Criteria for completing a local risk assessment

Acute inpatient areas

This risk assessment is based on NHS England and NHS Improvement's (NHSEI) acute in-patient risk assessment tool, we gratefully acknowledge their work and permission to modify for use in Wales.

21st April 2022, Version 1

Purpose:

To support health boards/trusts and employers to undertake a local risk assessment in the context of managing seasonal respiratory viral infections focussing on influenza, SARS-CoV-2 and respiratory syncytial virus (RSV) based on measures as prioritised in the hierarchy of controls.

This includes:

- A set of risk mitigation measures prioritised in the order: elimination, substitution, engineering, administrative controls, and PPE (including respiratory protective equipment [RPE]).
- Risk assessments must be carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents: this can be the employer, or a person specifically appointed to complete the risk assessment. Communication should take place with employees during this process and on completion of the risk assessment.
- The completed risk assessment can be used to populate local risk management systems.

Health Board/Trust organisation name	Date of initial assessment	Assessor's name and Job title	Date of review

What are the hazards?	Who might be harmed and how?	Standard required	What further action do you need to take to control risks?

Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections:
Influenza
RSV
	• Patients
	• Staff
	• Contractors
	• Visitors
		Variables that impact this risk assessment are:
		• Community prevalence of infections
		• New variants of concern (VOC)
		• Surveillance of HCAI admissions
		• Number of outbreaks
		Monitor:
		• Organisational operational capacity, for example:
		  ○ Emergency department (ED) pressure
		  ○ Trolley waits
		  ○ Bed capacity
		  ○ Staffing issues
		  ○ Single room and isolation facilities	

Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections: **Influenza** **RSV**	• Patients • Staff • Contractors • Visitors	**Elimination** (physically remove the hazard) **Redesign the activity such that the risk of encountering the infection is removed or eliminated** **Key mitigations** – check systems are in place to ensure: • Where treatment is not urgent, consider delaying this until resolution of symptoms – providing this does not impact negatively on patient outcomes. • Patients who are known or suspected to be positive with a respiratory pathogen, including SARs-CoV-2, and whose treatment cannot be deferred should receive care from services who are able to operate in a way which minimises the risk of spread of the virus to other patients. **Patients:** Screening, triaging, segregation and testing is in place for SARs-CoV-2 and other respiratory agents relevant to the setting, e.g. RSV/influenza. This must be undertaken to enable early recognition and to clinically assess patients prior to face to face attendance/procedures to identify whether: • Patient is fully vaccinated (currently 2 doses) • Patient has no respiratory symptoms linked to clinical case definition for SARs-CoV-2 including RSV and influenza. • For elective admissions, patients must be tested prior to admission, as advised by the clinician. For SARs-CoV-2 there may still be a requirement to self-isolate prior to surgery, and this will be determined on an individual risk basis.	

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		• Patients admitted as an emergency should undergo triaging and point of care testing as soon as this is practical, based on clinical need. • Limit movement of patients displaying respiratory symptoms **Staff:** Fully vaccinated staff and students who are identified as a contact of a positive COVID-19 case will no longer be expected to isolate and will be expected to return to work. • See updated WG guidance: https://gov.wales/covid-19-contacts-guidance-health-and-social-care-staff-html • Follow appropriate variant of concern (VOC)-specific guidance for self-isolation and testing. https://gov.wales/testing-coronavirus • Lateral Flow Device testing should be carried out for all staff as per national guidance **Ensure staff working in all clinical areas:** • Are encouraged to be fully vaccinated against respiratory infections (including COVID-19) as advised by public health/occupational health • Are asymptomatic • That staff are compliant with the necessary PPE and up to date with IPC training and guidance. **Ensure all contractors:** • Are asymptomatic when on site • Are not contacts for a confirmed case of a respiratory virus • Are not to enter high risk areas without any training **Visitors:** • Restriction of visiting may be appropriate in outbreak situations	

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Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections: **Influenza** **RSV**	• Patients • Staff • Contractors • Visitors	**Substitution** (replace the hazard) **Replace the hazard with one that reduces the risk** **Key mitigations:** This is not directly applicable or possible for healthcare to achieve as treatment needs to be carried out, so emphasis needs to be on the mitigating risks via other controls. However, some services may still consider the use of virtual consultations (telephone or video) and offering these where appropriate to patients with a suspected or confirmed respiratory infection. Delay non-essential contractor work in areas with outbreak situations.	

