### CDDFT Policy

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<tr>
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<td>Blood Borne Virus Policy</td>
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<tr>
<td>Version number</td>
<td>3.3</td>
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<td>Document Type</td>
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<td>April 2005</td>
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<td>February 2012</td>
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<td>Approving body</td>
<td>Quality and Healthcare Governance Committee</td>
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<td>Originating Directorate</td>
<td>P &amp; OD</td>
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<td>Quality and Healthcare Governance Committee</td>
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<td>Occupational Health Clinical Lead</td>
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### Approval

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<th>Diane Murphy</th>
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<tr>
<td>Name / job title of Chairman of approving Body:</td>
<td>Diane Murphy Chair of Quality and Healthcare Governance Committee</td>
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<td>Signed paper copy held at (location):</td>
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<td>January 2007</td>
<td>Full</td>
<td>To ensure policy meets best practice, service needs and NHSLA 1.3.6</td>
<td>Eve Adams</td>
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<td>To ensure policy meets best practice, service needs and NHSLA 1.3.6</td>
<td>Kevin Smith</td>
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<td>Style for NHSLA</td>
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<td>Minor Amendments</td>
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<td>February 2012</td>
<td>Minor Amendments</td>
<td>Training information expanded, processes restructured under headings and appendices modified. Duties for line managers amended. Timeframe for reporting of incidents added to process section.</td>
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1. POLICY STATEMENT

County Durham & Darlington foundation Trust (hereafter referred to as the Trust) are committed to reducing the incidence of accidental occupational exposure to blood borne viruses. In incidents of accidental exposure the Trust is committed to early intervention and the full application of its duty of care to the exposed employee.

2. INTRODUCTION

This policy updates and replaces previous Trust policies for blood borne viruses. This policy complies with the UK National Guidelines and seeks to minimise the risk of acquiring a blood borne virus (BBV’s) in the workplace.

3. PURPOSE

This policy defines the process to be followed and the actions to be taken in the event of an inoculation exposure injury. It is necessary for all health care workers (HCW) to take precautions to protect themselves from contact with blood and other high risk body fluids. In the event of exposure to blood and other high risk body fluids via needlestick injury or other inoculation incidents it is important that HCW’s know:

- first aid action to take
- to report the incident to the responsible person within their work area
- where to go for risk assessment to be undertaken
- how to report the incident via the Trust reporting system.

4. SCOPE

This policy applies to all employees of the Trust (volunteers, visitors and external clients of the Occupational Health Service of the Trust are also covered by this policy).

5. DEFINITIONS

Blood Borne Viruses (BBV) are carried in blood and high risk body fluids there are more than 20 viruses that can be spread in this way but, for the purposes of this policy the three viruses covered by the Department of Health guidelines regarding occupational exposure to serious communicable diseases: Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV) are abbreviated to BBV.

‘Significant exposure’ is defined nationally as a percutaneous (needlestick/cut with sharp instrument) or mucocutaneous exposure (splash to mucosal or open tissues) to blood or other body fluids with the potential to spread virus, from a source that is known to be, or as a result of the incident is found to be positive for Hepatitis B virus (HBsAg), Hepatitis C virus or Human Immunodeficiency virus. (Eye of the Needle, HPA January 2005) This should not be confused with a significant incident which doesn’t take into account of the source status.

Significant Source in defined as: a source that is known to be, or as a result of the incident is found to be positive for Hepatitis B surface antigen (HBsAg), Hepatitis C (HCV) or HIV.
**Significant Incident** is defined as:
Percutaneous injury (from needles, instruments, bone fragments, significant bites with break to the skin) or, exposure of broken skin (abrasions, cuts, eczema) or the exposure of mucous membrane including the eyes, where another person’s blood or body fluids are involved.
Significant Source + Significant incident = Significant Exposure

**Exposure Prone Procedures (EPP)** “are those where there is a risk that injury to the worker may result in exposure of the patient’s open tissues to the blood of the worker. These procedures include those where the worker’s gloved hands may be in contact with sharps instruments, needle tips or sharp tissues (spicules of bone or teeth) inside a patient’s open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.”

**Post Exposure Prophylaxis (PEP)** is treatment after exposure to a BBV that is given with the aim of preventing the virus multiplying and becoming an established infection in the body e.g. HIV PEP or Hepatitis B immunoglobulin.

**Universal Bloods** the blood test undertaken on source patients following an exposure incident to a high risk body fluid. The current UK guidelines encourage universal testing of all source patients (whose hepatitis B/C or HIV status is unknown) regardless of the presence of risk factors. Informed consent must be sought before requesting these tests. The rational for universal blood testing is that hepatitis C and HIV cannot be identified with the risk approach. Also the universal approach “avoids the need to make difficult judgments, simplifies and normalizes the process and avoids the appearance of discrimination (Department of Health 2004, Para 27)

**GUM** - Genitourinary medicine

**HBeAg** - Hepatitis B envelope antigen

**HBV** - Hepatitis B virus

**HCV** - Hepatitis C virus

**HIV** - Human immunodeficiency virus

**Source Patient** - The individual whose blood or body fluids have caused the exposure

**Legislation/Risk Assessment**
The Health and Safety at Work Act 1974 and the Control of Substances Hazardous to Health Regulations 2002 (as amended) place a duty on the Trust to undertake a suitable and sufficient written risk assessment relating to microorganisms in the workplace and control the risk to employees, patients and visitors to its premises. Employee should receive information, instruction and training to enable them to
follow the measures designed to prevent harm and should cooperate with the measures put in place for their protection.

**Prevention**

Apart from HBV none of the BBV can be reliably prevented. However, post exposure PEP for HIV and early treatment for HCV can reduce the likelihood of serious health problems. It is therefore of the utmost importance to make the prevention of Significant Exposures a number one priority. Universal Precautions should be adopted – which means making the assumption that any patient could be a carrier of a BBV. The prevention of sharps injuries is covered in the *Infection Control Manual (Section 12) The Safe Use and Disposal of Sharps.*

**Professional and Ethical Duties**

Professional groups involved in healthcare have duties imposed by their regulatory bodies and all staff have an ethical duty to protect their own health and that of the trust’s patients. For doctors, paragraph 78&9 of “Good Medical Practice” from the General Medical Council states:

78 “You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available”.

79 “If you know that you have, or think that you might have, a serious condition that you could pass on to patients… …you must consult a suitably qualified colleague. You must ask for and follow their advice… …You must not rely on your own assessment of the risk you pose to patients.”

All Health Care Workers (HCW) should be aware of the possible risks from occupational exposure to BBV and should be aware of the importance of urgently seeking advice. All sharps injuries and splashes of blood and blood stained body fluids to broken skin and mucous membranes have the potential to transmit blood borne viruses from the source patient to the HCW. All such exposures need to be dealt with immediately by reporting under this policy and completing an IR1 form. An incident during EPP can pose a risk of transmission of BBV from the HCW to the patient. In these circumstances a risk assessment should be completed by the senior clinician for the patient and if risk is significant, source screening undertaken and PEP started.

