# Practical steps towards completing a local risk assessment – Acute inpatient areas

1. Purpose

To support organisations, practices and employers to undertake a local risk assessment in the context of managing seasonal respiratory viral infections including influenza, SARS- CoV-2 and respiratory syncytial virus (RSV) based on the measures as prioritised in the Hierarchy of Controls.

This includes:

A set of risk mitigation measures prioritised in the order: elimination, substitution, engineering controls, 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 what must be done to control the risk from the hazards associated with respiratory infectious agents: this can be the employer, or a person specifically appointed to complete the risk assessment. Communication and consultation should take place with employees during this process and on completion of the risk assessment. [Risk assessment: Steps needed to manage risk - HSE](https://www.hse.gov.uk/simple-health-safety/risk/steps-needed-to-manage-risk.htm) [Managing for health and safety (hse.gov.uk)](https://www.hse.gov.uk/pubns/priced/hsg65.pdf)

The completed risk assessment can be used to populate local risk management systems.

* If there is a change in circumstances for whatever reason that invalidates the risk assessment and its’ findings, a new risk assessment must be carried out.
* **Additionally, there is a need to regularly monitor the effectiveness of the identified control measures implemented and periodically review the assessment document. Triggers that may indicate the need for a review include increases in bed occupancy, increased rates of nosocomial infection and outbreaks in risk assessed areas.**

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| **Trust/organisation/practice name** | **Date of initial assessment** | **Assessor’s name** | **Date of review** |
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| What are the hazards?What are the risks of harm associated with the hazard? | Who might be harmed and how? | Standard required | What further action do you need to take to control risks? |
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| **Contracting or spreading respiratory viral infections including:** **Influenza****SARs-CoV-2****RSV** | * Patients
* Staff
* Contractors
* Visitors/Other accompanying person/carer
 | **Regularly Monitor and Review:*** community prevalence of infections
* new variants of concern (VOC)
* number of outbreaks and nosocomial infection rates where data is collected.
* current UKHSA Guidance and [NHS England » National infection prevention and control](https://www.england.nhs.uk/publication/national-infection-prevention-and-control/).

**Regularly Monitor and Review:*** Organisational operational capacity, for example:
* staff absence
* number of face-to-face contacts.
* Bed occupancy and operational matrixes that report on patient flow
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| **Contracting or spreading seasonal respiratory viral infections including:****Influenza****SARs-CoV-2****RSV** | * Patients
* Staff
* Contractors
* Visitors/Other accompanying person/carer
 | **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 that:* where treatment is not urgent, consider delaying this until resolution of symptoms – providing this does not impact negatively on patient outcomes – or consider virtual alternatives to support diagnosis and treatment.
* Some services may still consider the use of implementing virtual consultations (telephone or online modes of access) and offering these where appropriate to patients with a suspected or confirmed respiratory infection.

**Patients:**Triaging and where appropriate testing is in place for respiratory agents relevant to the setting and if the patient is known/suspected to have an infectious respiratory agent. This must be undertaken to enable early recognition and to clinically assess patients, if possible, prior to face-to-face attendance/procedures to identify whether: * patient is appropriately vaccinated
* patient has respiratory symptoms refer to [NICE guideline [NG191] – COVID-19 rapid guidelines: managed COVID-19](https://www.nice.org.uk/guidance/NG191); Seasonal influenza: guidance, data and analysis - GOV.UK (www.gov.uk); [Respiratory syncytial virus (RSV): symptoms, transmission, prevention, treatment - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/respiratory-syncytial-virus-rsv-symptoms-transmission-prevention-treatment)

**Staff:** – check systems are in place to ensure:* staff who are immunocompromised/pregnant should have a risk assessment undertaken to identify health and care staff who may be at high risk of complications from infectious agents - this could be via occupational health/GP.
* that staff follow current guidance for testing protocols: [C1662\_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)](https://www.england.nhs.uk/wp-content/uploads/2022/08/C1662_covid-testing-in-periods-of-low-prevalence.pdf)
* ensure staff working in clinical areas:
* have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs); (Criteria 10, Health and Social Care Act Code of Practice ) [Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance)

**Visitors/Contractors:*** Restriction of visiting may be appropriate in outbreak situations.
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* Staff
* Contractors
* Visitors/Other accompanying person/carer
 | **Substitution** (replace the hazard)**Replace the hazard with one that reduces the risk****Key mitigations:**This is not directly applicable for healthcare to achieve as treatment needs to be carried out, so emphasis needs to be on the mitigating risks via other controls. |  |
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 | **Engineering controls** (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, ie 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](https://www.england.nhs.uk/publication/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.

