Notice to staff using a paper copy of this guidance

The policies and procedures page of Healthnet holds the most recent and approved version of this guidance. Staff must ensure they are using the most recent guidance.

Author          Director of Infection Prevention & Control.

Asset Number    29
**Reader Information and Asset Registration**

<table>
<thead>
<tr>
<th>Title</th>
<th>Inoculation (Contamination) Incidents incorporating Blood Borne Virus Standard Operating Procedure. V.1.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Asset Register Number</td>
<td>29</td>
</tr>
<tr>
<td>Rights of Access</td>
<td>Public</td>
</tr>
<tr>
<td>Type of Formal Paper</td>
<td>Policy</td>
</tr>
<tr>
<td>Category (Please identify type)</td>
<td>Clinical</td>
</tr>
<tr>
<td>Format</td>
<td>Word Document/PDF</td>
</tr>
<tr>
<td>Language</td>
<td>English.</td>
</tr>
<tr>
<td>Subject</td>
<td>This Standing Operating Procedure (SOP) sets out the procedures to be followed in the event of a Contamination Incident.</td>
</tr>
<tr>
<td>Document Purpose and Description</td>
<td>This SOP aims to: Ensure that individuals who are the recipients of a contamination injury receive effective and appropriate care.</td>
</tr>
<tr>
<td>Author</td>
<td>Director of Infection Prevention &amp; Control.</td>
</tr>
<tr>
<td>Ratification Date and Group</td>
<td>26th July 2012. Policy Ratification Group</td>
</tr>
<tr>
<td>Publication Date</td>
<td>15/08/2012</td>
</tr>
<tr>
<td>Review Date and Frequency of Review</td>
<td>15/08/2014</td>
</tr>
<tr>
<td>Disposal Date</td>
<td>The Policy Ratification Group will retain an e-signed copy for the database in accordance with the Retention and Disposal Schedule; all previous copies will be destroyed.</td>
</tr>
<tr>
<td>Job Title of Person</td>
<td>Director of Infection Prevention &amp; Control.</td>
</tr>
<tr>
<td>Responsible for Review</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Target Audience        | All Staff.  
| Circulation List       | Electronic: Plymouth Healthnet and PCH website  
|                        | Written: Upon request to the Policy Ratification Secretary on 01752 435104.  
|                        | Please note if this document is needed in other formats or languages please ask the document author to arrange this.  
| Consultation Process   | Infection Control Team  
|                        | Consultant Medical Microbiologists  
|                        | Infection Control Committee  
|                        | Clinical Governance Steering Group  
|                        | Risk Management  
| Equality Analysis Checklist completed | Yes.  
| References/Source      | See section 13.  
| Supersedes Document    | New document  
| Author Contact Details | By post: Local Care Centre Mount Gould Hospital  
|                        | 200 Mount Gould Road  
|                        | Plymouth  
|                        | Devon PL4 7PY  
|                        | Tel: 0845 155 8085  
|                        | Fax: 01752 272522 (LCC Reception)  
| Publisher: (for externally produced information) |  

Plymouth Community Healthcare have adopted this policy and procedure from Plymouth Hospitals NHS Trust (PHNT).

Please note where reference is made to PHNT or PHNT staff this would also apply to Plymouth Community Healthcare (PCH).

Brenda Dale
Director of Infection Prevention & Control. (PCH).

