County Durham and Darlington NHS
NHS Foundation Trust

CDDFT Policy

Reference Number	POL/PD/0011
Title	**Blood Borne Virus Exposure Policy**
Version number	4.1
Document Type	Policy
Original Policy Date	April 2005
Date approved	02/09/2016
Effective date	02/09/2019
Approving body	Planning and Workforce Committee
Originating Directorate	Workforce& OD
Scope	Trust wide
Lead Director	Morven Smith
Last review date	Sept 2016
Next review date	Sept 2019
Reviewing body	Clinical Standards and Therapeutics Committee
Document Owner	Occupational Health Clinical Lead
Equality impact assessed	Yes
Date superseded	N/A
Status	Approved
Confidentiality	Unrestricted
Keywords	Blood, Virus, Needlestick

Ratification

Signature of Chairman of Ratifying Body	
Name / Job Title of Chairman of Ratifying Body:	Morven Smith, Executive Sponsor, Planning and Workforce Committee
Date Ratified	02/09/2016
Signed copy held at (location):	Corporate Records Office, DMH

Document Control Information

VERSION CONTROL TABLE

Date of issue	Version number	Status
April 2005	1.0	Superseded
January 2007	2.0	Superseded
June 2010	3.0	Superseded
November 2011	3.1	Superseded
January 2012	3.2	Superseded
February 2014	3.3	Superseded
June 2013	4	Superseded
August 2016	4.1	Approved

TABLE OF REVISIONS

Date	Section	Revision	Author
January 2007	Full	To ensure policy meets best practice, service needs and NHSLA 1.3.6	Eve Adams
June 2010	Full	To ensure policy meets best practice, service needs and NHSLA 1.3.6	Kevin Smith
November 2011	Minor Amendments	Style for NHSLA	D Turnbull-Adams
January 2012	Minor Amendments	Addition of training information, linked policies and style	D Turnbull-Adams
February 2012	Minor Amendments	Training information expanded, processes restructured under headings and appendices modified. Duties for line managers amended. Timeframe for reporting of incidents added to process section.	D Turnbull-Adams
June 2013	Full	Amendments made to general process, risk assessment forms and Appendices. To ensure policy meets best practice.	Dr. Jyothi Pranesh
August 2016	Minor Amendments	Minor grammar corrections. Re draft of Reverse or Bi-directional BBV incidents. Appendix 1 re drafted for clarity. Appendix 3, page 4 changes to follow up process and page layout. Further minor amendments to improve clarity, changes to follow-up for HIV in accordance with BASHH/EAGA guidelines.	D Turnbull-Adams Dr.Jyothi Pranesh

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1. DOCUMENT SUMMARY

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.

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 (BBVs) infection in the workplace.

2. PURPOSE

This policy defines the process to be followed and the actions to be taken in the event of an Blood or blood stained body fluid 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 exposure incidents it is important that HCWs know:

The 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

3. SCOPE

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

4. 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 incidents, 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. In the event of a BBV exposure incident, the employee should request a senior clinical member of the team to carry out a source patient risk assessment and if it indicates high risk, the concerned employee should immediately contact SHWB (during its opening hours) or A&E if SHWB is closed. If the source patient risk assessment indicates it is low risk source; then, it is expected that the employee will contact the SHWB at the earliest for further assessment (during SHWB opening hours).

- It is also a duty of employees of the Trust to collaborate with the Staff Health and Wellbeing or the Emergency Department and risk 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 (on safeguard) following an inoculation incident.

"The Health and Safety at Work Act 1974 (HSWA)… [and] …The *Control of Substances Hazardous to Health Regulations* 2002 (as amended), require employees to take responsibility to avoid any risk where possible e.g. safe handling and disposal of sharp instruments and the use of personal protective equipment (gloves, face visors etc.) to minimise exposure to blood or body fluid. "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 a Blood/blood-stained body fluid exposure and ensure that this policy is followed.

