

Livewell Southwest

**Inoculation (Contamination) Incidents
incorporating Blood Borne Virus
Standard Operating Procedure**

Version No. 2.3

Review: July 2018

Notice to staff using a paper copy of this guidance.

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: Director of Infection Prevention & Control.

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Reader Information

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Document review history

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V.2.	Reviewed	December 2014	Director of Infection Prevention & Control.	New format applied to document. To make it easier for staff to use.
V.2.1	Minor amendment	December 2015	Infection Prevention & Control.	Minor amendment to page 11
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V.2.3	Minor amendment	March 2017	Infection Prevention and Control Manager	Change of tel. no. of the ED Minors nurses station.

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Inoculation (Contamination) Incidents incorporating Blood Borne Virus. Standard Operating Procedure.

1 Purpose and scope

LSW has a duty of care to ensure that any member of staff, patient or visitor who is in receipt of a contamination incident is adequately and efficiently assessed and cared for. The SOP covers all staff; to include contractors; those employed on a fixed term contract, honorary contract, agency or locum staff and students affiliated to educational establishments and volunteers.

2 Definitions

2.1 Contamination Incident - a generic term which encompasses any **percutaneous** or **mucocutaneous** exposure to an object or fluid that has the potential to cause physical injury and possibly transmit a blood-borne virus (BBV).

2.2 Percutaneous Exposure - commonly referred to as a 'Needlestick' injury, is caused by a sharp, the commonest of which is hollow bore needles, particularly following blood sampling (venepuncture). This type of injury carries the greatest risk for the transmission of BBVs in a healthcare setting.

2.3 Mucocutaneous Exposure - occurs as a result of contamination of the mucous membranes of eyes, mouth or nose or of broken skin with infected blood or other infectious material.

2.4 Significant Contamination Incidents – incidents that occur by means of the following High Risk situations:

- A deep puncture wound
- Sharps device had been in the Source's artery or vein
- Sharps device was visibly blood-stained
- Sharps device has a hollow bore ~ such as a needle
- A large volume of body fluid into member of staff's eyes, mouth or nose
- A large volume of body fluid onto non-intact skin.

Or contamination with body fluid from a Source, where they:

- If male, has had sexual relationships with other men
- Were born outside of Europe, in Australia or the United States
- Have injected drugs into their veins in the past
- Have received a blood transfusion or operation outside of Europe, in Australia or the United States
- Have had a sexual partner who originates from outside of Europe, from Australia or the United States

2.5 High Risk Body Fluid – the following are considered a high risk of transmitting a blood-borne virus:

- Blood
- Amniotic Fluid
- Human breast milk

- Vaginal secretions or semen
- Cerebrospinal fluid
- Peritoneal fluid
- Pericardial fluid
- Pleural fluid
- Saliva in association with dentistry
- Synovial fluid
- Exudative or other tissue fluid from burns or skin lesions
- unfixed human tissues and organs
- **visibly blood-stained** urine, vomit, saliva or faeces

2.6 Blood Borne Viruses (BBVs) - referred to in this SOP are:

- Human Immunodeficiency Virus (HIV)
- Hepatitis B
- Hepatitis C

2.7 Sharps - any item having corners, edges, or projections capable of cutting or piercing the skin. Sharps include medical devices such as razors blades, injection needles, suturing needles, lancets and scalpel blades sharp body tissues such as teeth and fragments of bone.

2.8 Exposure Prone Procedures (EPPs) - includes procedures where the member of staff's hands may be in contact with sharp instruments, needle tips, and sharp tissues (teeth or spicules of bone) 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.

When there is any doubt about whether a procedure is exposure prone or not, advice should be sought in the first instance from the Occupational Health and Wellbeing Department (OH&WB) Consultant.

Procedures where the hands and fingertips of the worker are visible and outside the patient's body at all times, and internal examinations or procedures that do not involve possible injury to the worker's gloved hands from sharp instruments and/or tissues, are considered not to be exposure prone provided routine infection control procedures are adhered to at all times.

Examples of procedures that are not exposure prone include:

- Taking blood (venepuncture);
- Setting up and maintaining IV lines or central lines (provided any skin tunnelling procedure used for the latter is performed in a non-exposure prone manner i.e. without the operator's fingers being at any time concealed in the patient's tissues in the presence of a sharp instrument);
- Minor surface suturing;
- The incision of external abscesses;
- Routine vaginal or rectal examinations;
- Simple endoscopic procedures.

2.9 The Responsible Person – refers to the Recipient's a Line Manager or the person in charge of an area where the Recipient is working.

2.10 The Competent Person - will be **appointed by the Responsible Person** - a senior nurse, the Night Co-ordinator out of hours or a doctor caring for the Source patient (*or a suitably competent deputy*). They will be aware of the epidemiology of

BBV infection, the risk of transmission in a health care setting and the management of contamination incidents as outlined in this SOP and related policies

2.11 The Recipient - refers to the person who has been contaminated.

2.10 The Source - refers to the origin of the contaminant.

2.13 Safeguard- is the Incident Reporting System used by LSW

2.14 OPAS – is the Occupational Health Computerised Management System used by the Occupational Health & Wellbeing Department (OH&WB).

2.15 Contamination Incident Standing Operating Procedure and associated forms are available through LSW Intranet under Standard Operating Procedures (Occupational Health & Wellbeing).

3 Regulatory Background

The Health and Safety at Work etc. Act 1974 states that an employer must make provision for securing the health, safety and welfare of persons at work and for protecting others against risks to health or safety in connection with the activities of persons at work.

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended) represents the main piece of legislation covering control of the risks to employees and other people arising from exposure to harmful substances generated out of or in connection with any work activity under the employer's control.

The Health and Social Care Act 2008 provides a Code of Practice and related guidance for health and adult social care on the prevention and control of infections.

4 Key Responsibilities

The LSW Director of Infection Prevention and Control has responsibility for:

- Seeking assurance that incidents are managed in accordance with the SOP.

All Employees have a responsibility for:

- Ensuring they are familiar and comply with this SOP and associated policies/guidance.

The Responsible Person* where a Contamination Incident has occurred has a responsibility for:

- Ensuring that Competent Persons are appointed .
- Arranging for designated Competent Persons to have training in the requirements of the role.
- Referring affected members of Staff to a Competent Person.
- Ensuring emotional support is provided to the member of staff.
- Documenting findings and actions on SAFEGUARD.

* **Nurses** should report to the nurse in charge in area where the incident occurred.

* **Doctors** should report to a colleague (middle grade, SpR or consultant).

* **Non clinical staff, Hotel Services, volunteers and students** (medical, dental, nursing) should report to the nurse in charge **in the clinical area** where the incident occurred (Hotel Service staff must also report to their own Management).

- * All incidents occurring in **non-clinical areas** report to the Emergency Department (ED).

The Competent Person's responsibilities:

- Ensuring they are competent to undertake the duties required of them.
- Completing the contamination incident risk assessment.
- Obtaining consent and a blood sample from the Source to test for BBVs.
- Obtaining consent from the Source to disclose result to the affected Member of Staff.
- Obtaining a blood sample from the Member of Staff for 'Serum Save'.
- Referring members of staff who suffer a significant incident to ED immediately (together with the completed risk assessment form).
- If the incident is classed as 'non-significant', sending the completed risk assessment form to OH&WB for filing.
- Informing the Source's Clinical Team of their patient's BBV results.
- Informing the member of staff (where the Source has consented) of the Negative blood results. OH&WB will inform the member of staff of a positive result.

The Occupational Health & Wellbeing Department (OH&WB) has responsibility for:

- Providing confidential advice and on-going support to the affected member of staff in the event of a contamination incident.
- Organising the health surveillance of an affected Member of Staff.
- Referring where appropriate to GUM Department and Hepatology Department.
- Informing relevant parties via SAFEGUARD where the policy has not been followed correctly.
- Inform LSW Risk Management Department where there is a RIDDOR Reportable Contamination Incident (where a Source is positive to a BBV).
- Providing information and training for staff in the management of contamination incidents; risk assessment, clinical management and follow-up care of staff etc.
- Reviewing and updating this SOP in line with national guidance.

The Emergency Department (ED) has responsibility for:

- Assessment and care of members of staff referred to them following a contamination incident.
- Administration of Post Exposure Prophylaxis (PEP) if appropriate.
- Ensuring that adequate stocks of Hepatitis B immunoglobulin and HIV PEP Packs are available.
- Referring where appropriate to GUM Department and the OH&WB Department.

The Genito-Urinary Medicine (GUM) Department has responsibility for:

- Providing expert advice where appropriate on the risk assessment, clinical management, follow-up care and treatment of members of staff following a contamination incident.
- Providing training to 'Competent Persons' with regard to risk assessment.

The Infection Prevention & Control Microbiologist has a responsibility for:

- Providing expert advice where appropriate on the clinical management when not covered by this SOP.
- Providing Source BBV test results.
- Informing the Occupational Health & Wellbeing Department of positive BBV results from the Source.
- Providing urgent test results will only be undertaken if the result will alter patient management.

The Source Patient's clinical team has a responsibility for:

- Contacting the Source's GP to arrange BBV testing if the Source has been discharged.
- Informing the Source's GP of the results of BBV blood testing (with consent) if it was carried out whilst an in-patient.
- Arranging for confidential testing through the GUM Health Advisors where this is preferred by the Source, or where they are not registered with a GP in this area.

The Health and Safety Department has a responsibility for:

- Assisting in the provision of training for staff in the management of contamination incidents.
- Informing the HSE of contamination incidents which fulfil the RIDDOR criteria.

5 Training

Mandatory training is concerned with minimising risk and ensuring the organisation meets external standards such as those laid down by The Health and Social Care Act 2008 and the NHS Litigation Authority.

The importance of training in relation to how a Contamination Incident is managed is recognised by the LSW. The training needs of staff have therefore been identified and documented in the Training Needs Analysis in the Management of Contamination Incidents which can be found at **Appendix M**.

6 Monitoring and Assurance

The OH&WB Clinical Manager will assign a nurse, advisor or other suitably competent staff member to monitor the Management of each and every Contamination Incident via

SAFEGUARD and through OPAS records. Where incidents are reported to OH&WB prior to being reported on SAFEGUARD OH&WB will advise that SAFEGUARD should be completed without delay. Where incidents have not been reported via SAFEGUARD OH&WB will inform the member of Staff's Manager in writing either by e-mail or via SAFEGUARD. This will also be reported to the Committees listed below.

The monitoring and assurance process will be carried out on a monthly basis by the OH&WB Department and results will be reported where applicable to LSW.

- Health & Safety Committee
- Infection Control Committee

Where it is found that this procedure has not been followed, risk will be assessed and reported in line with LSW Procedure for the Assessment and Management of Risk. Learning will be based on action plans related to the specific situation and risk as detailed in the aforementioned procedure.

7 Document Ratification, Dissemination and Implementation Process

The design and process of review and revision of this procedural document will comply with the LSW formal policy on policy and procedural documents.

The review period for this policy document is set as default of five years from the date it was last ratified, or earlier if developments within or external to LSW indicate the need for a significant revision to the procedures described.

Significant reviews and revisions to this document will include a consultation with the following named groups, or grades across the LSW:

- Infection Prevention and Control Team
- Infection Control Committee
- Occupational Health & Wellbeing Team
- Health & Safety Committee
- All Consultants
- All Matrons
- All Senior Nurses
- All Ward Managers

Dissemination and Implementation

Following approval and ratification, this procedural document will be published on LSW intranet and all staff will be notified through the LSW normal notification process, currently the 'LSW electronic newsletter.