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Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections: **Influenza** **RSV**	• Patients • Staff • Contractors • Visitors	**Engineering** (Control, mitigate or isolate people from the hazard) **Design measures that help control or mitigate risks, such as ventilation, barriers, and screens.** **Priority should be given to measures that provide collective protection rather than those that just protect individuals or a small group of people.** **Key mitigations:** • Ensure adequate ventilation systems are in place, i.e. mechanical/or natural national recommendations for minimum air changes are met as defined for the care area. This should be carried out in conjunction with organisational estates teams/specialist advice from ventilation group and/or authorised engineer on how best to achieve the recommended number of air changes as appropriate. See HTM 03-01 Specialised ventilation for healthcare buildings. Maintenance and monitoring of ventilation systems should be in place to ensure that they remain effective and continue to provide the expected performance. • Identify areas (clinical and non-clinical) which are poorly ventilated or where existing ventilation systems are inadequate. • Dilute air with natural ventilation by opening windows and doors where appropriate. • If considering screens/partitions in reception/waiting areas to ensure air flow is not affected and cleaning schedules are in place, ensure they are not a fire hazard or risk of falls and trips. Consult with appropriate facilities and estate teams. • Assess whether room provision (negative, neutral and positive ventilation) is and would continue to be sufficient were there to be an increase in patients requiring isolation for respiratory infection. Work in a multidisciplinary team with hospital leadership, engineering and clinical staff to plan for creation of adequate isolation rooms/units. • Assess the function of the care area and ensure overcrowding is not an issue – particularly if patients with known or suspected respiratory infections are being cared for. Where is there is adequate ventilation this should be the priority area for infected patients to be cared for. Where a clinical space has very low air changes and it is not practical to increase dilution effectively then consider alternative technologies with the Estates/ventilation group. Please refer to WHBN 04-01 adult in-patient facilities	

Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections:
 	
Influenza
 	
RSV
	• Patients
	• Staff
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		Administrative controls (change the way people work)
		
		Administrative controls are implemented at an organisational level (e.g. the design and use of appropriate processes, systems and engineering controls, and provision and use of suitable work equipment and material) to help prevent the introduction of infection; and to control and limit the transmission of infection in healthcare.
		
		Key mitigations – check systems in place to ensure that:
		
		• There is provision of appropriate infection control education and information for staff, patients, visitors and contractors
		• The provision of additional hand hygiene stations (alcohol-based hand rub) and signage, to ensure good hygiene practices in staff, patients and visitors
		• Screening, triaging and testing is undertaken to enable early recognition of SARs-CoV-2 and other infectious agents (e.g. influenza, RSV)
		• Separation is maintained in space and/or time between patients with or without suspected respiratory infection, especially in patient flow areas such as Emergency Departments, by appropriate:
		  ○ appointment and clinic scheduling
		  ○ patient placement for infectious patients in isolation or cohorting.
		  ○ Mixing of infection such as SARs-CoV-2 and influenza is not advised, especially when awaiting test results.
		  ○ regular assessments of physical distancing and bed spacing, taking into account potential increases in staff-to-patient ratios and equipment needs (dependent on clinical care requirements).
		  ○ consider lowering occupancy thresholds to reduce the density in shared areas, to enable physical distancing and improve ventilation.
		• For patients who are known or suspected to be positive with a respiratory pathogen, including SARs-CoV-2, and treatment cannot be deferred, care should be provided via services that can operate in a way that minimises the risk of spread of the virus to other patients/individuals
		• Safe spaces are provided for staff break areas/changing facilities
		• Both the environmental and patient equipment cleaning regimen and frequency should be appropriate to the risk with compliance monitored
		• Staff and patients comply with current public health measures, including masks/face coverings, physical distancing measures, limiting the number of visitors, as appropriate.
		• Directional flow of footfall e.g. floor markings, clear signage at entrances and to ward/department	

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		• Minimise movement of staff between respiratory and non-respiratory pathways – if essential then non- respiratory to respiratory (non-infected to infected) • Identifying admitted patient movement by bed space and ward/department to allow tracking	
Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections: **Influenza** **RSV**	• Patients • Staff • Contractors • Visitors	**Person protective equipment (PPE)/respiratory protective equipment (RPE)** (Protect the worker with personal protective clothing) **Employers are under a legal obligation – under the control of COSHH regulations, to adequately control the risk of exposure to hazardous substances where exposure cannot be prevented.** **PPE must** be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or **in line with SICP and TBPs** **PPE is required for protection of individuals when, after working through the risk assessment, adequate control of exposure to the hazard cannot be achieved after applying the other controls. Considered to be the least effective measure of the hierarchy of controls. PPE should be considered in addition to all previous mitigation measures higher up in the hierarchy of controls.** **Key mitigations** – check systems in place to ensure: • There is adequate supply and availability of PPE – including RPE – to protect staff, patients and visitors. • All staff required to wear RPE including FFP2, FFP3 or reusable respirators must have been fit-tested (this is a legal requirement). • Face masks/coverings should be worn correctly by staff and patients in all healthcare facilities as per government guidelines. • All staff (clinical and non-clinical) are trained and assessed in donning, doffing and disposing of PPE. Ensuring there is a dedicated area for donning and doffing and all PPE is disposed of safely, reducing the risk of contamination spread covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures • For reusable PPE there are adequate facilities for decontamination and cleaning, and PPE is kept in adequate working order. • Visual reminders are displayed communicating the importance of wearing face masks or face coverings (visitors), compliance with hand hygiene and maintaining physical distance.	

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If transmission remains following this risk assessment, it may be necessary to consider the extended use of RPE (FFP3) for patient care in specific situations			

References and Useful information:

COVID-19: infection prevention and control (IPC) - GOV.UK (www.gov.uk)

NIPCM - Public Health Wales (nhs.wales) https://gov.wales/health-professionals-coronavirus

Information for Health and Social Care - Public Health Wales (nhs.wales)

https://gov.wales/preparing-health-care-environments-autumn-and-winter-2021-2022-operational-guidance

https://www.england.nhs.uk/coronavirus/publication/infection-prevention-and-control-supporting-documentation/