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Purpose and Scope</td>
<td>7</td>
</tr>
<tr>
<td>2 Definitions</td>
<td>7</td>
</tr>
<tr>
<td>3 Regulatory Background</td>
<td>9</td>
</tr>
<tr>
<td>4 Key Responsibilities</td>
<td>10</td>
</tr>
<tr>
<td>5 Training</td>
<td>11</td>
</tr>
<tr>
<td>6 Monitoring and Assurance</td>
<td>11</td>
</tr>
<tr>
<td>7 Document Ratification, Dissemination and Implementation Process</td>
<td>12</td>
</tr>
<tr>
<td>8 Step-by-Step Guide for the Management of a Contamination Incident by the Affected Member of Staff</td>
<td>13</td>
</tr>
<tr>
<td>9 Step-by-Step Guide for Contamination Incident Management by the Competent Person</td>
<td>15</td>
</tr>
<tr>
<td>10 Step-by-Step Guide for the Management of a Contamination Incident by the Emergency Department (ED)</td>
<td>17</td>
</tr>
<tr>
<td>11 Step-by-Step Guide for the Management of a Contamination Incident by the Staff Health &amp; Wellbeing Department (SH&amp;WB)</td>
<td>21</td>
</tr>
<tr>
<td>12 Step-by-Step Guide for the Management of a Contamination Incident where a Patient is Contaminated by a member of Staff “Reverse Incident”</td>
<td>26</td>
</tr>
<tr>
<td>13 Reference Material</td>
<td>27</td>
</tr>
</tbody>
</table>

### Appendices

<table>
<thead>
<tr>
<th>Reference Material</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A “What do I do in the Event of a Contamination Incident?” Flowchart</td>
<td>28</td>
</tr>
<tr>
<td>B Contamination Incident Risk Assessment Form (NHS Staff)</td>
<td>29</td>
</tr>
<tr>
<td>C Contamination Incident Risk Assessment Form (Non NHS / Member of Public)</td>
<td>33</td>
</tr>
<tr>
<td>D Source Consent Form for BBV Testing</td>
<td>36</td>
</tr>
<tr>
<td>E Information Leaflet - Source BBV Testing</td>
<td>37</td>
</tr>
<tr>
<td>F Completing the Member of Staff’s Laboratory Request Form for “Serum Save”</td>
<td>38</td>
</tr>
<tr>
<td>G Completing the Source’s Laboratory Request Form for “BBV Screen”</td>
<td>39</td>
</tr>
<tr>
<td>H HIV Post Exposure Prophylaxis (PEP)</td>
<td>40</td>
</tr>
<tr>
<td>I Information Leaflet – HIV PEP</td>
<td>41</td>
</tr>
<tr>
<td>J Hepatitis B Post Exposure Prophylaxis (PEP)</td>
<td>42</td>
</tr>
<tr>
<td>K Information Leaflet – Members of Staff with a BBV</td>
<td>43</td>
</tr>
<tr>
<td>L Assessing Fitness for EPP Work – Staff Who Are BBV Positive</td>
<td>45</td>
</tr>
<tr>
<td>M</td>
<td>Training needs Analysis</td>
</tr>
<tr>
<td>----</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>N</td>
<td>Review and Approval Checklist</td>
</tr>
</tbody>
</table>

1 Purpose and scope

PCH 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 splash of body fluid into member of staff’s eyes, mouth or nose
- A splash 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
- **visibly blood-stained** vomit
- **visibly blood-stained** saliva
- **visibly blood-stained** faeces

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

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

Transfer of a blood-borne virus can occur when blood, or blood-stained body fluids from the infected individual comes in contact with an uninfected individual’s open skin lesions or mucous membranes

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 Staff Health and Wellbeing Department (SH&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 **Competent Person** – the Competent Person is a senior nurse or the Night Matron out of hours, or a doctor caring for the Source patient. They are familiar with 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.

Appropriate training will be delivered by the GUM Department regarding all aspects of the role.

2.10 **Recipient** - refers to the person who has been contaminated.

2.11 **Source** - refers to the origin of the contaminant.

2.12 **DATIX** - is the Incident Reporting System used by PCH.

2.13 **OPAS** – is the Occupational Health Computerised Management System used by the Staff Health & Wellbeing Department (SH&WB).

### 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.
Key Responsibilities

The Chief Executive:
- 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.