Document control arrangements will be in accordance with the LSW formal policy on policy and procedural documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Medical Director if required, to arrange for the required training to be delivered.

8 Step-by-Step Guide for the Management of a Contamination Incident by the Affected Member of Staff

In the event of a Contamination Incident occurring, the following explains the sequence of events that should take place in order to ensure you are cared for appropriately and effectively. A concise flowchart of the management process is shown in **Appendix A**.

First Aid should take place immediately as follows:

For a **Sharps Injury**, encourage bleeding at the wound site and wash the site thoroughly with soap and water.



For a **Body Fluid Splash**, where **skin** is exposed - wash the site thoroughly with soap and water.

For a **Body Fluid Splash**, where **eyes** are exposed – ensure copious irrigation of the eyes (before and after contact lenses are removed).

For a **Body Fluid Splash**, where **mouth or nose** is exposed - irrigate with water.



Report the incident in your area as follows to the **Responsible Person (see details below)** as soon as first aid has been administered – they will appoint a Competent Person to take you through the process.

- * **Nurses** should report to the nurse in charge in area where the incident occurred.
- * **Doctors** should report to a colleague (middle grade, SpR or consultant).
- * **Non clinical staff, Hotel Service, volunteers and students** (medical, dental, nursing) should report to the nurse in charge **in the clinical area** where the incident occurred (Hotel Service staff must also report to their own Management).
- * All incidents occurring **in non-clinical areas** report to the Emergency Department (ED).

Record the Incident firstly by completing Section 1 of the Contamination Incident Risk Assessment Form.

Also record on **SAFEGUARD** – if you need help with this inform the Responsible Person. Follow link:-

[Incident Reporting, Risk Registers & Assets \(Safeguard\)](#) Click on 'New Incident'.

Risk Assessment - The **Competent Person** must undertake a Contamination Incident Risk Assessment of the incident (**Appendix B**) – this will determine the course of action required (if any).

Non - Significant Incident – (where 'NONE OF THESE' is ticked) there is no risk to health and the Recipient may return to work).

Significant Incident - (where any of the boxes other than 'NONE OF THESE' is ticked in sections 3.1 & 3.2) you must go to ED with the completed risk assessment form **within 1 hour, or , as close to 1 hour as possible of the incident, taking your geographical area into consideration**. ED will be responsible for your immediate care and will be responsible for assessing the need for Post Exposure Prophylaxis (PEP), arranging support as well as referrals as appropriate.

Phone the ED Minors Nurse on Ext. 52045 before proceeding to ED.

In every case you must report it to the Occupational Health & Wellbeing Department **within 24 hours** and complete the SAFEGUARD incident reporting form available on LSW Intranet so we can record the incident fully, offer further advice and guidance if you need it and plan your future care including any blood tests you need.

Occupational Health & Wellbeing Department Contact Details:

☎ (4) 37222 Mon - Fri 8am to 4pm + answer phone out-of-hours

📧 plh-tr.OccHealth-DutyNurse@nhs.net

9. Step-by-Step Guide for the Responsible Person

Complete Section 2 of the Contamination Incident Risk Assessment & Checklist form (**Appendix B**) placing a '✓' or 'x' and text in the relevant boxes.

Appoint a **Competent Person** who can fulfil, or delegate the responsibilities described in section 10.

N.B. The Competent Person duties will **not** be performed by the ED **except** for incidents occurring in non-clinical areas.

10. Step-by-Step Guide for the Competent Person

Competent Person's Responsibilities for RECIPIENT

ASSESS INCIDENT

Incident factors

- | | |
|--|---|
| <input type="checkbox"/> Visibly blood stained body fluid splashed into eyes, nose or mouth or onto non-intact skin? N.B. <i>There is no evidence that blood-borne viruses can be transmitted by: blood contamination of intact skin, inhalation or faeco-oral contamination.</i> | <input type="checkbox"/> Deep puncture wound? |
| <input type="checkbox"/> Sharps device was in Source patient's artery or vein? | <input type="checkbox"/> Sharps device has a hollow bore? |
| <input type="checkbox"/> Sharps device was visibly blood or body fluid stained (see 3.2)? | <input type="checkbox"/> NONE OF THESE |

Body fluid factors

- | | |
|---|--|
| <input type="checkbox"/> Blood? | <input type="checkbox"/> Saliva in association with dentistry? |
| <input type="checkbox"/> Amniotic Fluid? | <input type="checkbox"/> Synovial fluid? |
| <input type="checkbox"/> Human breast milk? | <input type="checkbox"/> Unfixed human tissues and organs? |
| <input type="checkbox"/> Vaginal secretions or semen? | <input type="checkbox"/> Exudative or other tissue fluid from burns or skin lesions? |
| <input type="checkbox"/> Cerebrospinal fluid? | <input type="checkbox"/> Any other visibly blood-stained body fluid e.g. urine, vomit, saliva, faeces? |
| <input type="checkbox"/> Peritoneal fluid? | <input type="checkbox"/> NONE OF THESE |
| <input type="checkbox"/> Pericardial fluid? | |
| <input type="checkbox"/> Pleural fluid? | |

3.2 SIGNIFICANCE OF CONTAMINATION INCIDENT

a) Has '**NONE OF THESE**' been ticked in **BOTH** 3.1.1 and 3.1.2 sections? No - go to

b) **Yes** – this means a **Non-Significant Incident** has occurred and there is no risk to health - Recipient may return to work. Please **complete section 6** and forward this form to: The Nurse Team, Occupational Health and Wellbeing Department, Kingstor House or e-mail to: plh-tr.OccHealth-DutyNurse@nhs.net

b) Apart from 'NONE OF THESE', have **ANY** other boxes been ticked in sections 3.1.1 – 3.1.2? No – see comments in a). **Yes** – this means a **Significant Incident** has occurred. Please **complete sections 4** and refer the Recipient to the Emergency Department **N.B.** *Please ring the ED Minors Nurse Ext 52045 to notify them that the recipient is en route.*

3.3 BLOOD SAMPLE

- Obtain consent and arrange for blood to be taken from the **Recipient** for 'Serum Save' (storage). **N.B.** ED will only obtain this in the case of a non-clinical Recipient (e.g. Serco, volunteer, estates).

Competent Person's Responsibilities for the SOURCE (if known)

Is the **Source** known? No **Yes** - please complete details of the Source below:

Source name: [Click here to enter text.](#) **Date of birth:** [Click here to enter text.](#)

Hospital No.: [Click here to enter text.](#) **Ward / Dept.:** [Click here to enter text.](#)

Is the **Source** Anaesthetised/Unconscious? No **Yes** - the **Source's** responsible clinician should make an initial risk assessment (high or low risk) if blood borne virus status is not known. This is not an ED or OH&WB decision as neither have direct access to the **Source**.

- Explain to the **Source** (or their Parent/Guardian or Next of Kin) why it is necessary to undergo a risk assessment.
- Ask the Source the questions in sections 4.3 & 4.4 whilst maintaining their privacy, dignity, and confidentiality during the assessment. If they are concerned at all about any of the specific questions or declines to answer please take the opportunity to discuss this with them. Also, they may wish to just answer the **last question** in section 4.3.
- Obtain bloods from the **Source** (or arrange for this to be taken) in one yellow Vacutainer tube (**N.B. tests required are: Hepatitis B Surface Antigen, Hepatitis C and HIV antibodies**). To request on iSoft, type "needlestick" into the test field. The Donor is the Source.
- Send the Source's sample to microbiology informing them by telephone that the result is required within 24 hours (or sooner depending on level of risk).
- Obtain consent from the **Source** for OH&WB to gain access to their results and send form to **The Nurse Team, Occupational Health and Wellbeing Department, Kingstor House**
- Follow up on the **Source's** results. If the result is Negative you may inform the Recipient (**N.B. Positive results are dealt with by OH&WB**).

Source Risk Factors (general)

- Was the source born outside of Europe, in Australia or the United States? **Yes** No
 - If the source is male, have they had sexual relationships with other men? **Yes** No
 - Has the source injected drugs into their veins in the past? **Yes** No
 - Has the source had a blood transfusion or operation outside of Europe, within Australia or within the United States? **Yes** No
 - Has the source had a sexual partner who originates from outside of Europe, from Australia or the United States? **Yes** No
- One or more of the above applies to the Source?** **Yes** No

Source Risk Factors - already known to clinical team

- HIV antibody positive? **Yes**
No
- Hepatitis C antibody positive? **Yes**
No
- HCV RNA positive? **Yes**
No
- Hepatitis B Surface Antigen positive? **Yes**
No
- HBeAg positive **Yes**
No
- HBV DNA > 10³ copies/ml **Yes**
No

Signature: _____ Date: [Click here to enter a date.](#) Time: [Click here to enter text.](#)

Name in CAPITALS: [Click here to enter text.](#) Designation: [Click here to enter text.](#)

Full details concerning consent can be found within the LSW Policy

Consent to Treatment Please discuss with a senior member of the Source's clinical team or GUM Team if you have any queries regarding consent.

What to do if:

- Source is concerned about the questions or declines to answer:** please take the opportunity to discuss their concerns with them. Reassurance surrounding the tests can be given to the Source that BBV testing is routinely conducted on pregnant women and any member of the public donating blood. It may be possible to test an existing Source blood sample but consent must be sought to test for BBVs (in this case, consent will need to be relayed to the laboratory). They may wish just to answer Question 6.
- Source has answered yes to the questions or just to Question 6:** The source should be offered a discussion with one of the GUM Health Advising Team.
- Source has been discharged:** contact Source's GP (initially by telephone if possible, with a letter following) explaining the situation and the usual blood screening tests that are carried out HIV Antibodies 1&2, Hepatitis B Surface Antigen and Hepatitis C Antibodies. **If Source is not registered with a GP contact GUM Advisors for assistance.**
- Source denies consent:** medico-legally no further progress can be taken; consider involvement of the GUM Dept. for assistance.
- Source requests total confidentiality:** tests that won't be documented in medical notes can be arranged in GUM Dept.
- Source consents to test but does not want to know result:** a referral to the GUM Dept. for advice/assistance is recommended.
- Source is unconscious:** the Human Tissue Act (HTA) states that under Scheduled Purposes consent is required when obtaining scientific or medical information about a living or deceased person which may be relevant to any other person (the Recipient).

- h) **Source lacks the capacity to consent:** follow guidance under the Mental Capacity Act 2005.
- i) **Source has died:** the issue of 'best interests' in common law does not apply in the case of deceased individuals. Consent for testing in this circumstance could be obtained from the next of kin or where there is no next of kin, a relative or nominated representative. Consent should be sought from the highest ranking individual as laid out in section 27 (4) of the HTA. If there is no such person, then there is no one in law that can consent.

Department Contact Details

GUM Dept. Health Advisors - ☎ Ext. 31804

Occupational Health & Wellbeing Department

☎ Ext. 37222 Mon - Fri 8am to 4pm + answer phone out-of-hours

✉ plh-tr.OccHealth-DutyNurse@nhs.net

Microbiology Department

☎ Ext. 52387 Enquiries (Mon - Fri 9am to 5.17pm & Sat 9am to 12.30pm):

On call Microbiologist - via switchboard

11 Step-by-Step Guide for Management of a Contamination Incident by the Emergency Department (ED)

(‘Needlestick’, Sharps injuries, Body Fluid splashes etc.)