### 6. DUTIES

**Trust Board**

The Trust Board is responsible for ensuring that there is a robust system in place to ensure employees and patient safety. This includes having a systematic process in place for managing inoculation injuries, percutaneous or mucocutaneous exposure, in the health care setting. The Chief Executive has ultimate responsibility for the management of health and safety throughout the Trust and for delegating authority appropriately.
All staff

- It is a duty of every employee of the Trust to comply with this policy and to attend immediately for post exposure risk assessment at Occupational Health or the Emergency Department, if Occupational Health is closed.

- It is also a duty of employees of the Trust to collaborate with the Occupational Health Department or Emergency Department and assess the source patient, as requested. Completing the source risk assessment form and arranging testing of the source patient for blood borne viruses (bearing in mind that the Trust supports the national policy for universal screening of the source patient) whenever consent can be obtained.

- It is the duty of every employee to submit an incident report following an inoculation incident.

“The Health and Safety at Work Act (HSWA)... [and] ...The Control of Substances Hazardous to Health Regulations 2002 (COSHH) require employees to take responsibility to avoid any risk where possible e.g. safe handling and disposal of sharp implements and the use of personal protective equipment (gloves, face visors) to minimise exposure to blood or body fluids…. … Immunisation against the Hepatitis B virus is recommended for all healthcare workers.”
Health Protection Agency, website.

Line Managers

- The Line Manager or their deputy will provide support to any employee who has suffered from an exposure and ensure that this policy is followed.

- To commence the risk assessments of the exposed employee and the source patient following policy process in section 7.

- Line managers will meet with employees who have had a BBV exposure and advise them on safe practices and up date for BBV risk.

- Line managers will investigate all BBV injuries that occur in their area(s) of responsibility and communicate learning outcomes to their employees.

Occupational Health Manager

It is the duty of the Occupational Health Manager and the Emergency Department Manager to make sure that all relevant members of their departments, including any new employees, are fully trained to follow this policy.

- Occupational Health (OH) is responsible for the initial risk assessment and follow up of employees who have significant exposure to BBV’s. OH will assume responsibility for the employee as soon as they are made aware of an exposure incident.
• OH will audit exposure incidents six monthly.

• OH will report significant exposures and those where PEP is initiated to the National Surveillance of Occupational Exposure to Blood Borne Viruses Scheme.

• OH will take the lead on policy development and will ensure all relevant Departments/Lead Clinicians are consulted.

• OH will advise on training requirements to support this policy.

• A fact sheet on blood borne virus risks/reporting process will be issued to all new entrants to the Trust at Induction Training and at OH immunisation appointments.

Ongoing support for employees who have been exposed will be provided by:
  • Occupational Health Nurses/Physician
  • GUM Specialist Nurses/Physician
  • Employee Counselling service

**Emergency Department**

• Outside of office hours and on Bank Holidays employees who have sustained a high risk exposure to Hepatitis B or HIV and who need to be risk assessed or receive treatment (vaccination, immunoglobulin or HIV antiretroviral) should attend A&E.

• In a high risk exposure scenario if A&E is uncertain of what action to take, the senior A&E medical officer can seek advice from their consultant colleagues in microbiology.

• A&E will leave an answer phone message or send a fax to OH identifying employees seen out of hours, to enable OH to schedule follow up screening as appropriate.

• To be involved in the review of the BBV policy content.
Department of Genitourinary Medicine

- To support OH during office hours if required regarding the prescription of PEP for HIV exposure incidents and provide appropriate counseling.
- Follow-up of non employees who have been exposed on Trust premises e.g. Paramedics, volunteers, members of the public and follow-up of all who have been prescribed PEP drugs.
- To be involved in the review of the BBV policy content.

Microbiology

- To provide advice regarding the management of HIV, hepatitis B and C positive incidents to OH, A&E and Genitourinary Medicine both during and outside office hours.
- To order hepatitis B Immunoglobulin as required.
- To arrange for emergency testing of source patient universal bloods.
- To be involved in the review of the BBV policy content.
- To ensure that OH is informed of the source patients universal blood result by telephone and that confirmation is provided on paper.

7. POLICY PROCESS - ACTION FOLLOWING INCIDENT

When an incident occurs:

A senior member of clinical staff on duty, other than the injured employee, at the time of the incident, leads on the risk assessment process for the employee and the source, ensuring that process is followed and all paperwork is completed and submitted. All forms are available on the intranet on the OH website.

Process:

Employee:

- Apply First Aid
  - Encourage local bleeding of wounds by gentle squeezing. Do not suck the area.
  - Wash the affected area with soap and warm water. Do not scrub the area.
  - Treat mucosal surfaces such as mouth or conjunctiva by rinsing with warm water or saline. Water used for rinsing the mouth must not be swallowed.
• Immediately report the incident to the senior on duty e.g. department manager or lead nurse and commence the assessment to establish the significance of the incident and if the BBV Policy if applicable, Appendix A & N.

• On the day of the incident contact Occupational Health (during office hours) to arrange a full risk assessment.

• Submit an incident report form.

**Senior member of staff (doctor or nurse):**

• Ensure first aid measures have been followed.

• Ensure the incident has been reported through the Trusts reporting system.

• Commence the assessment process to establish the significance of the injury Appendix A & N.

• Take blood from for the exposed employee for a serum hold remembering to ID validate the sample.

• Immediately following the initial assessment send the exposed employee to OH for a full assessment and management to be undertaken. If out of hours and the injury is considered to be high risk send injured employee to A&E.

• Undertake a risk assessment of the source patient for BBVs. All source patients should be approached and an explanation of the incident given, a risk assessment undertaken and universal bloods collected, Appendix J1.

• Universal testing requires consent from the source patient, Appendix B, C and E. If the source patient is considered to be high risk for HIV an urgent blood test should be arranged with Microbiology or out of hours the on call Microbiologist.

• For injuries occurring in the community the source patient risk assessment should be completed by an experienced health care professional in liaison with the GP responsible for the source patient. Universal blood tests should be arranged by the source patients GP. **NOTE** in the community setting the *initial* incident risk assessment may need to be done by the exposed employee to ensure appropriate action is taken in a timely manner. Where possible, advice/support should be sought from a senior colleague who is on duty.

• If consent from the source patient for universal blood tests are denied supplement the risk assessment with information collected using Appendix J2

Risk assessment and referral to OH or A&E for the employee should be undertaken immediately post injury and should not be withheld while waiting for source patient assessment/results of universal testing.
High Risk Source Patients:

- If the source patient is known or suspected to be HIV positive, the exposed employee needs to attend the OH or out of hours A&E, within 1 hour of the incident, bringing the completed paperwork along to the assessment. Appendix A and Appendix J1.