Line Managers / Persons in charge of an area where Contamination Incidents may occur have a responsibility for:
- Ensuring that Competent Persons are appointed and receive training in the requirements of the role.
- Referring affected staff to a Competent Person
- Ensuring emotional support is provided to the member of staff
- Documenting findings and actions on DATIX

The Competent Person has a responsibility for:
- Ensuring they are competent to undertake the duties required of them.
- Completing the contamination incident risk assessment form immediately after the member of staff has been referred to them.
- Obtaining (or organising a colleague to obtain) a blood sample from the Member of Staff for ‘Serum Save’.
- Obtaining (or organising a colleague to obtain) a blood sample from the Source (with consent) and arranging testing for BBVs and informing the Source of the results.
- Referring members of staff who suffer a significant exposure to ED immediately.
- Giving the completed risk assessment form to the Member of Staff if they are to report to ED.
- Sending the completed risk assessment form to SH&WB in the case of a low risk incident.
- Informing the member of staff of the Source’s Negative blood results within 24hrs.

The Staff Health & Wellbeing Department (SH&WB) has responsibility for:
- Supporting affected members of Staff.
- Recording all Contamination Incidents on OPAS
- Providing advice where appropriate on the risk assessment, clinical management and follow-up care of staff following a contamination incident.
- Providing confidential advice and support to affected members of staff in the event of a contamination incident.
- Informing relevant parties via DATIX where the policy has not been followed correctly.
- Informing PCH’s Health & Safety Department and Health Protection Agency (HPA) where there is a RIDDOR Reportable Contamination Incident (where a Source is positive to a BBV).
- Organising the health surveillance of an affected member of staff.
- Providing information and training for staff in the management of contamination incidents.
- 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 SH&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.
- Training of Competent Persons

**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.

**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 HIV test results.
- 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 if it was carried out whilst an in-patient.

## 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 PCH. 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 SH&WB Nurse Manager will assign a nurse or advisor to monitor the Management of each and every Contamination Incident via DATIX and through OPAS records. Where incidents are reported to SH&WB prior to being reported on DATIX, SH&WB will advise that DATIX should be completed without delay.

Where incidents have not been reported via DATIX, SH&WB will inform the member of Staff's Manager in writing (usually by e-mail). This will also be reported to the Committees listed below.

The monitoring and assurance process will be carried out by the SH&WB Department and results will be reported on a monthly basis to PCH's;
- Health & Safety Committee
- Infection Prevention Sub Committee
- Infection Control Committee

Where it is found that this procedure has not been followed, risk will be assessed and reported in line with PCH’s 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 Trust’s 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 the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the named group or committee and ratified by the named director or senior manager.

Non-significant amendments to this policy document may be made, under delegated authority from the named director or senior manager, by the nominated author. These must be ratified by the named director or senior manager and should be reported, retrospectively, to the named group or committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust’s formal documents library and all staff will be notified through the Trust’s normal notification process, currently the ‘Vital Signs’ electronic newsletter.

Document control arrangements will be in accordance with the Trust’s 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 named director or senior manager and for working with the Trust’s training function, 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.

![Bleed it](image)

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 to your Line Manager. If you are not in your usual place of work – inform the person in charge of the area you are in as soon as first aid has been administered – they will appoint a Competent Person to take you through the process.

Record the Incident via DATIX – if you need help with this inform your Line Manager or the person in charge of the area you are in.

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).

Significant Incident - you must go to ED with the completed risk assessment form within 1 hour of the incident. 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.

Non-Significant Incident – there is no further immediate action to take.

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

Follow-up Care - In every case you must report it to the Staff Health & Wellbeing Department 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.

Staff Health & Wellbeing Department Contact Details:
☎️ (4) 37222 Mon - Fri 8am to 4pm + answer phone out-of-hours

Log onto the main HealthNET Screen and ‘double click’ on the DATIX icon.

Complete the DATIX Incident Report Form giving as much information as possible.
The following guide has been arranged to help you in managing a Contamination Incident and will help you make the right decisions and give the right advice.

**The Competent Person** will be a senior nurse, the Night Matron out of hours or a doctor caring for the Source patient who has had training from the GUM Department. 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.