Managing staff or patients who have been referred for ED management following a contamination incident is easy. The following guide has been arranged into 6 sections and will help you make the right decisions and give the right advice.

Management of Contamination Incidents Standing Operating Procedure and associated forms available In the LSW SOP (under Occupational Health & Wellbeing)

Recipient refers to the person who has been contaminated.

Source refers to the origin of the contaminant.

Section	Title
1	Staff working within LSW.
2	Staff working outside LSW or employed by other NHS Trusts.
3	Non NHS staff or Members of the Public
4	PEP prescribing.
5	Essential elements in the pre-test discussion
6	Department Contact Details

1. Staff working within LSW and PHNT

Hotel Services, Medical or Dental School students, LSW community staff, University of Plymouth student nurses, those with honorary contracts and volunteers etc. (list not exhaustive).

- a. The affected member of staff (the Recipient) will phone the ED Minors Nurse on Ext 52045 to inform them that an incident has occurred and they will make their way to ED.
- b. A risk assessment form (**Appendix B**) must be completed by their nominated competent person and handed to the Recipient to bring to ED. Where there is no form the Recipient is to contact the Competent Person by phone to arrange this without delay. (Community teams may need to ensure they have a copy of the Risk Assessment).

- c. Ensure that an incident has been filed through SAFEGUARD. The responsibility falls to the Recipient and their nominated competent person and should not be completed in the ED.
- d. Bloods need to be taken for 'Serum Save' (this can be done in the ED but result in a longer stay in the ED) therefore, staff will be encouraged by OH&WB Dept campaigns to have this done in their area of work by their nominated competent person. Guidance for completion of the sample request form is at (**Appendix F**).
- e. The risk assessment form will guide you as to the need for PEP and Hep B boosters or immunoglobulin. In general, a Hepatitis B booster is recommended if the last Hep B vaccine given was greater than 1 year ago. The Occupational Health & Wellbeing Department in most cases can verify the status of staff.
- f. Complete the ED part of the risk assessment form, make a copy for the ED notes and send the original to Occupational Health and Wellbeing Department.
- g. Refer all recipients who require PEP to the GUM clinic as well.
- h. **If the source is unknown** i.e. used needles in a sharps container, discarded needles in a ward etc. (or where the source has not co-operated or consented); take bloods for serum save and consider a Hepatitis B booster. HBIG (Hepatitis B Immunoglobulin) and HIV PEP is not generally required in the local Devon and Cornwall area unless the source needle is suspected to be both fresh and from an 'at risk population' in which case the Recipient is likely to know the details of the source. Also consider tetanus status in these cases.
- i. Where HIV PEP is required, print off HIV Post Exposure Prophylaxis (PEP) Information Leaflet (**Appendix I**) for the Recipient.
- j. **If the source is unable to consent** for BBVs (comatose, anaesthetised, without mental capacity etc.) and is deemed high risk by the information available, in the majority of situations, PEP should be given and the case discussed with GUM at the earliest opportunity.
- k. The Recipient must also contact The Occupational Health & Wellbeing Department. This is to ensure the correct support and health surveillance is organised.

2. Staff working outside LSW and PHNT or employed by other NHS Trusts

Includes community NHS staff (such as midwifery, etc.) and some Dental practices

- a. A risk assessment form (**Appendix B**) should ideally have been completed before attending the ED, but may have to be completed in the ED due to circumstances such as the Source being seen in their own home many miles away etc. Please print off a risk assessment form should the recipient not have one. This can then be completed whilst the recipient waits to be seen.
- b. **If source risk information cannot be completed** by the recipient, the ED should contact the Source's GP to obtain the information. Alternatively, and often a more practical option, is that the recipient may contact the source directly to obtain the information. Bear in mind that the ED does not automatically have access to previous results for BBVs tested in the source as we're not part of the care team for the source and consent will be required.
- c. Bloods for BBVs (Hep B Surface Antigen, Hep C Antibodies, HIV Antibodies) can be taken in the ED if the source is willing to attend. Alternatively, the source's GP may be able to undertake the tests. Counsel the source and seek written consent to obtain a blood sample (**Appendix D**). This consent must be fully informed and obtained from a staff member who is competent in the process. Complete the request form making sure the relevant information is included (it must state only the tests that the source has consented to). The source should be referred to the GUM Department.
- d. If the **source is unknown** i.e. used needles in a sharps container, discarded needles in a ward etc. (or where the source has not co-operated or

consented); take bloods for 'Serum Save' and consider a Hepatitis B booster. PEP (HIV and HBIG Hepatitis B Immunoglobulin) is not generally required in the local Devon and Cornwall area unless the source needle is suspected to be both fresh and from an 'at risk population' in which case the Recipient is likely to know the details of the source. Also consider tetanus status in these cases.

- e. Ensure that an incident has been filed through the relevant community incident reporting systems. The responsibility falls to the recipient and their nominated competent person (this may of course be the recipient themselves) and should not be completed in the ED.
- f. Bloods need to be taken for 'Serum Save' in the ED.
- g. The risk assessment form will guide you as to the need for PEP (HIV and Hep B boosters or immunoglobulin). In general, a Hepatitis B booster is recommended if the last Hep B vaccine given was greater than 1 year ago. The Occupational Health & Wellbeing Department in most cases can verify the status of staff whose OH care is provided by them. Complete the ED part of the risk assessment form, make a copy for the ED notes and give the original to the Recipient.
- h. Refer all patients who require PEP to the GUM clinic as well.
- i. The Recipient must also contact their Occupational Health Service – if this is unknown, refer all to LSW Occupational Health & Wellbeing Department where they will be directed to their correct provider if required.

3. Non NHS staff or Members of the Public

- a. Print off the amended risk assessment form (**Appendix C**).
- b. This risk assessment form need to be completed by the ED as it provides a helpful guide, specifically if the source is known and the incident is considered fresh (freshly used needle, saliva, etc.)
- c. If the **source is known**, but risk information cannot be completed by the patient, the ED should contact the source's GP to obtain the information. Alternatively, and often a more practical option, the ED may contact the source directly to attend the ED for a risk assessment and bloods for BBVs (Hep B Surface Antigen, Hep C Antibodies, HIV Antibodies). Counsel the source and seek written consent to obtain a blood sample. This consent must be fully informed and obtained from a staff member who is competent in the process. Use the consent form which should also reflect that results will be passed (if necessary for the purposes of determining the appropriate treatment) to ED staff and the recipient's GP. Complete the request form making sure the relevant information is included (it must state only the tests that the source has consented to). The source should be referred to the GUM clinic.
- d. If the **source is unknown** i.e. used needles in a sharps container, discarded needles in a ward etc. (or where the source has not co-operated or consented); take bloods for serum save and consider a Hepatitis B booster. HBIG (Hepatitis B Immunoglobulin) and HIV PEP is not generally required in the local Devon and Cornwall area unless the source needle is suspected to be both fresh and from an 'at risk population' in which case the Recipient is likely to know the details of the source. Also consider tetanus status in these cases.
- e. A SAFEGUARD incident report does not need to be completed unless the incident has resulted because of a lapse in LSW procedures.
- f. Bloods need to be taken for 'Serum Save' in the ED from the recipient
- g. An accelerated Hep B vaccine course may be recommended. Also consider tetanus status. Discuss suspected need for PEP with microbiology first.
- h. Complete the ED part of the risk assessment form and send a copy with the electronic discharge to the GP by mail. Do not give this document to the recipient as it may contain sensitive information about the source.

- i. Refer all source patients who require PEP to the GUM clinic as well
- j. Where HIV PEP is required, print off HIV Post Exposure Prophylaxis (PEP) Information Leaflet (**Appendix I**) for the Recipient.

4. PEP Prescribing

HIV PEP (Appendix H)

PEP for HIV is not useful after 72 hours

One Truvada tablet (300mg Tenofovir and 200mg Emtricitabine- FTC) once a day **and**
Two Kaletra film-coated tablets (200mg Lopinavir and 50mg Ritonavir) twice a day
as a 28 day course.

Overnight, the decision to commence HIV PEP will be made by the most senior member of medical staff on shift in the ED. This would be followed-up in the GUM clinic on the next available clinic slot.

PEP for Hepatitis C is currently not available. However, early treatment of acute Hepatitis C infection may prevent chronic infection. Follow-up of exposed patients should follow that described in management for occupational exposure to Hepatitis C.

PEP for Hepatitis B (Appendix J)

This may be recommended following exposure to Hepatitis B and consists of a course of immunoglobulin with or without a booster dose of Hepatitis B vaccine.

Hepatitis B Immunoglobulin (HBIG) is recommended in unimmunised, partially immunised (1 dose of vaccine pre-exposure) or known non-responders of hep B vaccine following a significant exposure from a HBsAg positive source.

HBV status of person exposed	Significant Exposure			Non-significant	
	HBsAg positive source	Unknown source	HBsAg negative source	Continued risk	No further risk
1 dose HB vaccine pre-exposure	Accelerated course of HB vaccine* HBIG x 1	Accelerated course of HB vaccine*	Initiate course of HB vaccine	Initiate course of HB vaccine	No HBV PEP Reassure
2 doses HB Vaccine pre-exposure (anti-HBs not known)	One dose of HB vaccine followed by second dose one month later	One dose of HB vaccine	Finish course of HB vaccine	Finish course of HB vaccine	No HBV PEP Reassure
Known responder to HBV vaccine (anti-HBs 10 miU/ml)	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster of HB vaccine	No HBV PEP Reassure

Known <u>non-responder</u> to HB vaccine (anti-HBs <10 miU/ml 2-4 months)	HBIG x 1 Consider booster dose of HB vaccine	HBIG x 1 Consider booster dose of HB vaccine	No HBIG Consider booster dose of HB vaccine	No HBIG Consider booster dose of HB vaccine	No HBV PEP Reassure
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*An accelerated course of vaccine consists of doses spaced at 0, 1 and 2 months. A booster dose may be given at 12 months to those at continuing risk of exposure to HBV.

5. Essential elements in the Source pre-test discussion

- The benefits to the Recipient of testing the Source.
- The benefits (and disadvantages) to the Source of knowing their BBV status.
- Details of how the result will be given (check contact details are correct).
- Answer any questions and ensure they are aware hospital notes are confidential
- Obtained signed consent.
- If the Source requires any further information or wishes to speak in depth about testing, please contact the Health Advisers in GUM 53924.

Department Contact Details

GUM Dept. Health Advisors

☎ Ext. 31804

Occupational Health & Wellbeing Department

☎ Ext. 37222 Mon - Fri 8am to 4pm + answer phone out-of-hours

✉ plh-tr.OccHealth-DutyNurse@nhs.net

Microbiology Department

☎ Ext. 52387 Enquiries (Mon - Fri 9am to 5.17pm & Sat 9am to 12.30pm):

On call Microbiologist - via switchboard

Compiled by Dr S. Bruijns for the ED in collaboration with the Microbiology and Occupational Health & Wellbeing Departments. Version 1

12 Step-by-Step Guide for the Management of a Contamination Incident by the Occupational Health & Wellbeing Department

Managing staff that have been affected by a contamination incident is straightforward. The following guide has been arranged into 3 sections and will help you make the right decisions and give the right advice.