- They will commence the risk assessments of the source patient as outlined in the Source Patient risk assessment form.

- 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 exposure incidents that occur in their area(s) of responsibility and communicate learning outcomes to their employees.

Staff Health and Wellbeing Manager

It is the duty of the Staff Health and Wellbeing 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.

- Staff Health and Wellbeing (SHWB) is responsible for the initial risk assessment and follow up of employees who have significant exposure to BBV's. SHWB will assume responsibility for the employee as soon as they are made aware of an exposure incident.

- SHWB will audit exposure incidents six monthly.

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

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

- SHWB 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.

- The SHWB manager is responsible for the training of staff in their department to undertake BBV exposure risk assessments.

On-going support for employees who have been exposed will be provided by:

- Occupational Health Nurses/Physician

- GUM Specialist Nurses/Physician
- Employee Counselling service

Emergency Department (A&E)

- Outside of office hours (Mon – Fri 8.30 – 4.30 and on Bank Holidays) employees who have sustained a high risk exposure to Hepatitis B, C or HIV and who need to be risk assessed or receive treatment (vaccination, immunoglobulin or HIV antiretrovirals) 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 should seek advice from their consultant colleagues in microbiology.

- A&E will fax the risk assessment forms (both healthcare worker and source patient) for those employees seen out of hours to SHWB, to enable SHWB to schedule immediate and further follow up appointments as appropriate.

- The A&E manager is responsible for the training of staff in their department to undertake BBV exposure risk assessments.

- To be consulted in the review of the BBV policy content.

Department of Genitourinary Medicine (GUM)

- To support SHWB during office hours if required for the prescription of PEP following HIV exposure incidents and provide appropriate counselling.

- On the Darlington site (during office hours), SHWB will not be running a daily service. Exposed HCW will be risk assessed by telephone contact to SHWB at UHND. High risk exposure cases requiring HIV PEP will be referred by SHWB to DMH GUM. The risk assessment paperwork will be completed by SHWB and faxed to GUM to support HIV PEP issue. Confirmation that HIV PEP has commenced will be advised back to SHWB by fax. HCW at low risk will be seen in the SHWB department, on the UHND/DMH site, by appointment.

- GUM will undertake monitoring for HCW commenced on HIV PEP.

- GUM will follow-up non-employees who have been exposed on Trust premises e.g. Paramedics, volunteers, members of the public.

- GUM to be consulted in the review of the BBV policy content.

Microbiology

- To provide advice to SHWB, A&E and GUM on the management of HIV, and Hepatitis B or C positive exposure incidents 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 consulted in the review of the BBV policy content.

- To ensure that blood results of source patients are routinely available at least within 8 hours of tests requested.

- To ensure that SHWB is informed of the source patients universal blood results by telephone when contacted.

5. POLICY PROCESS - ACTION FOLLOWING INCIDENT

When an incident occurs:

A senior member of clinical staff on duty at the time of the incident, other than the exposed employee, will lead on the risk assessment process of the source and the incident, ensuring that process is followed and all paperwork is completed and submitted. The required forms are available at the end of this policy in the Appendices or can be found on the intranet.

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 is applicable.

- Following the initial assessment by senior on duty report to SHWB for a full assessment/management. If out of hours and the exposure is considered to be high risk attend A&E.

- Submit an incident report form via Safeguard.

Senior member of staff (doctor or nurse):

- Ensure first aid measures have been followed.

- Ensure the incident is reported through the Trusts reporting system - Safeguard.

- Following the initial assessment send the exposed employee to SHWB for a full assessment/clinical management. If out of hours and the injury is considered to be high risk for BBVs send injured employee to A&E.

- Undertake a risk assessment of the source area/patient for BBVs. If the source is a patient they should be informed of the incident, a risk assessment undertaken and universal bloods should be collected without exception (on condition that the patient has consented to risk assessment and testing). Using source risk assessment form Appendix 2 and the consent form Appendix 5.