- If the source patient is known or suspected to be hepatitis B positive the employee needs to attend the OH as soon as possible after the incident. Out of hours they should attend A&E only if they have not had Hepatitis B vaccine or are a known non responder to the hepatitis B vaccine taking the completed Appendix A and J1.

- If the source patient is known or suspected to be hepatitis C positive the employee should attend the OH as soon as possible during normal opening hours taking the completed Appendix A and J1.

Unknown Source

- If the source of the exposure cannot be identified e.g. discarded needle, the risk assessment should be based on the circumstances of the exposure and the likelihood of the presence of a BBV e.g. in clinics where it is known patients have a high incidence of Hepatitis B/ C or HIV.

Clarification of the above can be obtained by contacting the Sharp’s Hotline.

Sharp’s Hotline 0191 333 7128

Management of the Exposed Employee

Occupational Health/ Accident and Emergency Department Staff:

- Employees should be assessed and treated as a priority, ideally within one hour.

- Complete Employee Risk Assessment form.

- Liaise with the person responsible for the area where the source patient is located:
  - Ensure source patient risk assessment is in process/ completed
  - Ensure universal source patient blood tests have been ordered

- Take blood for storage (viral hold) if not already collected at departmental level.

- Assess the need for hepatitis B post exposure prophylaxis.

- Assess the need for HIV PEP. Remember, time is of the essence and therapy should be started as soon as possible following injury, ideally within one hour. If PEP is commenced, the exposed employee will be referred to GUM for follow
• OH to follow up the source patient universal blood results.

• OH to arrange follow-up of exposed employee at appropriate intervals following national guidelines.

• Referral for specialist counselling/ support via GUM will be made if required.

• OH will report significant BBV exposures and if PEP was commenced to the National Surveillance of Occupational Exposure to Blood Borne Viruses Scheme.

Reverse or Bi-directional BBV incidents.

A **reverse** BBV incident occurs when a employees blood or blood stained body fluids enters a patient’s body tissues or membranes. The same principles of management apply but must be considered in reverse. The clinicians managing the patient may wish to get advice from occupational health but it is the clinicians who are responsible for the patient that undertakes the patient risk assessment, PEP and follow up if applicable. The employee will need to be approached for consent to be tested for universal bloods for the benefit of the patient. Label the sharps paper work as a reverse needle stick and explain what happened under “clinical details.”

A **bi-directional** BBV incident occurs when the sharp first enters the patient then the employee then the patient again. This might occur during venepuncture or during an Exposure Prone Procedure (EPP) – for example if a knife has cut a surgeon and then returned into / remained briefly in the patient’s operative field. If a bi-directional BBV incident occurs during an EPP and the employee has not been cleared for EPP work this could have potentially serious implications for the Trust especially if the employee then tests positive for a blood borne virus.

The same principles apply to management of such an incident but each party is both source and recipient. Please mark all the forms as bidirectional BBV incident and explain what happened under clinical details. Occupational Health will need to deal with the implications for the member of staff and the clinicians for the patient.

**Ethical Note:** If you are the source of contamination to a patient, you must not rely on your own assessment of the risk posed to the patients. Failure to report potential hazardous incidents may breach the duty of care to patients.

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**8. TRAINING**

Attendance at Essential Training is recorded by P&OD and entered onto the Trust Training Management system, OLM. Monitoring of non-attendance will be in line with
the Training Needs Analysis, monitoring and Evaluation Policy and carried out by P&OD. Please refer to this policy for detailed information.

The OH and A&E managers are responsible for the training of staff in their departments to undertake BBV exposure risk assessments.

Line managers will meet with employees who have had a BBV exposure and advise them on safe practices and up date for BBV risk.

9. MONITORING

In addition the NHSLA monitoring form will be submitted on an annual basis

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<td>The OH Head of Service and the OH Consultant will monitor compliance with and the effectiveness of this policy.</td>
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<td>When will the monitoring be performed?</td>
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| What will be monitored? | Compliance with inoculation incident policy:  
  - duties  
  - inoculation reporting procedure requirements and timely intervention  
  - the management of inoculation incidents (prophylaxis)  
  - training |
| How are you going to monitor? | Audit of all risk assessments undertaken post BBV exposure incidents will be undertaken to identify incident reporting requirements are followed, management requirements have been met and to identify injury trends. The audit will be undertaken by the OH team.  
  OH will undertake a gap analysis of all risk assessments undertaken by the OH and A&E correlated to incident reports submitted to the Trust.  
  Training of employees will be evidenced by the Trusts training management system, OLM. (see statement below) |
| What will happen if any | |

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Inoculation injuries will be investigated at ward/department level by the line manager or their appointed person and Health & Safety controls implemented as required.

Data will be submitted to The “National Surveillance of Occupational Exposure to Blood Borne Virus Scheme” in keeping with their requirements.

10. REFERENCES

1. HIV Post Exposure Prophylaxis (Guidance from the UK Chief Medical Officers’ Expert Advisory Group on AIDS) – Department of Health – February 2004
4. Serious Communicable Diseases – General Medical Council 1997
5. Serious Communicable Diseases – Special Notice, General Medical Council website: www.gmc-uk.org/guidance/serious_communicable_diseases/index.asp accessed 29.05.09
6. Consent: patients and doctors making decisions together, GMC 2 June 2008
7. Reference guide to consent for examination or treatment, Department of Health 6 April 2001, product No. 23617

**Associated Documents**
- Consent Policy
- Incident Policy
- Sharps Policy
- Clinical Audit
- Induction Policy
- Training Needs Analysis
- Health & Safety Policy
- Policy for Policies
11. Equality Analysis / Impact Assessment

**Full Assessment Form v2/2011**

**Division/Department:**
- Occupational Health

**Title of policy, procedure, decision, project, function or service:**
- Blood Borne Virus Policy

**Lead person responsible:**
- OH Clinical Lead

**People involved with completing this:**
- OH Clinical Lead/Senior Nurse
- A&E Consultants
- GUM Consultants

**Type of policy, procedure, decision, project, function or service:**
- Existing ✓
- New/proposed □
- Changed □
Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

Policy for the reporting of inoculation incidents. Purpose is to ensure timely access to risk assessment and prophylactic treatment for the employee and suitable documentation of the incident.

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Will benefit all employees who may be exposed to potential blood borne virus risks/injury regardless of which diversity group they may belong to

What outcomes do you want to achieve?

Timely access to risk assessment, prophylactic treatment, suitable documentation and follow up for the employee where applicable that applies equally to all.

What barriers are there to achieving these outcomes?

Young workers may be more prone to take risks with their health and safety.

How will you put your policy, procedure, project, decision, function or service into practice?

Existing policy – review/changes will be disseminated to Trust employees via induction and essential training and intranet update. The message will be given to new starters that their health and safety is important and that they should report inoculation injuries.