Sustaining a contamination incident can involve physical pain and discomfort; psychological effects, emotional trauma; hardship and inconveniences to the member of staff, family and friends. The impact cannot be underestimated.

In view of the seriousness of a contamination incident, the OH&WB Team will ensure that a support mechanism is in place to assist the member of staff by;

- Providing timely, competent and confidential advice.
- Guidance through the recommended process (dependant on the result of the risk assessment and communication with the member of staff).

1. Receiving Initial Calls or Emailed Report Forms:

Issues to be Considered

1. Possible adverse impact on psychological health
2. Possible adverse impact on relationships with family, friends and work colleagues
3. Identification of previously unknown disease so that treatment can be started earlier
4. Opportunity for referral to the appropriate specialist
5. Sexual partners may be protected
6. Plans for the future can be made
7. In the past there have been difficulties obtaining insurance but it now possible to be insured through specialist firms (The Terence Higgins Trust can assist). Existing Policies are not affected.

The majority of calls to OH&WB will be after the immediate actions and risk assessment have been carried out. However, Members of Staff will occasionally call OH&WB first as they are not aware of the correct reporting procedures. In this case, basic information should be recorded on OPAS such as:

- **Date Incident occurred**
- **Time of incident**
- **Has the incident been reported to the Line Manager/Manager in charge of area?** If not – advise to do so without delay.
- **Has a Risk Assessment been carried out?** This would be carried out by the ‘Competent Person’ – Line manager will arrange this if not already done. It is important that this is carried out within 30 minutes as in the case of a significant incident the member of Staff will need to be seen in ED within 60 minutes.
- **Has ‘Serum Save’ been obtained?** If not, needs to be carried out without delay by the Competent Person or colleague (before attending ED if possible).
- **Has the incident been reported on SAFEGUARD** If not, needs to be carried out without delay.
- **The Member of staff will need to call back once all the necessary actions above have been carried out.** This is to ensure their health, safety and wellbeing is addressed at the earliest opportunity and to ensure all details of the incident are correct.

2. Action by the OH&WB Nurse Team:

- a. Commence reporting of the incident by completing a Contamination Incident questionnaire on OPAS. The information gathered may anonymously be reported to the HSE (Health and Safety Executive) and LSW Health & Safety and Infection prevention and Control Committees.
- b. Assesses and manage the affected Member of Staff on a case-by-case basis.
- c. Arranges an appropriate appointment for the Member of Staff to be seen in the OH&WB Department if required.
- d. Where informed that a test has proved positive (likely to be informed by the microbiologist by phone) ensure that the OH&WB Consultant or Senior Nurse is informed so that a care plan can be arranged.
- e. On instruction from OH&WB Consultant or Senior Nurse, inform the Member of Staff of the results of the Source BBV screening.


- f. If Member of Staff is on PEP or there are other complex issues, refers Member of Staff to consultant or delegated competent professional.
- g. Where HIV PEP is required, print off HIV Post Exposure Prophylaxis (PEP) Information Leaflet (**Appendix I**) for the Member of Staff.
- h. Refer Member of Staff to Employee Assistance Service (Counsellor) if required.
- i. Refer Member of Staff to GUM for counselling / advice if required.
- j. Arrange completion of the course of Hepatitis B immunisation of Member of Staff (initiated in the ED) and for recall of staff for necessary booster doses.
- k. Arrange appropriate health surveillance for BBV screening.
- l. Informs the member of staff of the results of health surveillance BBV testing in writing. This may be preceded by a telephone notification in distressing or urgent cases.
- m. Military staff's documentation (with consent) will be copied and sent to the Military Occupational Health Department, c/o SNO, Royal Naval Sick Quarters, HMS Drake, Plymouth.
- n. Identifies incidence, trends and hotspots of contamination incidents (and actions taken to address & learn).
- o. Identifies incidence of transmitted infections from contamination incidents
- p. Where Member of Staff does not attend recommended appointments - sends a letter with disclaimer section to Member of Staff (copied to Line Manager). The letter states that no further appointments will be arranged unless they are booked by themselves.
- q. On receipt of disclaimer, completes OPAS and closes Contamination Incident Episode. Informs Line Manager.
- r. Informs relevant parties via SAFEGUARD where the policy has not been followed correctly.
- s. Informs the Health & Safety Department where there is a High Risk (RIDDOR Reportable) Contamination Incident.
- t. Provides information and guidance concerning safe systems of work and the prevention of contamination incidents to all Stakeholders as required.

3 Action by OH&WB Consultant or delegated competent professional

- a. Assesses and manages Members of Staff referred by the Nurse Team on a case-by-case basis.
- b. Issue the Information Leaflet – 'Members of Staff with a Blood-Borne Virus' (**Appendix K**) to the affected Member of Staff.
- c. Where required, contacts consultant in GUM or consultant microbiologist for advice.
- d. Referral to the designated consultant hepatologist where staff are affected by HBV or HCV infection.
- e. Referral to the designated GUM consultant where staff are affected by HIV infection.
- f. Referral to the designated consultant hepatologist where staff are affected by HBV or HCV infection.
- g. Referring to the GUM Dept. where specialist psychological support is required (and Employee Assistance Team if necessary or requested).
- h. Advises the LSW regarding suitable alternative work if required for the affected Member of Staff.

Department Contact Details

GUM Dept. Health Advisors

 Ext. 31804

Microbiology Department

 Ext. 52387 Enquiries (Mon - Fri 9am to 5.17pm & Sat 9am to 12.30pm)

4. Health Surveillance Following a Contamination Incident

	Blood tests at 6 weeks	Blood tests at 3 months	Blood tests at 6 months
Source HIV positive (see note a & c)	HIV antibodies	HIV antibodies	
Source HBsAg positive (see note c)		HBsAg HB core antibody	HBsAg
Source HCV positive (see note b & c)	HCV PCR	HCV PCR HCV antibodies	HCV PCR HCV antibodies
Source BBV status unknown		HBsAg HIV antibodies HCV antibodies	HBsAg HIV antibodies HCV antibodies
Source Unknown		HBsAg HIV antibodies HCV antibodies	HBsAg HIV antibodies HCV antibodies

Follow-up may be longer in certain cases. For instance, when the source patient has HCV and HIV the exposed member of staff should be tested for HCV and HIV antibodies at 12 months. Please contact the GUM consultant or the consultant microbiologist for expert advice in such cases.

Notes:

- a. Investigating the recipient for evidence of HIV infection may additionally be required if symptoms compatible with a seroconversion illness occurs at any time during follow-up (typically fever, rash, myalgia, fatigue, malaise or lymphadenopathy).
- b. An incident involving a Source who is HCV antibody positive but HCV PCR negative will require the same follow-up as for that from a HCV PCR positive source. The risk of transmission from a HCV PCR negative source will however be much lower.
- c. The Recipient should be advised that, during the follow-up period they should;
 - Adopt safer sexual practices.
 - Avoid pregnancy.
 - Avoid donating blood or other tissues.

5. BBV Positive Members of Staff - Adjustments and Restrictions to Working Practices

Because of the increased risk of transmission of infection to patients, restrictions apply to HCWs performing EPPs, or working in Renal Dialysis Units. A flowchart is available to guide through the process of assessment entitled 'Assessing Fitness for EPP Work – Staff who are BBV Positive' (**Appendix L**). If doubts exist about the need for to modify a member of staff's working practices, or change their area of work, the OH&WB Consultant will consult the UK Advisory Panel for Health Care Workers Infected with BBVs (UKAP) for advice. Contact should be made through the UKAP's DH secretariat on an anonymous basis.

The Expert Advisory Group on AIDS and the Advisory Group on Hepatitis have published guidelines on the management of staff infected with BBVs. These are kept under continuing review and updated in the light of emerging epidemiological evidence. The OH&WB clinical staff should be aware of the latest recommendations.

Hepatitis B Virus - If positive for HBsAg testing for hepatitis B e-markers should be undertaken. If they are e-antigen (HBeAg) positive, they should not be allowed to perform EPPs.

- If HBeAg negative, Hepatitis B viral load (HBV DNA) should be tested. If the HBV DNA is greater than 10^3 genome equivalents/ml, they should not be allowed to perform EPPs. HBV DNA testing should be carried out in designated laboratories (see HSC 2000/020).
- There are no restrictions on the working practices of hepatitis B-infected healthcare workers who have HBV DNA at or below 10^3 genome equivalents /ml or below. This is subject to annual monitoring by a consultant occupational physician.
- Hepatitis B infected members of staff who are e antigen negative and who are receiving antiviral treatment with a pre-treatment viral load of $10^3 - 10^5$ geq/ml are allowed to perform EPPs if their viral load is suppressed to below 10^3 geq/ml and they cooperate with regular OH&WB and Specialist follow up. See DH (March2007) Hepatitis Infected healthcare workers and antiviral therapy.

Hepatitis C Virus - Staff who will perform EPPs should be tested for hepatitis C antibody. Those who are positive should be tested for hepatitis C RNA to detect the presence of current infection. Qualitative testing for hepatitis C virus RNA should be carried out in accredited laboratories that are experienced in performing such tests and which participate in external quality assurance schemes. The assays should have a minimum sensitivity of 510U/ml. Those who are hepatitis C RNA positive should not be allowed to perform EPPs. This extends existing guidance on hepatitis C testing to cover all staff new to the NHS who will perform EPPs regardless of career stage.

Staff should be asked about antiviral treatment when submitting a blood sample, because special arrangement exist for healthcare workers who are receiving or have recently received interferon and/or antiviral therapy for hepatitis C.

Health Surveillance of HBV & HCV Positive Staff

The Information Leaflet - Members of Staff with a Blood-Borne Virus (**Appendix K**) should be issued to affected Members of Staff.

The OH&WB nurse team will obtain blood samples for HBV DNA and HCV RNA.

The PHNT microbiology laboratory staff must be informed that the sample should **only** be sent to the DoH approved reference laboratory named below together with the DoH-recommended request form;

The Virology Department, Heartlands Hospital, Birmingham

HIV - Staff who will perform EPPs should be tested for HIV antibody. Those who are HIV antibody positive should not be allowed to perform EPPs.

- a. Those who are HIV positive might be able to undertake other types of clinical work provided they avoid areas requiring contact with patients who have open pulmonary tuberculosis.
- b. Other situations, such as pre-hospital trauma care and care of patients where the risk of biting is regular and predictable, should be avoided by health care workers restricted from performing exposure prone procedures. It may also be necessary to consider workplace adjustments if the Member of Staff has HIV related complications.

The OH&WB nurse team will pass the results of the blood tests to the OH&WB Consultant.

13 Step-by-Step Guide for the Management of a Contamination Incident where a Patient is Contaminated by a Member of Staff - "Reverse Incident"

The risk that a patient may be exposed to the blood of a member of staff is minimised by ensuring that preventative measures (**see Prevention of Contamination Incidents SOP**) are in place when performing exposure-prone procedures.

Staff must not rely on their own assessment of risk of transmission to patients.

Scenarios and Circumstances that may result in a patient being contaminated:

- a. During an Exposure Prone Procedure (EPP) performed by a member of staff who is not cleared by the OH&WB Department to undertake EPPs.
- b. During a non-EPP performed by a BBV-infected member of staff (e.g. physical assault on the member of staff, spontaneous nosebleed).
- c. In the event that an invasive device or product contaminated by use on one patient is accidentally re-used on another patient.
- d. Visible laceration occurring to a member of staff's hand in circumstances where the patient's open tissues or mucous membranes could be contaminated with the member of staff's blood.
- e. Visible bleeding of a member of staff from any other site (e.g. nosebleed) leading to significant bleed-back into a patient's open tissues or mucous membranes.
- f. An instrument or needle contaminated with the blood of the member of staff is inadvertently introduced into the patient's tissues.