- 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 via the on call Microbiologist.

- Line managers will meet with employee(s) who have had a BBV exposure and advise them on safe practices and up date for BBV risk.
- For incidents occurring in the community the source patient risk assessment should be completed by an experienced health care professional in liaison with the General Practitioner (GP) responsible for the source patient. Universal blood tests should be arranged by the source patient's GP. ***NOTE*** in the community setting the initial 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 on duty.

Risk assessment and referral to SHWB or A&E for the employee should be undertaken **immediately** post exposure and should not be withheld while waiting for the source patient results from universal testing.

Unknown Source

- If the source of the exposure cannot be identified e.g. injury from a discarded needle, the risk assessment should be based on the circumstances of the exposure and the likelihood of the presence of a BBV risk at the incident location e.g. assessment of the clinic/ward/theatre for Hepatitis B/ C or HIV risks.

Management of the Exposed Employee by Staff Health & Wellbeing/ Accident & Emergency Department Staff:

- Employees should be assessed and treated as a priority, ideally **within one hour**.
- HCW Risk Assessment form (Appendix 3) be completed.
- Liaise with the person responsible for the area where the exposure took place:
    - Ensure source patient risk assessment is in process/ completed
    - Ensure source patient universal blood tests have been requested and a sample collected (with source patient consent)
- 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 exposure, ideally within one hour. If PEP is commenced, the exposed employee will be referred to GUM for follow up during the treatment.
- Take blood from the HCW for storage: to be retained for 2 years. This needs to be an ID validated sample. The blood sample should be taken from the HCW after checking their identity against a Trust ID badge/driver's licence, passport or national identity card.
- SHWB will follow up the source patient universal blood results.
- SHWB will arrange follow-up of exposed employee at appropriate intervals as per national guidelines.
- Referral for specialist counselling/ support via GUM will be made if required.

- SHWB 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 an employee's 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 the Staff Health & Wellbeing Department but it is the clinicians who are responsible for the patient that undertakes the patient risk assessment, administration of PEP and follow up if applicable. The employee will need to be asked to consent by SHWB, to be tested for universal bloods, for the benefit of the patient. The blood request form should be labelled as a reverse inoculation exposure and details given of the incident under "clinical details" section of the form.

A **bi-directional** BBV incident occurs when a needle or instrument 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 contaminated scalpel cuts a surgeon and then returns into the patient's operative field contaminating tissues with the surgeons blood. Please mark all the forms as a bidirectional BBV incident and give details of the incident under "clinical details" section of the form. The Staff Health & Wellbeing Department will deal with the risk assessment and PEP if indicated for the employee and the senior clinicians will be responsible for the risk assessment and follow-up for the patient (Further advice can be sought from SHWB).

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 subsequently tests positive for a blood borne virus.

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 patient. Failure to report potential hazardous incidents may breach the duty of care to patients.

6. DEFINITIONS

Blood Borne Viruses (BBV) markers carried in blood and in high risk body fluids. There are more than 20 viruses that can be spread in this way. For the purposes of this policy the three viruses specified are those named 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.

Source Patient The patient whose blood or body fluids are involved in the exposure incident.

'Significant exposure' is defined as: percutaneous e.g. needles, instruments, bone fragments, human bites breaking the skin and blood spillage across open skin.
Or mucocutaneous e.g. body fluid splash to mucosal tissues or the eye.
With blood or other body fluids with the potential to spread viruses, 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.
This should not be confused with a significant incident which doesn't take into account the source status.

Significant Source is 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, human bites breaking 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 but the source patients risk status is not known.

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 sharp 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. [12]

Universal Bloods are the blood tests 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 rationale for universal blood testing is that hepatitis C and HIV cannot be identified by the risk assessment approach. 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)

SHWB-Staff Health and Wellbeing

GUM - Genitourinary Medicine

HBsAg – Hepatitis B surface antigen

HBeAg - Hepatitis B envelope antigen

HBV - Hepatitis B Virus

HCV - Hepatitis C Virus

HIV - Human immunodeficiency virus

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 to 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 infection 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 have an ethical duty to protect their own health and that of the Trust's patients. For doctors, paragraph 78&79 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 inoculation 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 a Safeguard 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.