**Contamination Incident Standing Operating Procedure and associated forms** are available on Trust Docs (under Staff Health & Wellbeing) or via HealthNET

**Recipient** refers to the person who has been contaminated

**Source** refers to the origin of the contaminant

**Actions of the Competent Person**

- Ensuring they are competent to undertake the duties required of them. Members of staff who do not feel competent must seek appropriate training on pre-test discussion and completion of risk assessment forms from the GUM Department.
- Completing the contamination incident risk assessment form *(Appendix B)* immediately after the member of staff has been referred to them.
- Obtaining (or organising a colleague to obtain) a blood sample from the Member of Staff for ‘Serum Save’ *(Appendix F)*.
- Obtaining (or organising a colleague to obtain) a blood sample from the Source (with consent) and arranging testing for BBVs and informing the Source of the results.
- Referring members of staff who suffer a significant exposure to ED immediately.
- Giving the completed risk assessment form to the Member of Staff if they are to report to ED.
- Sending the completed risk assessment form to SH&WB in the case of a low risk incident.
- Informing the member of staff of the Source’s blood results within 24hrs. (if consented to do so).

**Care of the Source following a Contamination Incident**

The **Competent Person** will coordinate the following sequence of events in the event of a Contamination Incident occurring. This will ensure that the Source will be cared for appropriately and effectively and in a way that maintains their privacy, dignity, and confidentiality during the assessment.

**Explanation**

An explanation of the incident and the implications of it should be given to the Source (or their Parent/Guardian or next of Kin). The information leaflet *(Appendix E)* should also be issued.

**Contamination Risk Assessment Form**
The Contamination Risk Assessment Form (Appendix B) needs to be completed to determine the degree of risk. 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. They may wish to just answer question 6.

If the Source has answered yes to any of the questions, 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.

Consent

Consent to Test for BBVs (Appendix D) can be made by the Competent Person or a suitably competent deputy.

Reassurance surrounding the tests can be given to the Source that BBV testing is routinely conducted on 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).

If consent to test has been obtained, complete the request form making sure the relevant information is included – and must state only the tests that the Source has consented to (Appendix G).

Ensure the completed consent form is stored in the Source’s hospital records.

What to do if:

• **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 Antibodies1&2, Hepatitis B Surface Antigen and Hepatitis C Antibodies.

• **Source denies consent:** medico-legally no further progress can be taken; consider involvement of the GUM Dept. for assistance.

• **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).

• **Source lacks the capacity to consent:** follow guidance under the Mental Capacity Act 2005.

• **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.
Full details concerning consent can be found within the Trust Policy TRW/CGV/POL/216/6 Consent to Examination or Treatment. Please discuss with a senior member of the Source’s clinical team or GUM Team if you have any queries regarding consent.

Issues to be Considered in a Positive BBV Result

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.

Results of BBVs will normally be passed to the Source’s clinical team by The Competent Person or a suitably competent deputy. If the Source had been discharged the clinical team would be required to liaise with the Source’s GP regarding obtaining a sample for BBV testing.

Department Contact Details

GUM Dept. Health Advisors
☎ Ext. 31804

Staff 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

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 on Trust Docs (under Staff Health & Wellbeing) or via HealthNET

Recipient refers to the person who has been contaminated
Source refers to the origin of the contaminant

Section  Title
1  Staff working within PCH.
2  Staff working outside PCH 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 PCH

This will include PCH, Medical or Dental School students, PCH 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 (usually a line manager) 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.
   c. Ensure that an incident has been filed through DATIX. 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 SH&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 Staff 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 Staff 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, PEP may be indicated. Please consult the on-call Microbiologist or GUM Team in these cases for advice.
   k. The Recipient must also contact The Staff Health & Wellbeing Department. This is to ensure the correct support and health surveillance is organised.

2. Staff working outside PCH or employed by other NHS Trusts

Includes community PCH staff and some Dental and GP surgeries practices/clinics.

   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 Staff 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 PCH’s Staff 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 DATIX incident report does not need to be completed unless the incident has resulted because of a lapse in Trust 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.