Immediate Action - Significant Incident

1. The injured person should stop the procedure as soon as reasonably practicable and initiate First Aid.
2. Report the incident to the Consultant responsible for the care of the patient who may inform a Consultant in Microbiology who will co-ordinate the management of the incident and provide advice as required.

3. The patient's clinical team will be responsible for obtaining blood for 'serum save' from their patient.
4. Inform the OH&WB Department who will be responsible for obtaining consent and the collection of blood for BBV testing.
5. Complete an incident form on SAFEGUARD.

Where active management is indicated, the patient should be informed that an exposure may have occurred. The patient should then be managed in accordance with current guidelines for the management of Contamination Incidents.

If the patient is subsequently found to be positive for a BBV on testing, follow up will be required either through their GP or by a consultant with a special interest in the infection to which they have been exposed.

Patient Notification - If the member of staff develops a BBV it may be necessary for the LSW to undertake a patient notification exercise.

The decision to conduct this exercise will be based on a detailed risk assessment and will be managed on a case-by-case basis by the directorate manager and human resources officer with advice from the OH&WB consultant, GUM consultant, DIPC, The Public Health Team as required.

14 Reference Material

- Department of Health (DH)1998 Guidance for clinical HCW: protection against infection with blood borne viruses: Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis. Available at:
http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002766
- DH 2002 Hepatitis C infected HCWs. Available at:<http://ocmed.oxfordjournals.org/content/57/8/599>
- Department of Health 2008 HIV post exposure prophylaxis: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS. Available at:
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088185?ssSourceSiteId=ab
- Department of Health. HIV infected HCWs: Guidance on management and patient notification. 2005.
- Department of Health. Hepatitis B infected HCWs and antiviral therapy. 2007.
- Department of Health. Hepatitis B; chapter 18. In: Immunisation against infectious diseases. 2009.
- Health and Safety Executive 2001 Blood borne viruses in the workplace: Guidance for employers and employees. Available at:
<http://www.hse.gov.uk/pubns/indg342.pdf>
- Health and Safety Executive The Reporting of Diseases, Dangerous Occurrences Regulations 1995. Available at: www.riddor.gov.uk
- National Institute for Occupational Health and Safety November 1999. Preventing needle stick injuries in healthcare settings. Available at:
<http://www.cdc.gov/niosh/docs/2000%2D108/>

- General Medical Council June 2008 *Consent: patients and doctors making decisions together*. Available at: http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.



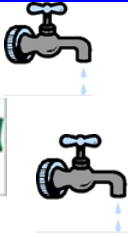


The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Infection Prevention & Control.

Date: 15th July 2015

What do I do in the event of a Contamination Incident?

Recipient	Clean it ...	Bleed & wash cuts / abrasions / inoculations Rinse eyes or mucous membranes	  
	Report it to a Responsible Person ...	The Responsible Person will be as follows: * Nurses should report to the nurse in charge in area where the incident occurred * Doctors should report to a colleague (middle grade, SpR or consultant), * Non clinical staff, Hotel Service Staff, volunteers and students (medical, dental, nursing) should report to the nurse in charge in the clinical area where the incident occurred (Hotel Service staff must also report to their own Management). * All incidents occurring ? in non-clinical areas report to the Emergency Department (ED).	
	Record it ...	All incidents must be recorded on SAFEGUARD	
	Discuss it with the Competent Person ...	The Competent Person will be a Senior Nurse, the Night Co-ordinator out of hours or a Doctor caring for the Source patient (<i>or a suitably competent deputy</i>) who has had training from the GUM Department. They will be appointed by the Responsible Person and will assess the risk.	
	If deemed a Significant Incident ...	 	Phone ED Minors Nurse 31315(4) to notify them of your imminent arrival. Report to ED with Completed Risk Assessment & Checklist form Ring Occupational Health & Wellbeing Dept to report incident & plan your future care. Tel: 37222

Responsible Person	Appoint a Competent Person	The Competent Person will be a Senior Nurse the Night Co-ordinator out of hours or a Doctor caring for the Source patient (<i>or a suitably competent deputy</i>) who has had training from the GUM Department.
	Assist the Recipient in Reporting & Offer Support to the Recipient	Refer to Occupational Health if required Tel: 37222 or e-mail: plh-tr.OccHealth-DutyNurse@nhs.net

Competent Person	Complete Risk Assessment & Checklist Form and determine actions:	Find on Standard Operating Procedure on the LSW Intranet
	Obtain Blood from the Recipient:	This is for storage known as 'Serum Save'
	Obtain Blood from the Source:	<ul style="list-style-type: none"> • Hep B Surface Antigen • Hep C Antibodies • HIV Antibodies

Significant Incident

High Risk Exposures include;

- A deep puncture wound
- Sharps device from source's artery or vein or visibly blood-stained
- An injury from a hollow bore sharps device
- A large volume of body fluid splashed in eyes or on other mucous membranes

High Risk Fluids/Tissues include;

- Blood, Human breast milk, Vaginal secretions or Semen
- Cerebrospinal fluid, Synovial fluid, Peritoneal fluid, Pericardial fluid, Pleural fluid, Amniotic Fluid, Saliva in association with dentistry
- Unfixed human tissues and organs, Exudative or other tissue fluid from burns or skin lesions
- Any other **visibly blood-stained body fluid** (urine, vomit, saliva, faeces)

High Risk Source;

- Known BBV infections
- Men who have sex with men, Intravenous drug users, Sex workers etc.

Non-significant Incident

Any other type of incident – not listed in the significant incident box ~ **No further action required**

If concerned, please ring Occupational Health & Wellbeing for advice
Tel: 37222

Contamination Incident Risk Assessment & Checklist

There are 6 sections on this form. Sections 1 to 4.4 and 6 can be completed electronically before printing and signing. Please read each section carefully and ensure all relevant information is completed - place a '✓' or 'x' and text in the relevant boxes.

1. Recipient's Responsibilities - Place a '✓' or 'x' and text in the relevant boxes.

- Apply First Aid (flush with water ~ body fluid splashes or squeeze to encourage bleeding ~ inoculation injuries/cuts)
- Report incident in your area to the **Responsible Person (see details below)**:
 - * **Nurses** should report to the nurse in charge in area where the incident occurred
 - * **Doctors** should report to a colleague (middle grade, SpR or consultant),
 - * **Non clinical staff, Hotel Services, volunteers and students (medical, dental, nursing)** should report to the nurse in charge in the **clinical area** where the incident occurred (**Hotel Services** staff must also report to their own Management).
 - * All incidents occurring in **non-clinical areas** (laboratories, community, Estates etc.) please report to the Emergency Department (ED).
- Report the incident via Safeguard (the **Responsible Person** can assist you with this).
- Contact OH&WB within 24 hours of the incident via e-mail plh-tr.OccHealth-DutyNurse@nhs.net or Tel: 01752 (4)37222 Option 4 (leaving a message if line is busy, unanswered or it is out of hours).

Employer/Sector: PHNT MOD MDHU Hotel Services Volunteer Student Nurse/
Midwife/ODP

Medical or Dental School Student

Other: [Click here to enter text.](#)

Department / Area where Incident occurred: [Click here to enter text.](#)

Signature: _____ Date: [Click here to enter text.](#) Time of Incident: [Click here to enter text.](#)

Name in CAPITALS: [Click here to enter text.](#) Job / Role: [Click here to enter text.](#)

2. Responsible Person's Duties - place a '✓' or 'x' and text in the relevant boxes.

- Appoint a **Competent Person** who can fulfil, or delegate the responsibilities described below. **N.B.** The competent person is **not** the ED **except** for incidents occurring in non-clinical areas.
- Provide emotional support for the Recipient.

Signature: _____ Time: [Click here to enter text.](#) Date: [Click here to enter text.](#)

Name in CAPITALS: [Click here to enter text.](#) Designation: [Click here to enter text.](#)

3. Competent Person's Responsibilities for RECIPIENT Place a '✓' or 'x' and text in the relevant boxes.

3.1 ASSESS INCIDENT

3.1.1 Incident factors

- A large amount of visibly blood stained body fluid splashed into eyes, nose or mouth or onto non-intact skin? *N.B. There is no evidence that blood-borne viruses can be transmitted by: blood contamination of intact skin, inhalation or faeco-oral contamination.*
- Sharps device was in Source patient's artery or vein?
- Sharps device was visibly blood or body fluid stained (see 3.1.2)?
- Deep puncture wound?
- Sharps device has a hollow bore?
- NONE OF THESE**

3.1.2 Body fluid factors

- Blood?
- Amniotic Fluid?
- Human breast milk?
- Vaginal secretions or semen?
- Saliva in association with dentistry?
- Synovial fluid?
- Unfixed human tissues and organs?
- Exudative or other tissue fluid from burns or skin lesions?

- Cerebrospinal fluid?
- Peritoneal fluid?
- Pericardial fluid?
- Pleural fluid?

- Any other visibly blood-stained body fluid e.g. urine, vomit, saliva, faeces?

NONE OF THESE

3.2 SIGNIFICANCE OF CONTAMINATION INCIDENT

- a) Has '**NONE OF THESE**' been ticked in **BOTH** 3.1.1 and 3.1.2 sections? No - go to b) **Yes** – this means a **Non-Significant Incident** has occurred and there is no risk to health - Recipient may return to work. Please **complete section 6** and forward this form to: The Nurse Team, Occupational Health and Wellbeing Department, Kingstor House or e-mail to: plh-tr.OccHealth-DutyNurse@nhs.net
- b) Apart from '**NONE OF THESE**', have **ANY** other boxes been ticked in sections 3.1.1 – 3.1.2? No – see comments in a). **Yes** – this means a **Significant Incident** has occurred. Please **complete sections 4** and refer the Recipient to the Emergency Department **N.B.** Please ring the ED Minors Nurse Ext 52045 to notify them that the recipient is en route.

3.3 BLOOD SAMPLE

- Obtain consent and arrange for blood to be taken from the **Recipient** for 'Serum Save' (storage). **N.B.** ED will only obtain this in the case of a non-clinical Recipient (e.g. Hotel Services, volunteer, estates).

4. Competent Person's Responsibilities for the SOURCE (if known)

- 4.1 Is the **Source** known? No **Yes** - please complete details of the Source below:

Source name: [Click here to enter text.](#) Date of birth: [Click here to enter text.](#)
 Hospital No.: [Click here to enter text.](#) Ward / Dept.: [Click here to enter text.](#)

- 4.2 Is the **Source** Anaesthetised/Unconscious? No **Yes** - the **Source's** responsible clinician should make an initial risk assessment (high or low risk) if blood borne virus status is not known. This is not an ED or OH&WB decision as neither have direct access to the **Source**.