7. DISSEMINATION ARRANGEMENTS

A Trust wide email will be sent via the communications department.

All new employees of the trust will be informed at their initial induction to the workplace.

All employees will be informed during their essential training session.

8. MONITORING

Monitoring forms will be submitted on an annual basis
Process for Monitoring Compliance

Monitoring Criterion	Response
Who will perform the monitoring?	The SHWB Head of Service and the OH Consultant will monitor compliance with and the effectiveness of this policy.
When will the monitoring be performed?	6 monthly
What will be monitored?	Compliance with inoculation incident policy: • duties • inoculation reporting procedure requirements and timely intervention • the management of inoculation incidents (prophylaxis)
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 SHWB team. SHWB will undertake a gap analysis of all risk assessments undertaken by the SHWB and A&E correlated to incident reports submitted to the Trust.
What will happen if any shortfalls are identified?	All results will be advanced to the Health and Safety Committee with a provisional action plan recommended. Failures in the management of the incident and prophylaxis will be investigated by the SHWB clinical lead.
Where will the results of the monitoring be reported?	Outcomes will be reported to the Head of Non Clinical Risk Management and presented to and reviewed by the Health & Safety Committee and its relevant sub groups.
How will the resulting action plan be progressed and monitored?	Action plans will be developed and finalised by The Health & Safety Committee and officers/sub groups identified by this committee. Monitoring of the progress of the action plan will be by the Health & Safety Committee and Head of Non Clinical Risk Management.
How will learning take place?	Outcomes will be shared via: minutes, intranet, e-mail forum, education, change in practice, re-audit

In addition to the monitoring outlined in the table above, attendance at Essential Training is recorded by HR&LD 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 HR&LD. Please refer to this policy for detailed information.

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.

9. REFERENCES

1. HIV Post Exposure Prophylaxis (Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS) – Department of Health – February 2004
2. Health Clearance for Serious Communicable Diseases: New Health Care Workers. Draft Guidance for Consultation – Department of Health 2003
3. Report re Hepatitis B and Hepatitis C – Department of Health 2003 – CDR Review 1992:2; R97-R101
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
8. The Mental Capacity Act 2005, available at www.opsi.gov.uk
9. HIV post-exposure prophylaxis: guidance from the chief medical officer's Expert Advisory Group on AIDS, Department of Health, 19 Sept 2008, product No. 289897
10. The Health and Safety at Work Act 1974, available at www.opsi.gov.uk
11. COSHH 2002, available at www.opsi.gov.uk
12. Health Service Circular 1998/226, Guidance on the management of HIV/AIDS infected health care workers.
13. Health & Safety (sharp Instruments in Health care) Regulations 2013 (HSE leaflet HS1S7)
14. BASHH/EAGA statement on HIV window period (November 2014)