[Ventilation in the workplace (hse.gov.uk)](https://www.hse.gov.uk/ventilation/)[Ventilation to reduce the spread of respiratory infections, including COVID-19 - GOV.UK (www.gov.uk)](https://www.gov.uk/guidance/ventilation-to-reduce-the-spread-of-respiratory-infections-including-covid-19)* Identify and take action to mitigate the risk for 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, consult with appropriate facilities 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. **Patients with respiratory infections should not be cared for in poorly ventilated/overcrowded areas**. 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.[NHS England » (HBN 04-01) Adult in-patient facilities: planning and design](https://www.england.nhs.uk/publication/adult-in-patient-facilities-planning-and-design-hbn-04-01/); [NHS England » NHS Estates Technical Bulletin (NETB 2023/01A): application of HEPA filter devices for air cleaning in healthcare spaces: guidance and standards](https://www.england.nhs.uk/long-read/application-of-hepa-filter-devices-for-air-cleaning-in-healthcare-spaces-guidance-and-standards/) |  |
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 | **Administrative controls** (change the way people work)**Administrative controls are implemented at an organisational level (eg the design and use of appropriate processes, systems, 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:* triaging and testing is undertaken to enable early recognition of infectious agents (eg influenza, SARs-CoV-2**,** RSA)
* appropriate patient placement systems are in place for those who continue to be at higher risk of serious illness eg.immunosuppressed
* separation is maintained in space and/or time between patients with or without suspected respiratory infection, by appropriate:
	+ appointment and clinic scheduling
	+ patient placement for infectious patients in isolation or cohorting.
	+ 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, 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/staff/ individuals.
* facemasks/coverings should be worn by patients with suspected or confirmed respiratory viruses as tolerated.
* there is provision of appropriate infection prevention and control education and compliance for staff, patients and visitors/carers, and contractors who work in clinical areas.
* the provision of additional hand hygiene stations (alcohol-based hand rub) and signage, to ensure good hygiene practices in staff, contractors who work in clinical areas, patients and visitors/carers.
* safe spaces are provided for staff and contractors who work in clinical areas, for breaks/changing facilities.
* regular cleaning regimes are followed, and compliance monitored, including shared equipment.
* an increase in cleaning frequency is considered beyond specified local and national schedules to mitigate risks, particularly when bed occupancy rates are high.
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 | **Personal protective equipment (PPE)/respiratory protective equipment (RPE)** (Protect the worker with personal protective clothing)**Employers are under a legal obligation – under the Control of Substances Hazardous to Health Regulations (COSHH) 2002** [Control of substances hazardous to health (Sixth edition) - L5 (hse.gov.uk)](https://www.hse.gov.uk/pubns/books/l5.htm) **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 [NHS England » Chapter 1: Standard infection control precautions (SICPs)](https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/chapter-1-standard-infection-control-precautions-sicps/) and [NHS England » Chapter 2: Transmission based precautions (TBPs)](https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/chapter-2-transmission-based-precautions-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 Hierarchy of controls.****Key mitigations:**Systems in place to ensure that:* there is adequate supply and availability of PPE – including RPE – to protect staff, contractors who work in clinical areas patients and visitors as indicated by PPE guidance.
* all staff who are required to wear an FFP3 (RPE) mask have been fit-tested (this is a legal requirement)

[Respiratory protective equipment at work: A practical guide HSG53 (hse.gov.uk)](https://www.hse.gov.uk/pubns/priced/hsg53.pdf).* all staff (clinical and non-clinical) are trained in putting on, removing and disposing of PPE and there are adequate facilities for them to do this, reducing the risk of contamination and spread.
* for reusable PPE, there are adequate facilities for cleaning and decontamination, and PPE is kept in in good working order.
* PPE ensembles, including type IIR masks and RPE should be used in accordance with current official guidance and / or guided by local risk assessment. Please check latest version of official guidance.
* visual reminders are displayed communicating the importance of compliance with Public Health measures specific to PPE [Every action counts (england.nhs.uk)](https://www.england.nhs.uk/coronavirus/publication/every-action-counts/)
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| **If risk of transmission remains following this risk assessment, it may be necessary to consider the extended use of RPE (FFP3) for patient care in specific situations.** |