- Explain to the **Source** (or their Parent/Guardian or Next of Kin) why it is necessary to undergo a risk assessment.
- Ask the Source the questions in sections 4.3 & 4.4 whilst maintaining their privacy, dignity, and confidentiality during the assessment. If they are concerned at all about any of the specific questions or declines to answer please take the opportunity to discuss this with them. Also, they may wish to just answer the **last question** in section 4.3.
- Obtain bloods from the **Source** (or arrange for this to be taken) in one yellow Vacutainer tube (**N.B. tests required are: Hepatitis B Surface Antigen, Hepatitis C and HIV antibodies**). To request on iSoft, type "needlestick" into the test field. The Donor is the Source.
- Send the Source's sample to microbiology informing them by telephone that the result is required within 24 hours (or sooner depending on level of risk).
- Obtain consent from the **Source** for OH&WB to gain access to their results and send form to **The Nurse Team, Occupational Health and Wellbeing Department, Kingstor House**
- Follow up on the **Source's** results. If the result is Negative you may inform the Recipient (**N.B. Positive results are dealt with by OH&WB**).

4.3 Source Risk Factors (general)

- Was the source born outside of Europe, in Australia or the United States? **Yes** No
- If the source is male, have they had sexual relationships with other men? **Yes** No
- Has the source injected drugs into their veins in the past? **Yes** No
- Has the source had a blood transfusion or operation outside of Europe, within Australia or within the United States? **Yes** No
- Has the source had a sexual partner who originates from outside of Europe, from Australia or the United States? **Yes** No

4.4 Source Risk Factors - already known to clinical team

- HIV antibody positive? Yes No
- Hepatitis C antibody positive? Yes No
- HCV RNA positive? Yes No
- Hepatitis B Surface Antigen positive? Yes No
- HBeAg positive Yes No
- HBV DNA > 10³ copies/ml Yes No

Signature: _____ Date: Click here to enter a date. Time: Click here to enter text.

Name in CAPITALS: Click here to enter text. Designation: Click here to enter text.

5. Emergency Department's Responsibilities - Complete sections 5.1 – 6 of this risk assessment form placing a '✓' or 'x' and text in the relevant boxes

- 5.1 For a non-clinical Recipient (e.g. Hotel Services, volunteer, estates); obtain blood for 'Serum Save'
- 5.2 **Hep B Booster***: Required Given Not given Declined
 * Recommended to give a Hep B Booster to the **Recipient** if not had a one in the previous year
- 5.3 **Post Exposure Prophylaxis (PEP)**: consider PEP where source risk is considered high (any Yes-boxes ticked in 4.3 – 4.4) or source is confirmed blood-borne virus positive (see prescribing guidance on ED intranet).

Special situations:

- * Source is not known (e.g. sharp found in rubbish bin or protruding from sharps container): PEP is not usually indicated and the decision to give PEP needs to be in context (e.g. Incident occurred in the HIV clinic).
- * Source is anaesthetised or unconscious: PEP can be started if the risk is deemed high or unclear by the source patient's clinician. If PEP has been started it can be stopped if the subsequent risk assessment determines low risk (e.g. negative source bloods).

HIV PEP: Required Prescribed Not prescribed Declined

HBIG: Required Given Not given Declined

- 5.4 **GUM referral***: Required (PEP was started) Not required (PEP not started)

*A referral to GUM is advised when PEP has been started. GUM operates a walk-in clinic Mon-Fri - information leaflets with times can be found in ED Reception.

6. Documentation - this section to be completed by the Competent Person if a Non-significant Incident has occurred or ED if a Significant Incident has occurred.

In all cases, send the completed form to: **The Nurse Team, Occupational Health and Wellbeing Department Kingstor House** or e-mail to: plh-tr.OccHealth-DutyNurse@nhs.net

Place a copy into the ED notes (only if seen in ED for a **Significant Incident**).

Signature: _____ Date: Click here to enter a date. Time: Click here to enter text.

Name in CAPITALS: Click here to enter text. Designation: Click here to enter text.



**Contamination Incident Risk Assessment Form
For Non NHS staff or Members of the Public**

This form should be completed by an ED staff member in consultation with the Recipient

a) Recipient's name:		DoB:	
Date of Incident:		Time of incident:	
Where Incident occurred:			

b) Incident factors (Indicate type of injury by placing a ✓ or X in the Yes or No columns)		Yes	No
1	Deep puncture wound		
2	Sharps device was in source patient's artery or vein		
3	Sharps device was visibly blood-stained		
4	Sharps device has a hollow bore		
5	Visibly blood stained body fluid splashed in eyes, mouth or nose?		
6	Visibly blood stained body fluid splashed onto non-intact skin?		

c) Body Fluid factors (Indicate type of body fluid by placing a ✓ or X in the Yes or No columns)		Yes	No
1	Blood		
2	Amniotic Fluid		
3	Human breast milk		
4	Vaginal secretions or semen		
5	Cerebrospinal fluid		
6	Peritoneal fluid		
7	Pericardial fluid		
8	Pleural fluid		
9	Saliva in association with dentistry		
10	Synovial fluid		
11	Unfixed human tissues and organs		
12	Exudative or other tissue fluid from burns or skin lesions		
13	Any other visibly blood-stained body fluid (urine, vomit, saliva, faeces)		

There is no evidence that BBV can be transmitted by blood contamination of intact skin or inhalation, or by faeco-oral contamination.

d) Source Known? Yes / No

If Yes, please complete this section.

Source name:		DoB:	
Contact details:			
Name of GP or surgery:			

If the **source is known** and risk information cannot be completed by the patient, the ED should contact the source's GP to obtain the information. Alternatively, contact the source directly to attend the ED for a risk assessment and bloods for BBVs (Hep B Surface Antigen, Hep C Antibodies, HIV Antibodies). Counsel the source and seek written consent to obtain a blood sample. Explain to the source patient why it is necessary to undergo a risk assessment by asking the questions below whilst maintaining the source's privacy, dignity, and confidentiality during the assessment.

If the source is concerned at all about any of the specific questions or declines to answer please take the opportunity to discuss this with them. Also, they may wish to just answer question 6.

If the source answers **Yes** to any of the following the clinician prescribing the PEP should be informed that the source is potentially high risk for HIV, whether the source consents to testing or not. The source should be offered a discussion with one of the GUM Health Advising Team.

e) Source Risk factors		Yes	No
1	Was the source born outside of Europe, in Australia or the United States?		
2	If the source is male, have they had sexual relationships with other men?		
3	Has the source injected drugs into their veins in the past?		
4	Has the source had a blood transfusion or operation outside of Europe, in Australia or the United States?		
5	Has the source had a sexual partner who originates from outside of Europe, from Australia or the United States?		
6	One or more of the above applies to the source		

f) Source Risk factors already known to clinical team		Yes	No
1	HIV antibody positive		
2	Hepatitis C antibody positive		
3	HCV RNA positive		
4	HBsAg positive		
5	HBeAg positive		
6	HBV DNA > 10 ³ copies/ml		

Emergency Department to complete:

Time Seen: HIV PEP required: Yes / No Prescribed: Yes / Declined

HBIG advised / prescribed: Yes / No / Declined Given: Yes / No

Hep B Booster advised / prescribed: Yes / No / Declined / Not given – will arrange with GP

Tetanus Booster advised / prescribed: Yes / No / Declined / Not given – will arrange with GP

Referral to GUM advised: Yes / No / Declined

Referral to recipient's own GP:

Send a copy with the electronic discharge to the GP including this risk assessment by mail. Do not give the risk assessment to the recipient as it may contain sensitive information about the source.

Message to GP:

This patient attended the Emergency Department with a contamination injury in the community detailed above. Blood has been taken for serology and for the serum to be saved. They have been given a dose of hepatitis B vaccine. To complete the accelerated course, please give further doses of hepatitis vaccine in four weeks and eight weeks.

Treating doctor details:

Signature: Date: T

Time:

Name in CAPITALS:..... Designation:

Source Consent Form ~ Testing for BBVs

Appendix D

This form is to be completed with the individual who is the Source of the exposure (or the parent / guardian of the Source).

Source name:		DoB:	
Hospital No.		Ward / Dept.	

I understand an incident has occurred where a member of staff has been exposed to my blood and/or body secretions.

I have read or been informed of the content of the 'Source Patient Testing Information Leaflet' and have had the opportunity to discuss this with the Doctor or Health Advisor (the Competent Person) named below.

I understand that if I consent to having my blood tested, the results will only be treated strictly as **Medical in Confidence** and that only for the purposes of determining any appropriate treatment will the results be shared with the affected member of staff via a nurse in the Trust's Occupational Health & Wellbeing Department.

a) To be completed by the Source

I DO / DO NOT* consent to my blood being tested for blood-borne viruses (Hepatitis B, Hepatitis C & HIV).

I DO / DO NOT* consent for the blood-borne virus results to be shared confidentially with a nurse in the Trust's Staff Health & Wellbeing Department.

(*delete as appropriate).

Signature: (*Parent/Guardian if applicable)

*Name of Guardian/Parent (CAPITALS): Date:

b) To be completed by the Competent Person

Recipient's name:		DoB:	
Employer		Ward / Dept.	

I have given or read the contents of the 'Source Patient Testing Information Leaflet' to the Source.

I will copy or fax the form to;

The Nurse Team, Occupational Health and Wellbeing Department, Kingstor House, Derriford Residences, Derriford Hospital, Plymouth. PL6 8DH

Fax No. 53589 (01752 763589)

I will then file form in the Source's case notes.

Signature: Date: Time: am / pm

Name in CAPITALS: Designation:

A member of staff involved in your care has sustained a contamination injury (by means of a needle / scratch / bite body fluid splash) during the course of your treatment. The nature of the injury is that there is a risk that the member of staff could have become infected with a virus you might be carrying without your knowledge.

It is LSW Policy and the Department of Health guidance that we approach you in order to gain consent to screen a sample of your blood for the most common blood borne viruses: Hepatitis B; Hepatitis C and HIV. You can decline the tests but if you are considering this, please discuss your concerns with the clinician who is coordinating the incident.

Should you consent to testing, this will help ensure that the injury sustained by the health care worker can be managed appropriately and that you have access to specialist help should it be necessary.

Before having blood taken the following points will be explained:

- Ways in which Hepatitis B, Hepatitis C and HIV viruses are transmitted (can include sexual intercourse, intravenous drug use, receiving a blood transfusion prior to 1991).
- The tests and your right to decline.
- A negative test will NOT affect life assurance applications or existing policies.
- Perceived insurance difficulties if the result of testing is positive – existing insurance will not be affected; a negative test will not affect future insurance applications. Specialist companies will offer insurance (but exclude the BBV).
- Written consent from you to test a sample of your blood for Hepatitis B, Hepatitis C and HIV
- Management of blood test and results including who will give you the results and how you wish to receive the results.

Advantages for testing for you:

- Identification of previously unknown disease so that treatment can be started as soon as possible
- Opportunity to be referred to an appropriate specialist
- Sexual partners may be protected
- Plans for the future can be made.

Disadvantages of testing for you:

- Anxiety
- Possible adverse impact on relationships with family

Blood Test Results

The results of the tests will be treated strictly as **Medical in Confidence**. Only for the purposes of reassurance and determining any appropriate treatment will the results be shared with the affected member of staff. This will be undertaken confidentially via the LSW's Occupational Health & Wellbeing Department.

Medical Confidentiality will be maintained at all times

We thank you for your co-operation.

Blood Tests Required - a 'Serum Save' blood sample to be obtained by the Competent Person (or colleague) and sent to the Laboratory before proceeding to ED.



