may pose to me (please tick)	
		I understand I may be contacted in the event of a COVID outbreak at the hospice and I consent to this **Agreement Signed By:**	
Pilgrims Representative:		Visitor's Name:	
Pilgrims Representative Signature:		Visitor's Signature:	
Date:		Date:	

Date	Temperature	Lateral Flow Serial Number	Any changes to Risk Assessment? (Y/N)	Signed by visitor	Signed by Pilgrims Representative