10. ASSOCIATED DOCUMENTS

Consent to Examination or Treatment Policy

Risk Management Strategy

Health & Safety Policy

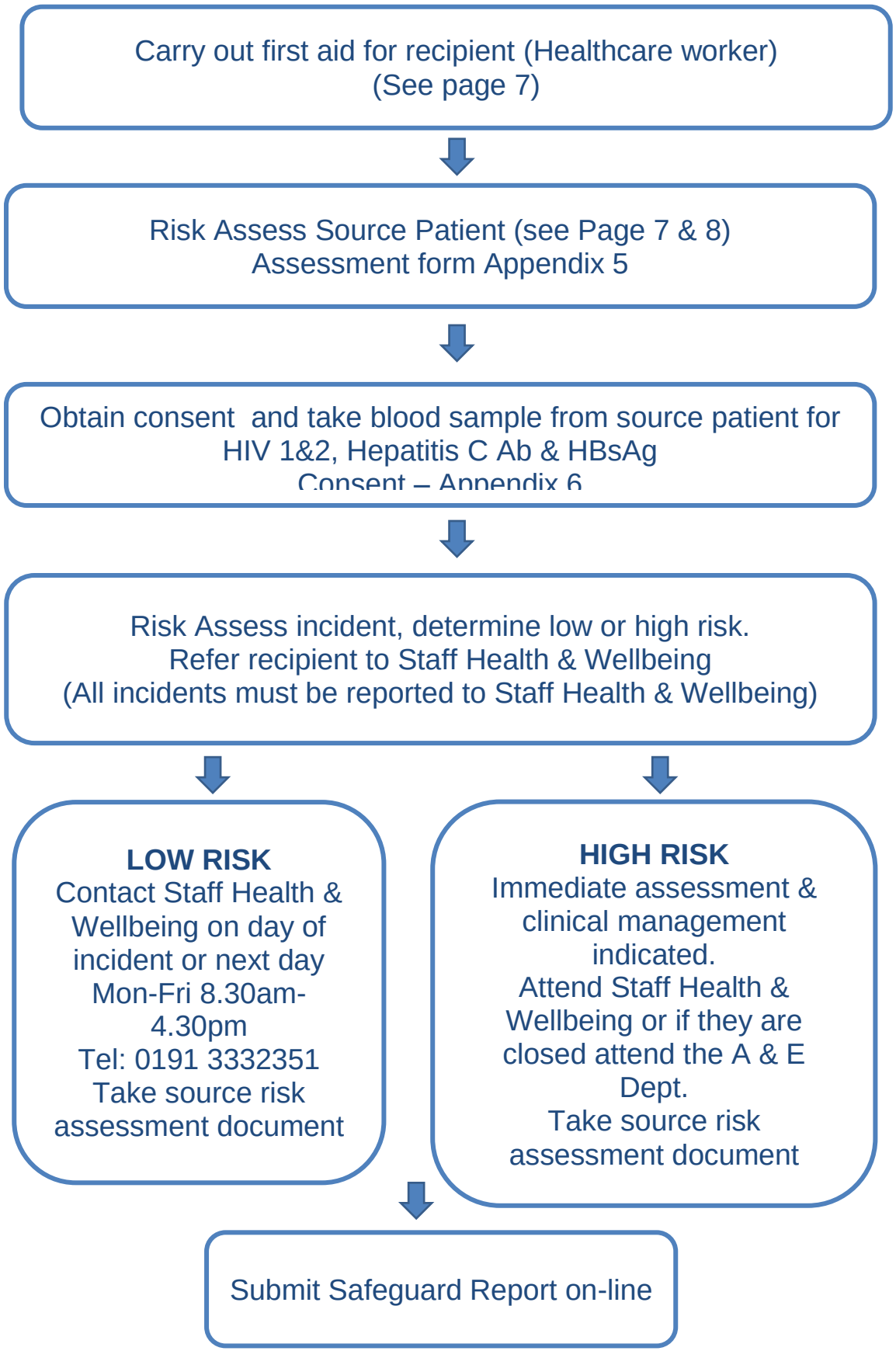
Policy for the Development of Procedural Governance Documents

11. APPENDICES

Appendix 1	Blood Exposure Incident Flow Chart
Appendix 2	Source Patient Risk Assessment Form
Appendix 3	Healthcare worker assessment form – to be used by Staff Health and Wellbeing department/GUM and Accident and Emergency
Appendix 4	Source Patient Information leaflet
Appendix 5	Consent form for testing Source Patient's bloods.
Appendix 6	Hepatitis B Immunisation Table
Appendix 7	Useful Contacts
Appendix 8	Equality Analysis/Impact Assessment

Appendix 1 Process Flow Chart

Blood Exposure Incident, Process – Flowchart



Appendix 2 Source Patient Risk Assessment form

(To be completed by a Senior Healthcare worker: not the recipient of the injury/exposure)

Hospital No of the Source patient……. **DOB of source patient**…….

