Criteria for completing a local risk assessment

Social Care

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

21st April Version 1

Purpose:

To support care settings 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 the measures as prioritised in the hierarchy of controls (HoC). Fundamentals of the HoC are described in existing National IPC guidance.

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 registered provider/ responsible individual, 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.

Care setting name	Date of initial assessment	Assessor’s name and title	Date of review

What are the risks and hazards?	Who might be at risk?	Actions to Manage Risk	If not possible to eliminate the risks, What further control measures do you need to take?
Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections: **Influenza** **RSV**	• Service users/ residents* • All Staff • Contractors • All types of visitors ***Consider vulnerable service users and staff** Vulnerable Definition Extremely Vulnerable Definition Guidance	**Guidance questions for the home in order to for assess risk:** • Check Welsh Government briefing updates - What is the community prevalence of infections and national alert level? – *A higher level of community transmission increases the risk of introduction to the home setting.* • Are there new variants of concern? (VOC) *does it cause more severe disease and for whom?* • What are the current number of positive cases in the home or are there any outbreaks or incidents – *are these linked to acquisition in the home?* • Check current IPC and Welsh Government guidance and review staff training needs – *consider the transmission routes of all infections and implement appropriate IPC practices, consider number of residents requiring Aerosol-Generating Procedures (AGPs) and where this practice can be performed.* • Review organisational operational capacity to manage cases, for example: ○ Are there adequate staffing levels? (absenteeism and skill mix) ○ What are the number of visitors to the care homes and any planned activities/ visits out of the home and level of supervision required ○ Capacity to segregate residents and staff when there is infection present/ outbreak A risk assessment should also consider the impact of isolation on wellbeing and the ethical values and principles framework here.	
Situations or actions that can cause transmission of respiratory infection e.g. visits to high exposure settings (Hospitals) or	• As above	**Elimination** (physically remove the hazard) **Redesign the activity such that the risk is removed or eliminated.** **Key mitigations – check systems are in place to ensure:** • Service users/ residents and care workers are encouraged to have their COVID-19 vaccinations including booster and annual flu	

exposure to infected individuals		• Where treatment is not urgent within a hospital setting, consider delaying any appointments providing this does not impact negatively on service user outcomes – or consider virtual alternatives to support care at home including home visits. • Communication of service user/resident infectious status prior to any transfer to or from another setting (including vomiting, diarrhoea, fever or respiratory symptoms) • Follow isolation guidance for service users/resident on admission or return to the care home **Service Users/ residents -** To enable early recognition of infection and take necessary action, check whether: • The service user/ resident is fully vaccinated for COVID-19, influenza and other respiratory infections such as pneumococcal and keep a record. • Whether there are any signs or symptoms of infections and whether cases are on the same floor • Staff recognise symptoms of respiratory infections including COVID-19 in service users see case definition • Service User/ resident has been advised to self-isolate by NHS Test Trace and Protect **Staff -** Check systems in place to ensure: • Staff and service users/resident are checked for wellbeing and to ascertain symptoms • Staff are aware of self-isolation. Welsh Government guidance here • Staff are competent and trained in IPC measures e.g. donning and doffing personal protective equipment • Staff are allocated to care for either infected or non-infected residents per shift **Visitors:** Visiting is supported by guidance https://gov.wales/infection-prevention-and-control-social-care-social-care-transition-plan-html#section-94086 **Check systems in place to ensure visitors:** • Are encouraged to have their COVID-19 vaccinations including booster and annual flu if in contact with vulnerable residents and service users • Are aware of symptoms and self-isolation here • Are asymptomatic before entering the home setting	

Transmission in high exposure settings	• As above	**Substitution** (replace the hazard) **Replace the hazard with one that reduces the risk** **Key mitigations:** This is not possible for healthcare to achieve as treatment needs to be carried out, so emphasis needs to be on the mitigating risks on other controls. However, some services may still consider the use of implementing virtual consultations (telephone or video) and offering these where appropriate to service users/ residents with a suspected or confirmed respiratory infection. Delay non urgent or essential contractor work during high community transmission if there is no impact on the service or care.	
Transmission of infection from poor ventilation/ crowding and other environmental factors	• Service Users/ residents • 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:** It is recommended to task a qualified and experienced consulting engineer to: • Assess ways to improve ventilation i.e. assess whether any mechanical ventilation within a home is functioning correctly - *Does the ventilation system (mechanical or combined) comply with Part F of the building regulations?* https://gov.wales/building-regulations-approved-documents. • Identify areas (clinical and non-clinical) which are poorly ventilated or where existing ventilation systems are inadequate. **Improvements:** • Consider better designed windows with larger opening areas providing cross flow ventilation where possible to improve air changes by dilution. • Opening doors to outside if it is safe to do so. • Consider installing mechanical ventilation in communal areas and air cleaning technologies to improve poorly ventilated areas. See WHO guidance on roadmap to improve indoor ventilation for COVID -19 here.	

		• CIBSE "COVID-19 ventilation" guide here (log in required). • If there are any screens/partitions in reception/waiting areas then ensure air flow is not affected and cleaning schedules are in place, consult with manufacturer instructions. • 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. • Avoid caring for groups of service users/ residents in poorly ventilated spaces with a known or suspected respiratory infection.	
Lack of systems/ policy and process in place to prevent the introduction of infection	• Service Users/ residents • 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 materials) to help prevent the introduction of infection and to control and limit the transmission of infection in healthcare.** **Key mitigations** – check systems are in place to ensure that: • Screening, triaging and testing are undertaken to enable early recognition of SARs-CoV-2 and other infectious agents (e.g. influenza, RSV) • Separation is maintained between service users with or without suspected respiratory infection • There is provision of appropriate infection control education and guidance for staff, service users/resident, contractors and visitors • Additional hand hygiene stations (alcohol-based hand rub) and signage are provided to ensure good hygiene practices in staff, service users, contractors and visitors • Safe spaces for staff break areas/changing facilities are provided. • Ensure regular cleaning regimes are followed and compliance is monitored including shared equipment guidance here. • Staff and contractors and visitors should comply with current public health measures such as masks/face coverings where appropriate and not provide care unless trained to do so.	
Staff at risk from transmission of infection via	• Service users/resident	**Person protective equipment (PPE)/respiratory protective equipment (RPE)** (Protect the worker with personal protective clothing)	

droplets, aerosols and contacts	• Staff • Contractors	**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 considered to be the least effective measure of the hierarchy of controls see here. PPE should be considered in addition to all previous mitigation measures higher up in the hierarchy of controls.** **Key mitigations:** Systems in place to ensure that: • There is adequate supply and availability of PPE – including RPE – to protect staff, resident/clients and visitors as indicated by PPE guidance here • All staff required to wear an FFP3 mask for aerosol generating procedures have been fit-tested (this is a legal requirement) • Face masks/coverings should be worn by staff in the care setting as per government guidelines • All staff (clinical and non-clinical) are trained in putting on, removing and disposing of PPE • Visual reminders are displayed communicating the importance of wearing face masks correctly, compliance with hand hygiene and maintaining physical distance	
If following this risk assessment it is clear that an unacceptable risk of transmission remains after rigorous application of the hierarchy of controls, it may be necessary to consider the extended use of RPE (FFP3) for patient care in specific situations. Where this is indicated, the RPE should be available to all relevant staff and staff should be provided with training in its correct use.			

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
- Operational guidance for healthcare services to assist with preparations for autumn / winter 2021/22 Welsh Government
- Information for Health and Social Care - Public Health Wales (nhs.wales)
- https://www.england.nhs.uk/coronavirus/publication/infection-prevention-and-control-supporting-documentation/