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

No
Step 2 – Collecting your information

What existing information / data do you have?

No special interest group has approached OH to state that their interests are not being met by the BBV policy.

Who have you consulted with?

No formal consultation.

What are the gaps and how do you plan to collect what is missing?

We do not expect discriminatory impact from this policy and therefore do not plan to collect any further information.

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

Nil

Sex/Gender

Nil
Age

Nil

Disability

Nil

Religion or Belief

Nil

Sexual Orientation

Nil

Marriage and Civil Partnership

Nil

Pregnancy and Maternity

Nil

Gender Reassignment
Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills

Nil

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act?

Yes ☐ No ☑

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.
Existing policy under going minor amendments for NHSLA requirements and style in place since 2005.

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

3 yearly or earlier if national guidance indicates changes to the management of inoculation injuries is required.

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be attached to any documentation to which it relates and must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk
**APPENDIX A**

**ASSESSMENT OF EXPOSURE OF HEALTH CARE WORKERS TO BLOOD BORNE VIRUSES**

- Sections 1 to 4 of this form should be completed immediately following exposure to blood or blood-stained body fluids & other high-risk body fluids, by the Health Care Worker (HCW) who has been exposed.
- This form is CONFIDENTIAL and when completed, will be retained within the Occupational Health Records of the HCW who has been exposed.

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<tbody>
<tr>
<td>FIRST AID MEASURES</td>
</tr>
<tr>
<td>• Encourage bleeding and wash with copious amounts of running water</td>
</tr>
<tr>
<td>• Cover with dressing where appropriate</td>
</tr>
<tr>
<td>DATE</td>
</tr>
<tr>
<td>INFORM MANAGER DATE TIME</td>
</tr>
<tr>
<td>COMPLETE INCIDENT FORM DATE TIME</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 ASSESSMENT OF INCIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Incident</td>
</tr>
<tr>
<td>Tick ✓</td>
</tr>
<tr>
<td>Contaminated Sharp (e.g. with blood etc)</td>
</tr>
<tr>
<td>Contamination of Broken Skin</td>
</tr>
<tr>
<td>Splash to Conjunctiva / Mouth</td>
</tr>
<tr>
<td>Human Bite (where skin is broken)</td>
</tr>
</tbody>
</table>

*If any of the above ticked, continue completion of this form.*

*If any of the above ticked, administer first aid No further action required re. BBV*

<table>
<thead>
<tr>
<th>4 MATERIAL INVOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tick ✓</td>
</tr>
<tr>
<td>• Blood / Plasma</td>
</tr>
<tr>
<td>• CSF</td>
</tr>
<tr>
<td>• Pleural/peritoneal fluid</td>
</tr>
<tr>
<td>• Other blood-stained fluid (specify)</td>
</tr>
</tbody>
</table>

If none of the above are involved, no further action re. BBV exposure is necessary. Urine, faeces & vomit, unless blood-stained, carry no risk of BBV transmission.

For all potential incidents review local risk assessments.
5A THIS SECTION SHOULD BE FOLLOWED AND COMPLETED BY A SENIOR HEALTH CARE WORKER AND NOT THE RECIPIENT OF THE INJURY.

- Complete Appendix Ji and give to recipient who should take this along with Appendix A to Occupational Health as soon as possible.
- The Senior Health Care Worker managing the incident should obtain informed consent from the source patient to test their blood.
- In circumstances where the source patient is a visitor to another department e.g. x-ray, or the recipient has been exposed via a biological specimen/contamination of equipment the Occupational Health Department will liaise on their behalf with the staff from the appropriate ward or department to manage the incident effectively. This process will require the sustained co-operation of all parties.

5B ACTION FOR HCW OUT OF HOURS/BANK HOLIDAYS

- * Senior Health Care Worker in charge of area where incident/exposure occurred to arrange baseline blood for storage to be taken from the HCW and to manage the source patient. (See Appendix E).
- For out of hours exposure incidents where the source patient is a visitor to a particular ward or department the Site Co-ordinator/Duty Manager will ensure appropriate liaison occurs to manage the process effectively.

Send a venous blood sample from HCW to Pathology in a serum gel (ochre topped) specimen tube with Microbiology/Virology form. (State “Blood Borne Virus Exposure of HCW (Recipient) – blood for storage”)

Signed * ___________________________ Date ___________________________ Time ___________________________

6. DETAILS OF SOURCE (Tick here if source unknown) □ and go to point 10)

Name of Patient ___________________________ Hospital No. ___________________________

Name of Consultant in Charge of Patient ___________________________ Ward ___________________________

7. ACTION FOR ‘KNOWN SOURCE’ AT ALL TIMES

- Ask the source patient to read the Patient Information Leaflet on Blood Borne Virus Infections, (Appendix B), ensuring they are competent to read and understand the leaflet.
- Obtain written consent from the source (Appendix C) to test their blood for some or all of the blood borne viruses: the source may not always consent to the testing of all three viruses. (The consent form should be filed in the source’s medical records). If the source refuses to have details of their consent and blood results in their medical record, this information may be filed in the OH notes of the HCW concerned as a separate record. N.B. If the source refuses or is incapable of giving consent please refer to Appendix D, extracts from the relevant GMC guidance.
8. SOURCE KNOWN, HIGH RISK HIV/Hep B – IMMEDIATE ACTION FOR HCW

- If the source is HIV positive or thinks that they may be HIV positive, go immediately to the Occupational Health Department (8:30 am to 4:30 pm Monday to Friday), or out of hours, the Accident and Emergency (A&E) Department. The same action should be taken if the Consultant in charge of the source’s care strongly suspects they are HIV positive.

- If it is suspected that the SOURCE patient is HIV positive emergency testing should be arranged (see Appendix E.)

- If the source is Hepatitis B positive or thinks s/he may be Hepatitis B positive, go to the Occupational Health Department as soon as possible during normal opening hours. Out of hours go to A&E ONLY if you have not been immunised against Hepatitis B, had only one vaccine or are a non-responder to the vaccine (Appendix K - Hepatitis B Immunisation Table).

Tick the blood tests that the source has agreed to have taken

- Hep B Surface Antigen
- Hep C Antibodies
- HIV

The Senior HCW managing the incident should arrange testing by the normal procedures. If it is suspected that the patient is HIV positive emergency testing should be arranged (Appendix E).

9. CONSENT REFUSED

If the source refuses to have blood tests taken, enquiry should be made for risk factors for Hep B, Hep C and HIV. Risk Assessment Form J2

If there is evidence to suggest that the patient may be high risk to HIV or Hepatitis B, appropriate management of the HCW should include informed consent for post exposure prophylaxis (PEP HIV or, Hepatitis B Immunoglobulin for unvaccinated or vaccine non-responders), otherwise treat as if source unknown.