Name of Consultant in charge
Of Patient …….. Ward ……..…….

1. Have you given the **patient information leaflet** (Appendix 4) Yes/No

2. Have you obtained **consent** for source testing for HBsAg, HIV 1&2 and Hepatitis C (Appendix 5) Yes/No

3. Have you sent source bloods for universal testing? (HBsAg, HIV 1& 2, Hepatitis C) Yes/No

4. Using the clinical notes and in consultation with the source patient complete the following questions.

Question	Yes	No
1) Is the source patient known to be HIV positive?		
2) Is the source patient known to be Hepatitis B positive?		
3) Is the source patient known to be Hepatitis C?		
4) Is there a history of recreational IV drug use?		
5) Is there a history of bi-sexual, homosexual practice, prostitute contact, sexual contact with partner from area with high prevalence for blood borne virus (BBV)?		
6) Is there a history of frequent changes of sexual partners?		
7) Has the source patient received blood transfusion(s) in developing countries where routine screening of blood products may be questionable?		
8) Has this source patient received plasma products prior to 1985 (in the UK)?		
9) Has the source patient been resident or worked in an area where Blood Borne Viruses are endemic?		
10) Does the source patient have multiple tattoos?		
11) Does this source patient have multiple piercings?		
12) Has this source received a blood transfusion prior to 1992 (in the UK)?		
13) Does the source have a disorder which requires transfusions of blood or blood products?		

HCW filling in the form, sign and Print Name……..

Contact number…….

(For use by Staff Health and Wellbeing/Accident and Emergency ONLY)

If **YES** to Q 1-9 or high index of suspicion for BBV infection: phone GUM for advice about post exposure prophylaxis (PEP).

If **YES** to Q 10-13: consider PEP but may wait for source patient serology results – phone GUM if in doubt.

If **NO** to Q 1-13 or the source is unsure about the answer; wait for urgent source patient serology results.

Recipient of blood exposure incident_____

Contact Telephone number_____

Appendix 3 Healthcare Worker Assessment Form

ASSESSMENT OF EXPOSURE OF HEALTH CARE WORKERS TO BLOOD BORNE VIRUSES- To be completed by Staff Health and Wellbeing Department or Accident and Emergency (A&E) Department staff ONLY.

If completed by A&E, form to be faxed to Staff Health and Wellbeing as soon as possible.
Consent/Signature of HCW (Full name and date)……..……

This form is CONFIDENTIAL and when completed, will be retained within the Occupational Health Records of the HCW who has been exposed.

Blood and Body Fluid Exposure Risk Assessment Form

Name	Date of Birth
Job Title	Ward/Department/Trust
Date of Assessment	Time of Assessment
Date of Incident	Time of Incident

Brief Description of the incident

Incident Details

During procedure?	Yes	No
After use of needle?	Yes	No
During disposal?	Yes	No
Inappropriate disposal?	Yes	No
Other?	Yes	No

Percutaneous Injury

Hollow bore needle?	Yes	No
Other sharp? Type	Yes	No
Used for		
Safety device	Yes	No
Was the contamination fresh blood?	Yes	No
Was the injury superficial (surface scratch)?	Yes	No
Was the injury deep (with or without bleeding)?	Yes	No
Site of injury		
Were gloves worn?	Yes	No
Gloves - indicate S – Single or D - Double	S	D
Comments		

Mucocutaneous Contamination

Mucocutaneous exposure to blood or blood containing body fluids	Yes	No
Area: Eye / Mouth / Nose/other mucosal tissues		
Was the contaminate fresh blood?	Yes	No
Comments		

Source Details

Is the source known?	Yes	No		
Source location?				
Infectious status known for Hep B?	Yes	No	+	-
Infectious status known for Hep C?	Yes	No	+	-
Infectious status known for HIV?	Yes	No	+	-

