Criteria for completing a local risk assessment

Acute inpatient areas

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

September 2024,Version 2a

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) and any other acute respiratory illness (ARI) 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 seasonal respiratory viral infections: SARs-CoV-2 Influenza RSV (and any ARI)	• Patients • Staff • Contractors • Visitors	Variables that impact this risk assessment are: • Community prevalence of seasonal respiratory viral infections. • New strains and variants of concern (VOC). • Surveillance of HCAI admissions. • Number of outbreaks. • Vaccine uptake in eligible groups. Monitor: • Organisational operational capacity, for example: o Emergency department (ED) pressure. o Trolley waits/on boarding. o Bed capacity. o Staffing issues. o Delayed discharges.	

		○ Single room and isolation facilities. ○ Cleaning resource.	

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Contracting or spreading seasonal respiratory viral infections SARs-CoV-2 Influenza RSV (and any ARI)	• 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, influenza and RSV and whose treatment cannot be deferred should receive care from services who are able to **Patients:** Screening, triaging, segregation and testing (as per national guidance Patient testing framework for autumn/winter 2023 (WHC/2023/037) | GOV.WALES) is in place for respiratory agents e.g., SARs-CoV-2 /RSV/influenza relevant to the setting. This must be undertaken to enable early recognition and to clinically assess patients prior to face-to-face attendance/procedures to identify whether: o patient is fully vaccinated (where appropriate) o patient has no respiratory symptoms.	

		o For elective admissions, please refer to national guidance Patient testing framework for autumn/winter 2023 (WHC/2023/037) | GOV.WALES o Patients admitted as an emergency should undergo triaging and testing as per national guidance. o Limit movement of patients displaying respiratory symptoms o Follow a clear protocol for prioritising the allocation of single/isolation room	

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		Staff: Check systems are in place to ensure that: • Fully vaccinated staff (where appropriate) 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, unless they are symptomatic. • Ensure staff working in all clinical areas: o Are encouraged to be fully vaccinated against respiratory infections (including COVID-19 and flu) as advised by public health/occupational health. o Are asymptomatic. o That staff are compliant with the necessary PPE and up to date with IPC training and guidance and can apply Transmission Based Precautions (TBP's).	

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		Contractors: • Are asymptomatic when on site. • Are not to enter high risk areas without any training. • Are not to enter outbreak areas without assessing the risk. Visitors • Restriction of visiting may be appropriate in outbreak situations. • Are asymptomatic when visiting (exceptions apply). • If they enter high risk areas, advice on IPC measures is given before entry.	

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Contracting or spreading seasonal respiratory viral infections SARs-CoV-2 Influenza RSV (and any ARI)	• 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. Consider virtual staff or visitor consultation/ meetings where appropriate. Delay non-essential contractor work in areas with outbreak situations.	

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Contracting or spreading seasonal respiratory viral infections SARs-CoV-2 Influenza RSV (and any ARI)	• 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.	

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		• Dilute air with natural ventilation by opening windows and doors where appropriate. • 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 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 evidenced based technologies with the Estates/ventilation group (e.g. air cleaners/scrubbers). Please refer to WHBN 04-01 adult in-patient facilities.	

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Contracting or spreading seasonal respiratory viral infections SARs-CoV-2 Influenza RSV (and any ARI)	• Patients • Staff • Contractors • Visitors	**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 hand hygiene stations (including alcohol-based hand rub) and signage, to ensure good hygiene practices in staff, patients, visitors and contractors. • Screening, triaging, and testing (as per national guidance) is undertaken to enable early recognition of seasonal respiratory viral infections - SARs-CoV-2, influenza, RSV and any ARI.	

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		• 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 symptomatic, infectious patients in isolation or cohort.
		  ○ Prevent mixing of infections such as SARs-CoV-2 and influenza. This is not advised especially when awaiting test results.
		• For patients who are known or suspected to be positive with a respiratory pathogen, and where 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 and changing facilities.
		• Both the environmental and patient equipment cleaning regimen and frequency should be appropriate to the risk with compliance monitored inline with the cleanliness policy.	

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		• Minimise movement of staff between respiratory and non-respiratory cohorts/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 and contact tracing.	

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Contracting or spreading seasonal respiratory viral infections SARs-CoV-2 Influenza RSV (and any ARI)	• 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. Universal masking should be consider in accordance to the ARI guidance - Infection Prevention and Control Measures for Acute Respiratory Infections (ARI) for Health and social Care Settings – WALES.	

What are the hazards?	Who might be harmed and how?	Standard required	What further action do you need to take to control risks?
		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 for example FFP3 or reusable respirators must have been fit-tested (this is a HSE legal requirement). • Face masks/coverings should be worn correctly by staff and patients in all healthcare facilities as per IPC guidance. • All clinically facing staff (and including those entering a high risk area) are trained and assessed in donning, doffing, and disposing of the any PPE required. Ensuring there is a dedicated area for donning and doffing and all PPE is disposed of safely, reducing the risk of contamination spread. • For reusable PPE there are adequate facilities and protocols for decontamination (cleaning, disinfection etc). The PPE is stored safely and is in good working order.	

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If transmission remains following this risk assessment, it may be necessary to consider universal masking and/or the extended use of RPE (FFP3) for patient care in specific situations e.g. outbreaks, high risk areas, VOC.			

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References and Useful information

Infection Prevention and Control Measures for Acute Respratory Infections (ARI) for Health and Social Care Settings - Wales

NIPCM - Public Health Wales (nhs.wales)

Patient testing framework for autumn/winter 2023 (WHC/2023/037) | GOV.WALES

Advice for health and care staff on respiratory viruses including COVID-19: guidance | GOV.WALES

Introduction of RSV vaccination programme 2024 (WHC/2024/032) [HTML] | GOV.WALES

The national influenza immunisation programme 2024 to 2025 (WHC/2024/028) [HTML] | GOV.WALES

Winter respiratory framework 2024 to 2025 (gov.wales)

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