<table>
<thead>
<tr>
<th>HBV status of person exposed</th>
<th>Significant Exposure</th>
<th>Non-significant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HBsAg positive source</td>
<td>Unknown source</td>
</tr>
<tr>
<td>1 dose HB vaccine pre-exposure</td>
<td>Accelerated course of HB vaccine* HBIG x 1</td>
<td>Accelerated course of HB vaccine*</td>
</tr>
<tr>
<td>2 doses HB Vaccine pre-exposure (anti-HBs not known)</td>
<td>One dose of HB vaccine followed by second dose one month later</td>
<td>One dose of HB vaccine</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Known responder to HBV vaccine (anti-HBs 10 miU/ml)</td>
<td>Consider booster dose of HB vaccine</td>
<td>Consider booster dose of HB vaccine</td>
</tr>
<tr>
<td>Known non-responder to HB vaccine (anti-HBs &lt;10 miU/ml 2-4 months post-vaccination)</td>
<td>HBIG x 1 Consider booster dose of HB vaccine</td>
<td>HBIG x 1 Consider booster dose of HB vaccine</td>
</tr>
</tbody>
</table>

*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

**Staff 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 Staff Health & Wellbeing Departments. Version 1

11 **Step-by-Step Guide for the Management of a Contamination Incident by the Staff Health & Wellbeing Department**

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

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 SH&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).

Contamination Incident Standing Operating Procedure and associated forms available on Trust Docs (under Staff Health & Wellbeing) or via HealthNET

**Recipient** refers to the person who has been contaminated  
**Source** refers to the origin of the contaminant

1. **Receiving Initial Calls:**

The majority of calls to SH&WB will be after the immediate actions and risk assessment have been carried out. However, Members of Staff will occasionally call SH&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 carried out without delay by the Competent Person or colleague (before attending ED if possible).
- **Has the incident been reported on DATIX?** If not, needs to be carried out without delay and before attending ED.
- **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 SH&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 HPA (Health Protection Agency), the HSE (Health and Safety Executive) and PCH’s 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 SH&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 SHWB Consultant or Senior Nurse is informed so that a care plan can be arranged.

e. On instruction from SHWB 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 DATIX where the policy has not been followed correctly.
s. Informs the Health & Safety Department and Health Protection Agency (HPA) 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 SH&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 Trust regarding suitable alternative work if required for the affected Member of Staff.

4. Health Surveillance Following a Contamination Incident

<table>
<thead>
<tr>
<th>Source HIV positive (see note a &amp; c)</th>
<th>Blood tests at 6 weeks</th>
<th>Blood tests at 3 months</th>
<th>Blood tests at 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source</td>
<td>HIV antibodies</td>
<td>HIV antibodies</td>
<td>HBsAg</td>
</tr>
</tbody>
</table>

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 SHWB 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 SHWB 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 $10^5$ 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 SH&WB and Specialist follow up. See DH (March 2007) 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 SHWB 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 SHWB nurse team will pass the results of the blood tests to the SHWB Consultant.
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 SH&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 SH&WB Department who will be responsible for obtaining consent and the collection of blood for BBV testing.
5. Complete an incident form on DATIX.

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 Trust 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 SH&WB consultant, GUM consultant, DIPC, The Health Protection Agency (HPA) and the Public Health Team as required.

### 13 Reference Material


- Department of Health. Hepatitis B infected HCWs and antiviral therapy. 2007.


- Health and Safety Executive The Reporting of Diseases, Dangerous Occurrences Regulations 1995. Available at: [www.riddor.gov.uk](http://www.riddor.gov.uk)


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

- **Member of Staff / Recipient**
  - Bleed it
  - Wash it
  - Rinse eyes or mucous membranes

- **Report it immediately** to Line Manager (or person in charge of area) who will appoint a Competent Person to Risk Assess

- **Competent Person**
  - Blood test needed from the Recipient: “Serum Save”
  - Complete Risk Assessment Form (Find on SHWB Page of HealthNET or Trust Documents)
  - Blood tests needed from the Source: Hep B Surface Antigen, Hep C Antibodies, HIV Antibodies