Use a Gold top Vacutainer bottle for the 'Serum Save' sample

The **Request Form** must be completed as the example below (the form uses old terminology so the box entitled 'Needlestick Recipient' should be filled in all cases of Contamination).

Ensure all areas shaded are completed on the request form

DEPARTMENT OF MICROBIOLOGY - SEROLOGY/VIROLOGY REQUEST
Derriford Hospital, Derriford Road, Plymouth PL6 8DH - Tel: 01752 792387 Fax: 01752 517725

CPA Accredited

Please complete the form in CAPITAL letters and in BLACK ink only. Place one letter in each box within the box boundaries. Fields marked * are MANDATORY. When selecting information using the check boxes place a line within the box to obscure it like this: Do not cross through boxes like this:

* Hospital No: [] [] [] [] [] [] [] [] [] []
* AHS No: [] [] [] [] [] [] [] [] [] []
* Surname: MOUSE [] [] [] [] [] [] [] [] [] [] [] []
* Forename: MICKEY [] [] [] [] [] [] [] [] [] [] [] []
* D.O.B. (dd/mm/yyyy): 01 / 01 / 2001 Sex: Male Female
If you have an address label please place it inside this pink box

* Private * NHS * Sample NOT to be used for education?
* GP / Consultant Code: JOHNSTON [] [] [] [] [] [] [] [] [] [] [] []
* Ward/OP code: OH4WB [] [] [] [] [] [] [] [] [] [] [] []

* Sample date (dd/mm/yyyy): 07 / 05 / 14 * Time as 24 hr format (hh:mm): 14:00
* Clinical Details: (Please include antibiotic treatment, foreign travel, symptoms, duration etc): SERUM SAVE
* Onset Date (dd/mm/yyyy) MANDATORY: [] [] [] [] [] [] [] [] [] [] [] []

Antibiotic Assays
Vancomycin Pre Post
Gentamicin Pre Post
Tobramycin Pre Post
* Last Dose* (dd/mm/yyyy): [] [] [] [] [] [] [] [] [] [] [] []
Chlamydia PCR on: Other
Cervical Urethral Urine Eye

Other tests:
[] [] [] [] [] [] [] [] [] [] [] []

C Reactive Protein (CRP)
Viral Serology (Red or Yellow top dotted blood)
Antenatal screen with HIV
Antenatal screen with NO HIV
HBsAg
HCV Antibodies
HIV Antibodies
H.pylori Ag Test (stool sample required)
Needlestick (donor)
Needlestick (recipient)
Post vaccination Hep' B
Rubella IgG
Syphilis
VZ IgG (Chicken pox immunity)

FOR LABORATORY ONLY
Place barcode within this box

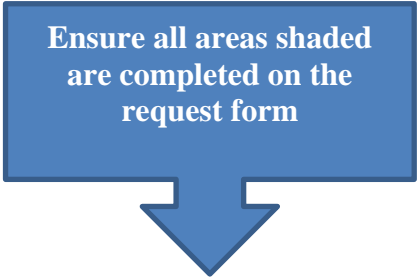
The **Request Form** must be completed as the example below (the form uses old terminology so the box entitled 'Needlestick Donor' should be filled in all cases of Contamination).

Tests Required – Hepatitis B surface antigen, HIV and Hepatitis C Antibodies.



Gold top Vacutainer bottle for the 'Source' sample

If the **Source** is a **High Risk** write this on the form so that the sample can be tested urgently (with the result available in 2hrs. if possible).



DEPARTMENT OF MICROBIOLOGY - SEROLOGY/VIROLOGY REQUEST
 Derriford Hospital, Derriford Road, Plymouth PL6 8DH - Tel: 01752 792387 Fax: 01752 517725

CPA Accredited

*Please complete the form in CAPITAL letters and in BLACK ink only. Place one letter in each box within the box boundaries. Fields marked * are MANDATORY. When selecting information using the check boxes place a line within the box to obscure it like this. Do not cross through boxes like this.*

* Hospital No: (IF KNOWN) Private NHS Sample NOT to be used for education?

* NHS No: GP / Consultant Code

* Surname: OTHER Ward/GP code

* Forename: ANN

* D.O.B. (dd/mm/yyyy): 24/01/1966 Sex: Male Female Requester signature/Bleep no. [Signature]

* Sample date (dd/mm/yyyy): 07/05/14 * Time as 24 hr format (hh:mm): 15:00

* **Clinical Details:** (Please include antibiotic treatment, foreign travel, symptoms, duration etc)
 POST CONTAMINATION INCIDENT TESTING URGENT*

Antibiotic Assays
 Vancomycin Pre *
 Gentamicin Post
 Tobramycin Random
 Last Dose* DD/MM hh:mm

Chlamydia PCR on: Other
 Cervical Urethral Urine Eye

Other tests:

C Reactive Protein (CRP)

Viral Serology (Red or Yellow top clotted blood)
 Antenatal screen with HIV
 Antenatal screen with NO HIV
 HBsAg
 HCV Antibodies
 HIV Antibodies
 H.pylori Ag Test (stool sample required)
 Needlestick (donor)
 Needlestick (recipient)
 Post vaccination Hep' B
 Rubella IgG
 Syphilis
 VZ IgG (Chicken pox immunity)

FOR LABORATORY ONLY
 Place barcode within this box

This is a combination of vaccines and oral medicines that are prescribed when an individual suffers a contamination incident in which the Source is actually or potentially HIV positive.

Headings	Key points
Sharps Guidelines and protocol (24-hour cover)	Risk assessment of exposure to determine if significant. Immediate access to advice on HIV PEP 24 hours, 7 days a week. Baseline member of staff serum stored for 2 years.
Source patient	Universal approach to source patient testing for antibodies to HIV. Source patient should be consented and a blood sample obtained, and consider risk for HBV and HCV. Guidelines clarify the implications of the Human Tissue Act 2004 and the Mental Capacity Act 2005 with regard to testing incapacitated source (adult) patients for serious communicable diseases without consent. Recommended good practice is that hospitals should have the capacity to obtain a source patient HIV test result within 8 hours (ideally) and no longer than 24 hours after blood is obtained.
Factors influencing transmission	Deep injury. Visible blood on the device. Needle from source patient's artery or vein. Terminal HIV-related illness in source patient.
Transmission rate: Low	3:1000 percutaneous. <1:1000 mucocutaneous. No risk where intact skin is exposed to HIV-infected blood.
Drugs (starter pack triple therapy HIV PEP)	One Truvada tablet (300mg tenofovir and 200mg emtricitabine-FTC) once a day. <i>plus</i> Two Kaletra film-coated tablets (200mg Lopinavir and 50mg Ritonavir) twice a day. <i>No antiretroviral drug has been licensed for HIV PEP, so must be prescribed on an 'off-label' basis only.</i>
Timing of HIV PEP	Initiated as soon as possible after the exposure, ideally within an hour following a careful risk assessment. PEP is now not generally recommended after 72 hours post-exposure.
Follow-up	Recommended follow-up period after occupational exposure to HIV, as a minimum, is now for at least 12 weeks after the HIV exposure, or if PEP was taken, for at least 12 weeks from when PEP was stopped. Longer follow-up with additional testing may be indicated in complex cases; e.g. member of staff is immunocompromised, member of staff experiences illness compatible with acute retroviral syndrome, or the source patient is dually infected.

Where the Source is the member of staff, PEP for HIV should only be offered following a positive test in the member of staff. This recognises that member of staff who are following the DH guidance are at low-risk for HIV infection and that there are considerable practical difficulties to administering PEP in the immediate post-operative period (e.g. obtaining valid consent, possible need for parenteral administration and toxicity of PEP for sick patients). Only in exceptional circumstances would it be warranted to initiate PEP in the absence of a positive HIV test result e.g. high likelihood of HIV infection in the member of staff and/or refusal of the member of staff to be tested.

A 28-day course of treatment with a triple combination of antiretroviral drugs is normally used and needs to be commenced rapidly for maximum efficacy. Particular consideration will need to be paid to the risk/benefit ratio of PEP for sick patients whose ability to tolerate antiretroviral therapy may be compromised. A higher threshold for commencing PEP may be appropriate because of the high incidence of side effects. Advice from GUM consultant on the best combination to use may be necessary for patients with systemic organ failure/organ insufficiencies.

In patients who are nil-by-mouth, antiretroviral drugs are available in a number of formulations suitable for naso-gastric or intravenous administration. If a patient is unconscious, PEP should not be withheld on the grounds that they are unable to consent, if clinical judgement deems it to be in their best clinical interests.

If a child is exposed, specialist advice from a paediatrician with experience in HIV should be sought.

This leaflet is to help you decide whether to take post exposure prophylaxis (PEP) following an actual or potential exposure to a BBV (blood borne virus).

Is the service confidential? All information discussed between you and the doctor is confidential.

What risk assessment is required? The doctor will discuss the risks of you becoming infected with you. This is based on the source (the person whose blood or other body fluid you were exposed to), and the type of injury.

Are there risks with PEP? The doctor will go through your medical history with you. They will also discuss the medication you're taking, to ensure there are no drug interactions.

What if I'm pregnant? This does not preclude use of PEP, but if this is the case, the GU consultant will discuss this with you in detail.

What are the risks of developing HIV? The worst case scenarios are that, following a needlestick-type injury, your risk is 1:300. Following a splash-type injury, the risk is about 1:1000. The risk is reduced by about 80% if you take PEP.

What are the side effects? The PEP can make you feel unwell, and a significant number of people stop the medication because of this. The main symptoms are nausea and diarrhoea. Less commonly, there can be problems with your liver and kidneys, bone marrow suppression, or pancreatitis.

When should I start PEP? The ideal time is within 1-4 hours, but it can be used up to 72 hours after the exposure.

What is the blood test for? You have an initial blood test done. This is only stored. If subsequently you do become HIV positive, this blood will be tested, to clarify whether you were HIV positive before the incident.

Can I work on PEP? If you feel well, you can continue to work normally. There is no need to restrict you from any work, including exposure prone procedures. If you don't feel well on the medication, the time off sick will not be recorded as normal sickness absence.

What about safe sex? You are advised to practise safe sex until the follow up period is complete. Likewise, you are advised not to try and fall pregnant, or to breast feed. You should not donate blood.

When will I be reviewed? You will be seen every week for 4 weeks. You will then be reviewed at 6-8 weeks, and 10-12 weeks. If the HIV after 12 weeks is negative, it is unlikely that you will become HIV positive.

PEP for Hepatitis B may be recommended following exposure to Hepatitis B and consists of a course of immunoglobulin with or without a booster dose of Hepatitis B vaccine.

HBV status of person exposed	Significant Exposure			Non-significant	
	HBsAg positive source	Unknown source	HBsAg negative source	Continued risk	No further risk
1 dose HB vaccine pre-exposure	Accelerated course of HB vaccine* HBIG x 1	Accelerated course of HB vaccine*	Initiate course of HB vaccine	Initiate course of HB vaccine	No HBV PEP Reassure
2 doses HB Vaccine pre-exposure (anti-HBs not known)	One dose of HB vaccine followed by second dose one month later	One dose of HB vaccine	Finish course of HB vaccine	Finish course of HB vaccine	No HBV PEP Reassure
Known responder to HBV vaccine (anti-HBs 10 miU/ml)	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster of HB vaccine	No HBV PEP Reassure
Known <u>non-responder</u> to HB vaccine (anti-HBs <10 miU/ml 2-4 months post-vaccination)	HBIG x 1 Consider booster dose of HB vaccine	HBIG x 1 Consider booster dose of HB vaccine	No HBIG Consider booster dose of HB vaccine	No HBIG Consider booster dose of HB vaccine	No HBV PEP Reassure

*An accelerated course of vaccine consists of doses spaced at 0, 1 and 2 months. A booster dose may be given at 12 months to those at continuing risk of exposure to HBV

Being informed that you have tested positive to a blood borne virus (BBV) can be devastating; involve psychological effects, emotional trauma; hardship and inconveniences to you, your family and friends. The impact cannot be underestimated and in view of the seriousness of a positive result, the OH&WB Team will ensure that a support mechanism is in place to support you.