10 SOURCE UNKNOWN - ACTION FOR HCW

- Most unknown sources are deemed low risk unless individual departmental risk assessment identifies a high-risk potential. The HCW should attend the Occupational Health Department at their earliest opportunity between 8:30 am and 4:30 pm Monday to Friday. When the situation surrounding the incident gives serious concern in relation to exposure to BBV, discuss the case with Occupational Health, Microbiology or GUM.
RESULTS of BLOOD TESTS from SOURCE (Circle result: NT = not tested)

<table>
<thead>
<tr>
<th>Hep B (HBsAg)</th>
<th>Pos / Neg / NT</th>
<th>Hep C</th>
<th>Pos / Neg / NT</th>
<th>HIV</th>
<th>Pos / Neg / NT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Received from……………………………..Designation……………………..

Received by………………………………Date……………..Time………………..

ACTION WHEN RESULTS OF SOURCE BLOOD TESTS ARE KNOWN

- If source is HIV positive go immediately to Occupational Health or, out of hours the Accident and Emergency Department, unless Post-Exposure Prophylaxis (HIV PEP) has already been prescribed. Treatment should be administered within the first hour following exposure.
- When PEP is started in A&E the most senior doctor available in A&E should be informed.
- When source is hepatitis B positive, attend the Occupational Health Department. ONLY attend the A&E Department out of hours if you have NOT been vaccinated against Hep B, had only one Hep B vaccine or if you are a non-responder to the vaccine.
- For all other incidents including those related to a positive hepatitis C result, contact the Occupational Health Department at the earliest opportunity during office hours, 8:30 am to 4:30 pm Monday to Friday, excluding Bank Holidays.
- The HCW will be informed of the need for further follow up through the Occupational Health Department during the aforementioned times.
- DO NOT file the results of blood tests taken from the source within their medical record if they have not consented for this to happen.
- The HCW should take the Assessment of Exposure of a HCW to Blood Borne Viruses Form (Appendix A) to the Occupational Health Department, as soon as possible, along with Appendix J1.
- The doctor in charge of the source patient should make arrangements to inform the source patient of the result and arrange appropriate follow up and support. These results should also be passed onto Occupational Health to ensure appropriate follow-up of the HCW.
- On receipt of the appropriate paperwork the Occupational Health Nurse following up the incident will remove the name of the source patient from the form. This is to ensure future anonymity of the source patient.
- See Flow Chart Appendix L
APPENDIX B

If you have further questions please ask the Senior Doctor or Nurse on duty, who will be able to explain things to you in more detail.

This leaflet is also intended for use when a health care worker has a significant exposure in a community setting.

Request for blood sample following significant exposure of a health care worker to a patient’s blood or body fluids.

County Durham and Darlington NHS Foundation Trust
Occupational Health Department

PATIENT (SOURCE) INFORMATION LEAFLET

Initial publication Date: January 2007
Date of review: September 2010
Date of next review: September 2013
Responsibility for review: Occupational Health
Leaflet reference: PIL/CG/0014
Version: 2.0
This leaflet explains the reasons for requesting a blood test from a patient whose blood or body fluid has been involved in an ‘exposure incident’

When a health care worker is exposed to blood or body fluids from a sharps injury (a penetrating injury to the skin by a sharp object) or splash on broken skin, eyes or mucous membranes there is a chance he or she may develop an infection.

**ABOUT THE VIRUSES**

The most worrying infections are:

- Hepatitis B virus
- Hepatitis C virus
- HIV (AIDS)

All three viruses can be transmitted by exposures to blood and body fluids and could result in the development of serious illness in the health care worker.

**WHAT WE ARE ASKING YOU**

We are asking you to allow us to take a small amount of your blood and test it for three viruses, hepatitis B, hepatitis C and HIV.

If the blood sample contains one of the viruses the health care worker will be able to start treatment to prevent them becoming ill. You would also be offered treatment.

**YOUR RIGHTS**

- We are asking for your consent in order to help the health care worker who has sustained the injury.
- You do not have to give consent to have your blood taken and can refuse to be tested for all or any of the viruses mentioned above.
- If you choose to refuse, this will not affect your treatment or future care within this hospital in any way.
- You will be informed of the results of these tests by the doctors looking after you and given advice, support and appropriate treatment should you have a positive result.
- The results will be filed in your medical record unless you request otherwise.
- Just having your blood tested will not affect any existing or future insurance policies you hold.
- If the result comes back positive, current policies will not be affected as long as you were unaware of this fact when the policy was taken out. In the event of a positive result, future policies may be affected.
- All information received will be kept strictly confidential.
- If you have any further questions please ask.
APPENDIX C

CONSENT FORM FOR BLOOD TESTING OF BLOOD BORNE VIRUSES

(HEPATITIS B, HEPATITIS C & HIV)

Consent to testing for a serious communicable disease

You must obtain consent from patients before testing for a serious communicable disease, except in rare circumstances. The information you provide when seeking consent should be appropriate to the circumstances and to the nature of the condition or conditions being tested for. Some conditions, such as HIV, have serious social and financial, as well as medical implications. In such cases you must make sure that the patient is given appropriate information about the implications of the test, and appropriate time to consider and discuss them. (Appendix B) (GMC guidance, Appendix D).

Consent form 3 “Patient/Parental Agreement to investigation or treatment procedures where consciousness not impaired” should be used. Copies of this should be available in the hospital setting. If not use a copy of the following two pages, offering the patient a photocopy of the completed consent form. (see form attached)
CONSENT FORM 3

Patient/Parental Agreement to Investigation or Treatment for procedures where consciousness not impaired

<table>
<thead>
<tr>
<th>Patient details (or pre-printed label)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Surname/Family Name: ………………..</td>
</tr>
<tr>
<td>Patient's First Name(s): ……………………..</td>
</tr>
<tr>
<td>Date of Birth: ………………………………..</td>
</tr>
<tr>
<td>Unit No.: ……………………………………….</td>
</tr>
</tbody>
</table>

Is the patient: Male ☐ Female ☐

Do they have any special requirements: (e.g. other language/other communication method)

Consultant/Responsible Health Professional: ………………………………………………………………. |

Name of proposed procedure or course of treatment
(include brief explanation if medical term not clear)
………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy).
I have explained the procedure to the patient/parent. In particular, I have explained:
The intended benefits ………………………………………………………………………………………………………………………………………….
…………………………………………………………………………………………………………………………………………………………
Serious or frequently occurring risks
…………………………………………………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………………………………………
I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.
☐ The following leaflet/tape has been provided
…………………………………………………………………………………………………………………………………………………………

Signed ………………………………………. Date ……………………………………….
Name (PRINT) ………………………………………. Job Title ……………………………………….

Statement of Interpreter (where appropriate)
I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe he/she/they can understand.