Source Risk Assessment

Received?	Yes	No
Risk – significant?	Yes	No
Comments		

Employee Risk Assessment

Action Post Contamination		
Gently Bled?	Yes	No
Washed?	Yes	No
Covered?	Yes	No

Hepatitis B vaccination History		
Primary course?	Yes	No
Booster within 5 years?	Yes	No
Immune response > 100iu	Yes	No
Immune response 10-100iu	Yes	No
Immune response <10iu	Yes	No

HIV Risk	
Section A (Employee)	**If answer Yes:**
Was the employee exposed to blood or OPIM	Go to section B
Was the exposure to non-infectious body fluid?	PEP not recommended
Section B (Incident)	**If answer Yes:**
Blood/Other potential Infectious materials (OPIM)* contact with healthy intact skin?	PEP not recommended
Prolonged contact/heavy with non-intact skin	Go to section C
Mucocutaneous exposure?	Go to section C
Superficial or deep injury with solid instrument/hollow bore needle with/without visible blood?	Go to section C
Bite from patient causing abrasion or penetrating injury?	Go to section C
Section C (Source Patient)	**If answer Yes:**
HIV positive and never had antiretroviral therapy (ART)?	Recommend PEP
HIV positive on ART or taken in the past?	Recommend PEP. Contact GUM Consultant
High-risk history for HIV**?	Recommend PEP
No high-risk history for HIV?	PEP not recommended

Is PEP recommended?	Yes	No
If Yes arrange PEP provision		
*Other Potential Infectious Materials (OPIM) = Amniotic fluid, vaginal secretions, semen, human breast milk, cerebrospinal fluid, pleural fluid, pericardial fluid, synovial fluid, saliva in		

association with dentistry, unfixed tissues and organs, exudate or tissue fluids from burns or skin lesions and any body fluid visibly blood stained.
**High risk for HIV infection: Men who have sex with men, Intravenous Drug Use (IVDU), men/women in countries where heterosexual transmission is common (notable sub-Saharan Africa, infants born to HIV infected mothers or adults with IV infected sexual partners.

Plan

Source		
SHWB/A&E to contact manager of department where source patient located to initiate risk assessment (if not already done)?	Yes	No
SHWB/A&E to contact manager of department where source patient located to ensure source bloods are taken for HBV, HCV, HIV 1 + 2	Yes	No

Employee		
Viral Hold?-save serum for 2 years.	Yes	No
Hepatitis B Booster / Course commenced?	Yes	No
Immunoglobulin?	Yes	No

Comments

Source Blood Results

Hepatitis B	+	-
Hepatitis C	+	-
HIV 1 + 2	+	-

Comments

Conclusion Assessment

Source patient risk	High	Low
Exposure injury	Significant	Insignificant
Incident form (safeguard) submitted?	Yes	No

Comments

YOU MUST ENSURE THAT THE EMPLOYEE IS AWARE THAT THEY REQUIRE FOLLOW UP, ADVISED OF THE BLOOD TEST RESULTS AND IF PEP HAS BEEN ISSUED REFER TO GUM.

Name of Assessor ……

COMMENTS:

RESULTS of BLOOD TESTS from SOURCE (Circle result: NT = not tested)

Hep B (HBsAg)	Positive Negative NT	**Hep C**	Positive Negative NT	**HIV**	Positive Negative NT

Received from……..Designation……..