You will see or have seen an Occupational Physician to discuss your own situation, and it is important that you read these notes carefully and keep them for later reference.

Obligations to your Patients

There is a risk that Healthcare workers who are infected with a BBV may pass the infection to a patient.

You have an overriding ethical and legal duty to protect the health and safety of patients and colleagues. You must consider your personal accountability as set out in the codes of professional bodies such as the NMC, GMC and GDC and also the Health and Safety at Work etc. Act 1974. You must keep yourself informed and updated on the codes of professional conduct and guidelines with reference to BBV infected staff.

You must not rely on your own assessment of the risks you pose to patients or others. You must have appropriate medical supervision of your clinical condition and take advice regarding risks to close family members and also regarding the need to inform your dentist or surgeon of your condition when undergoing procedures. You must also attend appointments with the Occupational Physician as deemed appropriate. When applying for new jobs you must declare your condition confidentially to PHCH / OH&WB Department or the Occupational Health Department of your new organization.

You must take particular care to observe good practice in control of infection matters including regular hand washing, wearing gloves where appropriate, covering existing wounds or skin lesions with waterproof dressings and avoiding contamination injuries. Always dispose of sharps correctly.

Exposure Prone Procedures (EPPs)

Health Care Workers with certain BBVs must not undertake EPPs. These are procedures where there is a risk that an injury to the worker may result in the patient's open tissues being exposed to the worker's blood. This is where the worker's gloved hands may be in contact with sharp instruments or spicules of bone or teeth inside a patient's open body cavity or wound where the hands and fingertips may not be completely visible at all times.

The Occupational Physician will explain to you whether or not you are permitted to do exposure prone procedures, and will give you specific advice regarding what procedures in your own workplace you are permitted to do.

Procedures which are not usually classified as exposure prone and may be undertaken even by workers whose practice is restricted include:

- Internal examinations where sharp instruments are not involved
- Giving injections, taking blood, inserting venflons
- Wound dressings, draining superficial abscesses
- Lumbar puncture, paracentesis
- Urethral catheterisation
- Cardiac and respiratory resuscitation including mouth-to-mouth resuscitation (if you are the only person available to do this), endotracheal intubation. Internal direct cardiac massage is excluded.

“Reverse Incidents”

In exceptional circumstances a patient may be exposed to your blood despite all precautions. In these circumstances you must stop the procedure immediately. The incident must immediately be reported to both OH&WB and to one of the Infectious Diseases Consultants or to the Consultant Microbiologist on call. These doctors will assess the risk to the patient and whether further action is necessary. 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.

Confidentiality

You have a right to confidentiality regarding your condition.

In certain circumstances where a change of duties is necessary (for example to avoid exposure prone procedures) advice will be given to your manager with regard to your duties but the diagnosis will not be divulged. In these circumstances, the need to provide such advice, how it will be given and the wording used will be discussed beforehand with you.

In rare cases when it is thought that patients may have been exposed to blood borne viruses from a health care worker, a “look back” exercise may need to be discussed with public health doctors and senior managers. In these circumstances the health care worker’s right to confidentiality is vigorously protected but inevitably certain senior professionals would need to know the diagnosis.

The OH&WB Team will never divulge your diagnosis to your manager or employer without your knowledge.

Health Surveillance & Review


The OH&WB Team will keep you under review at appropriate intervals. You must attend these appointments. The purpose of this is to:

- Review your general health and liaise with your clinician as necessary.
- Review your duties and the tasks you are required to perform, and to identify any aspects of your job that are a potential risk to patients or colleagues.
- Ensure your work is not putting you at risk, e.g. if you are unwell or immuno-suppressed.

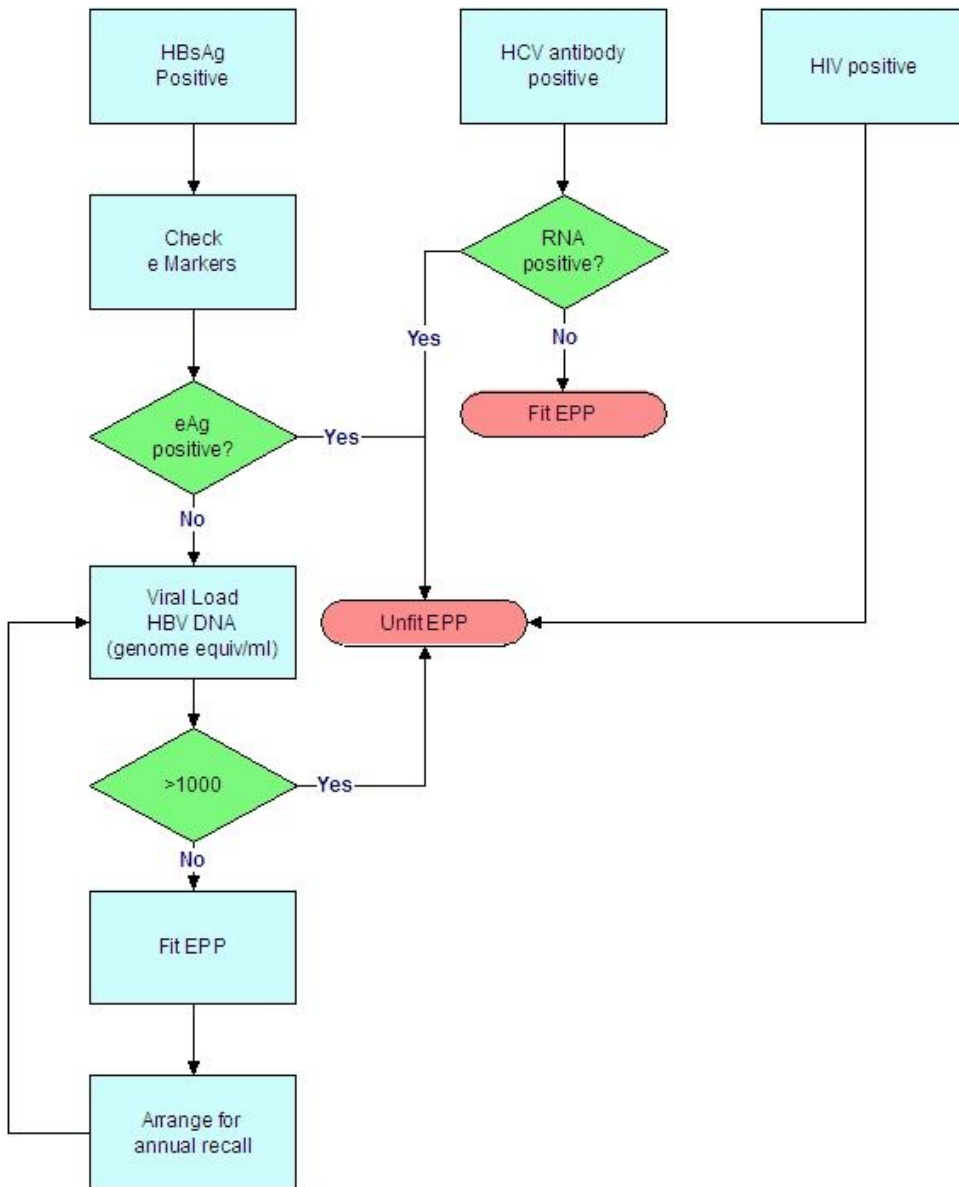
- Discuss any other problems in your workplace regarding confidentiality or difficulties arising because of the need to avoid certain activities.
- Give advice regarding career progression and to discuss proposed moves to new areas of work.
- Give you an opportunity to discuss any wider implications of your condition that you have not otherwise had a chance to discuss with a physician. We may be able to refer you for further specialist advice.

Department Contact Details

Occupational Health & Wellbeing Department

 **Ext. 37222** Mon - Fri 8am to 4pm + answer phone out-of-hours

 plh-tr.OccHealth-DutyNurse@nhs.net



This table should list all the staff groups that require this training as shown below. Consideration must be given to how this training can be accessed by all staff groups including, temporary staff, bank staff, part-timers, full-timers and volunteers.

Staff group	Core knowledge required The learner will:	Core skills required The learner will have the ability to:	Mode of delivery	How can this training be accessed by part-timers; temporary; bank/agency staff; volunteers
All new staff (and existing staff moving between Departments)	Gain an awareness of the Management of Contamination Incidents SOP	undertake first aid and report to the Line Manager	Corporate Induction presentation (with handbook). Local Dept. induction	On initial appointment at Corporate and Local induction
<ul style="list-style-type: none"> • Any member of staff who may manage a Contamination Incident • OH&WB clinical staff • Infection Control • Emergency Dept clinical staff 	Gain an understanding of: <ul style="list-style-type: none"> • The ways in which to prevent and reduce the incidence of Contamination Incidents • The appropriate procedures to follow if Contamination Incidents occur 	prevent and manage a Contamination Incident	e-Learning Corporate updates	Existing staff should update on a yearly basis
Groups of Staff (or individuals) identified by trend analysis of incidents	Update their understanding and awareness of: <ul style="list-style-type: none"> • The ways in which to prevent and reduce the incidence of Contamination Incidents • The appropriate procedures to 	prevent and manage a Contamination Incident	e-Learning Corporate updates Instruction and Guidance from Occupational Health & Wellbeing Department /	As and when identified

	follow if Contamination Incidents occur		Health & Safety Department	
Members of Staff who are appointed as Competent Persons by their Line Managers	<p>Gain understanding and awareness of:</p> <ul style="list-style-type: none"> • the epidemiology of BBV infection, • the risk of transmission in a health care setting • the management of contamination incidents as outlined in this SOP and related policies. 	manage the responsibilities in the event of a Contamination Incident	The Health Advisors within the Department of GUM	As and when identified

Review		
Title	Is the title clear and unambiguous?	Yes
Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?		Yes
Does the style & format comply?		Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
Are people involved in the development identified?		Yes
Has a reasonable attempt has been made to ensure relevant expertise has been used?		Yes
Is there evidence of consultation with stakeholders and users?		Yes
Content	Is the objective of the document clear?	Yes
Is the target population clear and unambiguous?		Yes
Are the intended outcomes described?		Yes
Are the statements clear and unambiguous?		Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
Are key references cited and in full?		Yes
Are supporting documents referenced?		Yes
Approval	Does the document identify which committee/group will review it?	Yes
If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?		Yes
Does the document identify which Executive Director will ratify it?		Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
Does the plan include the necessary training/support to ensure compliance?		Yes
Document Control	Does the document identify where it will be held?	Yes
Have archiving arrangements for superseded documents been addressed?		Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
Is there a plan to review or audit compliance with the document?		Yes
Review Date	Is the review date identified?	Yes
Is the frequency of review identified? If so is it acceptable?		Yes

Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes
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