Signed ………………………………………. Name (PRINT) ………………………………………. Date ……………………………………….
STATEMENT OF PATIENT/PERSON WITH PARENTAL RESPONSIBILITY FOR PATIENT

I agree to the procedure described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that the procedure will/will not involve local anaesthesia.

Signed ................................................................. Date .................................

Name (PRINT) .......................................................... Relationship to patient ..........

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent has signed the form in advance).

I have confirmed with the patient/parent that they have no further questions and wish the procedure to go ahead.

Signature ................................................................. Date .................................

Name (PRINT) .......................................................... Job Title ............................

COPY ACCEPTED BY PATIENT/_PARENT: YES/NO (please ring)

Guidance to health professionals (to be read in conjunction with consent policy)

What a consent form is for
This form documents the patient’s agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, providing they retain capacity to do so. The form should act as an aide-memoire to health professionals and patients, by providing a checklist of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussion with the patient.

The law on consent
See the Department of Health’s Reference guide to consent for examination or treatment for a comprehensive summary of the law on consent (also available at www.doh.gov.uk).

Who can give consent?
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”, then he or she will be competent to give consent for him or herself.

Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore
sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for him or herself, someone with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for his or herself, you should always involve those with parental responsibility in the child’s care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

**When NOT to use this form**
If the patient is 18 or over and is not legally competent to give consent, you should consider the advice on the GMC’s website and in appendix D in relation to the Mental Capacity Act 2005. You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives cannot be asked to sign this form on behalf of an adult who is not legally competent to consent for his or herself.

A statement from the GMC has indicated: “As we understand it, current law does not permit testing the infection status of an incapacitated patient solely for the benefit of a healthcare worker involved in the patient’s care.”

**Information**
Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about ‘significant risks which would affect the judgement of a reasonable patient’. ‘Significant has not been legally defined, but the GMC requires doctors to tell patients about ‘serious or frequently occurring’ risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 1 of the form or in the patient’s notes.
APPENDIX D

The General Medical Council has withdrawn its document, “Serious Communicable Diseases” and replaced it with a statement about the Mental Capacity Act 2005 which includes this advice:
“As we understand it, current law does not permit testing the infection status of an incapacitated patient solely for the benefit of a healthcare worker involved in the patient’s care.”

Some of the old guidance remains valid and this includes:

1. “If you or another health care worker has suffered a needlestick injury or other occupational exposure to blood or body fluids and you consider it necessary to test the patient for a serious communicable disease, the patient’s consent should be obtained before the test is undertaken. If the patient is unconscious when the injury occurs consent should be sought once the patient has regained full consciousness. If appropriate, the injured person can take prophylactic treatment until consent has been obtained and the test result is known.

2. If the patient refuses testing, is unable to give or withholds consent because of mental illness or disability, or does not regain full consciousness within 48 hours, you should reconsider the severity of the risk to yourself, or another injured health care worker, or to others. You should not arrange testing against the patient’s wishes or without consent”...

3. If the patient dies you may test for a serious communicable disease if you have good reason to think that the patient may have been infected, and a health care worker has been exposed to the patient’s blood or other body fluid. You should usually seek the agreement of a relative before testing.”


∗Taking blood from a patient without consent may leave you open to criminal charges.
APPENDIX E

SOURCE AND RECIPIENT BLOOD TESTING

1. All source blood samples will be labelled using standard patient identification labels, where possible. Should the Source patient request that the sample is tested anonymously, contact the laboratory for advice.

2. The Source Patient’s Laboratory Form should be completed as follows:

- **Surname/Name:** Use Source Patient Identification Label
- **Sex:** As appropriate to Source Patient
- **Date of Birth:** As appropriate to Source Patient
- **Consultant:** Responsible for the patient
- **Hospital/Ward:** As appropriate

**Clinical Summary:**
- **Microbiology:** Specimen Type: Venous Blood
- **Investigations Required:** Hep B, Hep C, HIV

Routine or Emergency as appropriate

3. The blood tube should be labelled with Source Patient Identification Label and then completed to conform with laboratory form. Emergency testing should only be done where the Source Patient’s blood is strongly suspected to be HIV positive. All other specimens should be sent to the Microbiology Laboratory routinely at latest, the next day. In South Durham, the Consultant Microbiologist or Duty BMS should be contacted to ensure next day dispatch of the sample.

Emergency testing should be arranged i.e. during working hours by contacting the Consultant Microbiologist, and out of hours contact the Duty BMS on call (via Switchboard) who will arrange transport of the specimen.

**Telephone Numbers:**
- **Consultant Microbiologist:**
  - UHND 0191 333 2430 or 2613
  - DMH 01325 743241 or 5274

**Emergency Results:**
- The Doctor/Senior HCW responsible for Source Testing must take responsibility for ensuring that the result is telephoned to Occupational Health (Mon – Fri 8.30 – 4.30 pm) or Accident and Emergency outside of these times. Liaison between Occupational Health and Accident and Emergency i.e. whoever is managing the Recipient HCW, is paramount to ensure that the HCW in need of PEP receives it as soon as possible.
4. The Recipient's Laboratory Form should be completed as follows:

**Name, Surname:** Details of the injured recipient

**Sex:** Gender of the injured recipient

**Date of Birth:** Details of the injured recipient

**Consultant:** OH Consultant Name

**Hospital/Ward:** Occupational Health

This is needed to ensure that results are available to occupational health

**Clinical Summary:** BBV Exposure – “Recipient” and “(name of the source patient = ………………………)”.

**Date/Time:** As appropriate

**Microbiology:**

**Specimen Type:** Venous Blood

**Investigations Required:** Blood for Storage

**Routine**

A Source Patient Identification Label should be attached to the top of the Assessment Form (HCW) (Appendix A, p10)

**Emergency testing:**

**During normal working hours:**

- UHND 0191 3332430/2613
- DMH 01325 743241/5274

Out of hours: Contact the Microbiology BMS on Call via switchboard
APPENDIX F1

Availability of Starter Packs/ Immunoglobulin
HIV PEP

Starter Packs of Post Exposure Prophylaxis drugs will contain a 5-day supply of the combination of drugs currently recommended by the Department of Health for the purpose. The GUM Consultants will advise on the appropriate drug combinations. The starter packs will be prescribed by either the Occupational Health Service or a member of the A&E medical staff or GUM. Starter packs are available in the Emergency Drugs Cupboards at DMH, UHND, BAGH and SBCH, in the Occupational Health Departments at UHND and DMH, Accident & Emergency and Pharmacy.

Hepatitis B Immunoglobulin (HBlg)

Ensure you have completed the risk assessment prior to making contact. Stocks of HBlg are held by the Health Protection Agency due to scarcity and in order to ensure appropriate use. Contact has to be made with one of their virologists on 0191 2261074 during office hours or out of hours you would need to contact the switchboard on 0191 2336161 and ask for the virologist on call.
APPENDIX F2

HIV Post Exposure Prophylaxis (PEP)

The use of drugs active against HIV has been recommended following a significant exposure to blood or body fluids known to be, or strongly suspected to be, infected with HIV. If started soon after the exposure it is hoped the drugs would prevent the person becoming infected with the virus.