Received by……Date……Time……

Employee Follow Up (For Staff Health and Wellbeing use ONLY)

Hepatitis B (Only if employee has no immunity)	
HBsAg	Result
6 weeks	
12 weeks	
26 weeks	

Hepatitis C	HCV Antibodies Result	RNA – Only if Source HCV +ve Result
6 weeks		
12 weeks		
26 weeks		

HIV	HIV antibodies and P24 antigen	(If specific risk of HIV exposure)
		Result
4 Weeks		
12 weeks		

COMMENTS:

Appendix 4 Source Patient Information Leaflet

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

Initial publication Date: January 2007
Date of review: August 2016
Date of next review: August 2019
Responsibility for review: Occupational Health
Leaflet reference: PIL/CG/0014
Version: 2.0

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

County Durham and Darlington NHS
NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust

Occupational Health Department(SHWB)

PATIENT (SOURCE) INFORMATION LEAFLET

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

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 5 Consent Form

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.
(GMC guidance, see below)

Consent form "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 below)

Consent Form
Consenting of Patient for Procedure

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

Patient details (or pre-printed label)	Is the patient: Male ☐ Female ☐
Patient's Surname/ Family Name: ……..	Do they have any special requirements: (e.g. other language/other communication method)
Patient's First Name(s) ……..	……
Date of Birth ……	Consultant/Responsible Health Professional: ……
Unit No. ……	

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."[5]

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.

Deceased Source Patient

In the event of a deceased patient being the source of the needlestick injury and whose HIV status is unknown, the taking and testing of samples requires consent in accordance with the Human Tissue Act 2004.

Appendix 6 Hepatitis B Immunisation Table

HBV status of HCW at time of exposure	Significant exposure			Non-significant exposure	
	Source known to be HBsAg positive	HBsAg status of source unknown	Source known to be HBsAg negative	Continued risk for HCW	No continued risk for HCW
≤ 1dose of Hep B vaccine	Accelerated course* of Hep B vaccine + HBIg x 1*	Accelerated course of Hep B vaccine	Initiate course of Hep B vaccine	Initiate course of Hep B vaccine	No need for HBV prophylaxis Reassure
2 or more doses of Hep B vaccine but anti-HBs not known	One dose of Hep B vaccine + 2nd dose one month later	One dose of Hep B vaccine	Finish course of Hep B vaccine	Finish course of Hep B vaccine	No need for HBV prophylaxis Reassure
Known responder to Hep B vaccine (anti-HBs > 10 mIU/ml)	Consider Hep B booster†	Consider Hep B booster†	Consider Hep B booster†	Consider Hep B booster†	No need for HBV prophylaxis Reassure
Known non-responder to Hep B vaccine (anti-HBs < 10 IU/ml 2-4 months post immunisation)	HBIg* x 1 + booster dose of Hep B vaccine	HBIG* x 1 + booster dose of Hep B vaccine	Consider Hep B booster†	Consider Hep B booster†	No need for HBV prophylaxis Reassure
			Ensure usual attempts to vaccinate are exhausted		

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

HBIg = 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.

† 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 7 Contacts

Staff Health and Wellbeing

UHND	Telephone:	0191 333 2351/2354
UHND	Fax:	0191 333 2353

Microbiology

UHND	0191 333 2430
DMH	01325 743241/3401

GUM - Phone

UHND	0191 333 2660
DMH	01325 743203
BAGH	01388 455700

GUM – Fax

DMH:	43617
UHND:	36901

Appendix 8 Equality Analysis/Impact Assessment

Equality Analysis / Impact Assessment

EAIA Assessment Form **v4/2016**

Division/Department:	Staff Health and Wellbeing
Title of policy, procedure, decision, project, function or service:	Blood Borne Virus Exposure Policy
Lead person responsible:	SHWB Clinical Lead
People involved with completing this:	SHWB Clinical Lead/Senior Nurse

Type of policy, procedure, decision, project, function or service:

Existing	☐
New/proposed	☐
Changed	☑

Date Completed: 22/08/2016

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 Blood exposure 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 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 blood exposure incidents.

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 SHWB to state that their interests are not being met by the BBV exposure 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 (applies to workforce issues only)

Nil

Pregnancy and Maternity

Nil

Gender Reassignment

Nil

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

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?

Nil

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?

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?

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 (with amendments for NHSLA requirements and style) has been 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 blood exposure incidents as applicable.

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be attached to any documentation to which it relates.