The risk of someone becoming infected with HIV after a definite exposure is low, (about 1:300 chance after a needlestick and between 1:33 – 1:1000 after sexual exposure) even if no drugs are taken. This low risk and the possibility of side effects from the drugs should be considered before starting the drugs.

The drugs are likely to be of most benefit if started early. It is important not to delay the decision (preferably start within 2 hours of the incident). The drugs can always be stopped at a later date if you perhaps change your mind after further discussion. You will be asked to sign a consent form before starting treatment.

HIV Tests

The HIV tests detects antibodies that your body produces in response to infection with the virus. Antibodies may take up to three months to be produced after infection. A blood test taken immediately after the incident cannot tell you if you have just been infected. It is useful however as a baseline test. Further blood samples will need to be taken over a three-month period to see if you have developed antibodies to HIV. A positive result means that infection with HIV has occurred.

IT IS VERY IMPORTANT THAT YOU TELL THE DOCTOR -

a. If you are taking other medications as they may interact with the HIV drugs
b. If you have ever had liver problems

OR

c. If there is any possibility that you could be pregnant - the drugs are not licensed for use in pregnancy, although there has been some experience with their use. The risks of using the drugs in pregnancy need to be weighed against the risk of infection. If in doubt please seek further advice from GUM.

Advice for HCWs who may be or who are pregnant

If a HCW is at risk, then a pregnancy test should be done ASAP, before starting PEP. If pregnant then specialist advice must be sought.

The Expert Advisory Group on AIDS 2008 guidance states:

“Pregnancy does not preclude the use of HIV PEP. Expert advice should always be sought if PEP is considered indicated for a female HCW who is pregnant, after
assessment of the circumstances of the exposure and of the source patient. Urgent pregnancy testing should be arranged for any female worker who cannot rule out the possibility of pregnancy, as part of the evaluation prior to the exposed worker reaching a personal informed decision about starting PEP."

“The British HIV Association has published guidelines for prescribing antiretroviral therapy in pregnancy (52). There has been no indication of particular problems for the babies of HIV-infected women who have become pregnant while already on antiretroviral medication. It should be noted that there is limited experience of the use in pregnancy of some of the newer drugs.”

“ A pregnant HCW who has experienced an occupational HIV exposure should be counselled about the risks of HIV infection, about the risks of transmission to her baby, and about what is known and not known about the potential benefits and risks of antiretroviral therapy for her and her baby, to help her reach an informed personal decision about the use of PEP.”

“Decisions about the use of specific drugs in pregnancy may be influenced by their individual adverse effects. For example, drugs that may cause nausea may exacerbate pregnancy-associated nausea. Efavirenz is contraindicated in pregnancy and not recommended for inclusion in PEP regimes…”

The Department of Genito Urinary Medicine is the most appropriate source of the specialist advice needed in these cases and they will normally supervise the affected worker’s course of PEP.
APPENDIX J1

BBV Exposure
Pre Test Risk Assessment of All Source Patients

To be completed prior to taking blood from the source patient or when the source refuses to have blood taken for BBV testing.

The assessment should be completed by the most senior doctor available who is caring for the source.

<table>
<thead>
<tr>
<th>Suspecion</th>
<th>Likely Risk</th>
<th>No Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ask the source if s/he is infected with, or may have had contact with others who are known to carry:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Assess source’s medical records for evidence of infection with HIV, HBV or HCV (e.g. positive blood tests; history suggestive of clinical infection; documented concern about possible infection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If a risk identified, follow guidance as if source is known to be positive for that virus. If no risk identified, follow guidance as if source is unknown.

Signed……………………………………………….Date…………………………………..
(Most senior doctor/health care worker available, caring for source patient)

Print Name…………………………………………Designation………………………….
APPENDIX J2

Factors to consider when Source Patient Refuses Blood Testing

When a source patient refuses to have blood taken for testing it is necessary to consider in more depth the risk factors for BBVs.

Risk Factors for BBV include:
- Known carriage of a BBV
- Close family member who is a carrier of a BBV
- IV drug abuser or user of other non-prescribed injected drugs
- Men who have sex with men (which does not equate with being homosexual)
- Having spent time in a custodial institution
- Having received payment for sex
- Having had unprotected sex abroad
- Having had body tattoos or body piercing in unlicensed premises
- Having learning disabilities and having spent time in an institution
- Having had blood transfusions in developing countries.

Some source patients may find discussing these issues difficult. Asking the question does not imply the source patient belongs to one of these groups. It may be more acceptable to show the questions to the source patient and if they are able to answer ‘No’ to all of them they are not in a ‘high risk’ group.

Following consideration of the risk factors with the source patient, if it is likely that the source patient is at risk of being a carrier of a BBV, i.e. has answered YES to one or more of the above questions, then the HCW who has had the exposure should be advised to consider starting PEP and to take it until additional information has been obtained about the risk factors.
# APPENDIX K

## Hepatitis B Immunisation Table

<table>
<thead>
<tr>
<th>HBV status of HCW at time of exposure</th>
<th>Significant exposure</th>
<th>Non-significant exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source known to be HBsAg positive</td>
<td>HBsAg status of source unknown</td>
<td>Source known to be HBsAg negative</td>
</tr>
<tr>
<td><strong>≤ 1 dose of Hep B vaccine</strong></td>
<td>Accelerated course of Hep B vaccine + HBlg x 1*</td>
<td>Accelerated course of Hep B vaccine</td>
</tr>
<tr>
<td>Source known to be HBsAg negative</td>
<td>Initiate course of Hep B vaccine</td>
<td></td>
</tr>
<tr>
<td><strong>2 or more doses of Hep B vaccine but anti-HBs not known</strong></td>
<td>One dose of Hep B vaccine + 2nd dose one month later</td>
<td>One dose of Hep B vaccine</td>
</tr>
<tr>
<td></td>
<td>Finish course of Hep B vaccine</td>
<td></td>
</tr>
<tr>
<td><strong>Known responder to Hep B vaccine (anti-HBs &gt; 10 mIU/ml)</strong></td>
<td>Consider Hep B booster†</td>
<td>Consider Hep B booster†</td>
</tr>
<tr>
<td></td>
<td>Consider Hep B booster†</td>
<td></td>
</tr>
<tr>
<td><strong>Known non-responder to Hep B vaccine (anti-HBs &lt; 10 mIU/ml 2-4 months post immunisation)</strong></td>
<td>HBlg* x 1 + booster dose of Hep B vaccine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HBIG* x 1 + booster dose of Hep B vaccine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consider Hep B booster†</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consider Hep B booster†</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure usual attempts to vaccinate are exhausted</td>
<td></td>
</tr>
</tbody>
</table>

Based on Guidance from the PHLS Hepatitis Subcommittee. CDR Review 1992:2; R97-R101 & The Green Book.

- HBBlg = Hepatitis B Immunoglobulin. Dose > 9 years 500 iu (NB Immunoglobulin will only be released where a full risk assessment has been undertaken of the source patient)
- Accelerated course of Hepatitis B Vaccine = three injections at 0, 1 & 2 months. Now recommended as standard practice.
- †A booster should be given if the current normal regime is not up to date or a booster would be due in the next 12 months.
- Laminated versions of this flow chart are available through Medical Photography, UHND
APPENDIX L

Sharps Injury/BBV Exposure

Appropriate First Aid

Assessment of the Injury, Page 1, Appendix A

SIGNIFICANT

YES

Senior HCW to complete Appendix J1 and rest of Appendix A
Consent and take blood from source on ward/department
(Appendix B,C&D) and send to laboratory urgently or routinely
depending on likelihood of HIV positivity (Appendix E)

Complete Incident Form (IR1)

HCW to report to Occupational Health
Monday/Friday 8.30am – 4.30pm

NO

Complete Incident Form

OUT OF HOURS OR BANK HOLIDAYS

HCW to attend A&E only if requires HIV PEP or
Hep B immunoglobulin

HCW to contact Occupational Health ASAP
for follow up and advice

No further action required
APPENDIX M

COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST
OCCUPATIONAL HEALTH SERVICE

Occupational Exposure Incidents Involving Hepatitis C Virus

Introduction
There is no preventative vaccine or post exposure treatment for the hepatitis C virus following an exposure incident to a known positive hepatitis C source. Appropriate action in this situation involves adhering to the basic principles of the Blood Borne Virus Policy. This information leaflet explains the risks from this type of exposure and the support and follow-up you will be offered should you experience an untoward incident involving blood or body fluids known to be positive to this virus.

What is hepatitis C?
Hepatitis C is a liver disease caused by the hepatitis C virus. It is transmitted by direct contact with infected blood. For a number of people the disease is an acute self limiting illness resulting in complete recovery but a number of people can go on to develop a chronic form of the disease. Most people who acquire the virus do not develop any symptoms or may experience only a mild flu like illness.

What should I do following a high-risk exposure?
Following any exposure incident you should undertake appropriate first aid as soon as possible i.e. encouraging a sharps injury gently to bleed, washing with soap and water and covering with an adhesive, waterproof dressing. Splashes to broken skin or mucous membranes require immediate irrigation with copious amounts of water. The source patient should undergo informed consent to obtain a blood sample for hepatitis C and hepatitis B and HIV. This should be carried out by a senior colleague looking after the patient. For a hepatitis C exposure there is no need for the patient blood sample to be sent urgently or for you to attend the Emergency Department.

What is the risk of acquiring the virus from an exposure incident?
Transmission only occurs from RNA positive sources, which means the source has active infection. Less than 0.5% or 1 in 200 of the population of England are estimated to have ever been infected. In general the risk of transmission of the virus by a needlestick injury is thought to be between 0.5% and 3%. A study carried out in England and Wales in 1999 reported one sero conversion amongst 360 occupational exposures. The risk of transmission is greater with deeper injuries from blood filled needles and transmission from solid needles/instruments is less likely.

What care and support will I receive following the incident?
You should contact the occupational health department when it is open and an appointment will be given to you at the earliest opportunity. If the source patient is positive for Hepatitis C you will be offered the opportunity to have your blood taken at intervals, i.e. 6, 12 and 24 weeks to check for potential development of the virus in accordance with national policy.
Should you develop Hepatitis C infection you will be referred to a specialist and be given the opportunity to receive treatment.

**Will the incident affect my job?**

If you develop the virus and your job involves the undertaking of “exposure prone procedures” (EPP, as defined in the BBV policy), you will unable to continue to undertake such activities because of the risk you could potentially transfer the virus to patients. Your employer will be informed of your exemption to carry out exposure prone procedures however only key people who need to be informed of the specific circumstances will be made aware of the reason why e.g. Consultant for Communicable Disease Control. If following treatment you clear the virus from your blood and remain free from the virus for 6 months you will be able to resume EPP work. A repeat blood test will be taken 6 months later to confirm the continuing absence of the virus.

**References**

2. HSC 2002/010 Hepatitis C Infected Healthcare Workers
Appendix N

Risk of Body Fluids/Risk of Injury Type

Risk of Body Fluids

<table>
<thead>
<tr>
<th>High Risk Body Fluids</th>
<th>Low Risk Body Fluids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>Urine</td>
</tr>
<tr>
<td>Blood-stained low risk body fluid</td>
<td>Vomit</td>
</tr>
<tr>
<td>Semen</td>
<td>Saliva</td>
</tr>
<tr>
<td>Vaginal Secretions</td>
<td>Faeces</td>
</tr>
<tr>
<td>CSF</td>
<td>Tears</td>
</tr>
<tr>
<td>Pericardial Fluid</td>
<td>Sweat</td>
</tr>
<tr>
<td>Peritoneal Fluid</td>
<td></td>
</tr>
<tr>
<td>Pleural Fluid</td>
<td></td>
</tr>
<tr>
<td>Saliva associated with dentistry</td>
<td></td>
</tr>
<tr>
<td>Amniotic Fluid</td>
<td></td>
</tr>
<tr>
<td>Breast Milk</td>
<td></td>
</tr>
<tr>
<td>Synovial Fluid</td>
<td></td>
</tr>
<tr>
<td>Unfixed tissues or organs</td>
<td></td>
</tr>
</tbody>
</table>

Risk of Injury

<table>
<thead>
<tr>
<th>High Risk Injury</th>
<th>Low Risk Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous exposure, e.g. needlestick or other sharps injury</td>
<td>Splash on intact skin – there is no known risk of BBV transmission from exposures to intact skin</td>
</tr>
<tr>
<td>Exposure to broken skin</td>
<td></td>
</tr>
<tr>
<td>Mucous membrane exposure</td>
<td></td>
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</table>

Contacts:

**Occupational Health**

<table>
<thead>
<tr>
<th>UHND</th>
<th>0191 333 2351/2354</th>
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<tr>
<td>DMH</td>
<td>01325 743493/3597</td>
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**Microbiology**

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**GUM**

<table>
<thead>
<tr>
<th>UHND</th>
<th>0191 333 2660</th>
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</thead>
<tbody>
<tr>
<td>DMH</td>
<td>01325 743203</td>
</tr>
<tr>
<td>BAGH</td>
<td>01388 455700</td>
</tr>
</tbody>
</table>

Evenings and weekends Contact switchboard for details of Consultant/Nurse Practitioner on call