- **Non-significant Incident**
  - Any other type of incident - not listed in the significant incident box – Ring Staff Health & Wellbeing to report incident & plan your future care
  - Tel: (4) 37232 or 37212

- **Significant Incident**
  - High Risk Exposures include:
    - A deep puncture wound
    - Sharp 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 dentists
    - Unfiltered human tissues and organs, Excavative or other tissue fluid from tumors or gliomas
    - Any other visibly blood-stained body fluid (urine, vomit, saliva, lacrimation)
  - High Risk Sources:
    - Known BBV infections
    - Men who have sex with men. Intravenous drug users, Sex workers etc.

- **Attend ED within 1 hr** Phone ED Nurse on 52045 to notify them of your imminent arrival. Take completed risk assessment form with you

- **Ring Staff Health & Wellbeing Dept to report incident & plan your future care.**
  - Tel: (4) 37232 or 37212
Staff Health & Wellbeing Department

Contamination Incident Risk Assessment Form

Part 1 - This should be completed by the Competent Person.

<table>
<thead>
<tr>
<th>a) Recipient’s name:</th>
<th>DoB:</th>
</tr>
</thead>
</table>

Employer/Sector: PHNT / MOD / Serco / Medical or Dental School Student / UoP Student Nurse / Volunteer / Other:

Job / Role Title:

Time of Incident: Dept. where Incident occurred:

<table>
<thead>
<tr>
<th>b) Incident factors</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Indicate type of injury by placing a ✓ or X in the Yes or No columns)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Deep puncture wound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Sharps device was in source patient’s artery or vein</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Sharps device was visibly blood-stained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Sharps device has a hollow bore</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Visibly blood stained body fluid splashed into eyes, nose or mouth or onto non-intact skin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
c) **Body Fluid factors**
   (Indicate type of body fluid by placing a ✓ or X in the Yes or No columns)

<table>
<thead>
<tr>
<th>No.</th>
<th>Body Fluid</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Amniotic Fluid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Human breast milk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Vaginal secretions or semen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Cerebrospinal fluid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Peritoneal fluid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Pericardial fluid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Pleural fluid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Saliva in association with dentistry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Synovial fluid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Unfixed human tissues and organs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Exudative or other tissue fluid from burns or skin lesions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Any other <strong>visibly blood-stained body fluid</strong> (urine, vomit, saliva, faeces)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Source name:</th>
<th>DoB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital No.</td>
<td>Ward</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The competent person should explain to the source patient why it is necessary to undergo a risk assessment by asking the questions below whilst maintaining their 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 ‘Yes’ to 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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Was the source born outside of Europe, in Australia or the United States?</td>
</tr>
<tr>
<td>2.</td>
<td>If the source is male, have they had sexual relationships with other men?</td>
</tr>
<tr>
<td>3.</td>
<td>Has the source injected drugs into their veins in the past?</td>
</tr>
<tr>
<td>4.</td>
<td>Has the source had a blood transfusion or operation outside of Europe, in Australia or the United States?</td>
</tr>
<tr>
<td>5.</td>
<td>Has the source had a sexual partner who originates from outside of Europe, from Australia or the United States?</td>
</tr>
<tr>
<td>6.</td>
<td>One or more of the above applies to the source</td>
</tr>
</tbody>
</table>

f) Source Risk factors already known to clinical team

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>HIV antibody positive</td>
</tr>
<tr>
<td>2.</td>
<td>Hepatitis C antibody positive</td>
</tr>
<tr>
<td>3.</td>
<td>HCV RNA positive</td>
</tr>
</tbody>
</table>
4 Hepatitis B surface antigen positive
5 HBeAg positive
6 HBV DNA > 10^3 copies/ml

Please obtain ‘Serum Save’ from Recipient and send to Microbiology. Obtained: Yes / No

If ANY of the questions in sections B, C, E or F are answered as ‘YES’ the Recipient MUST go to the Emergency Department.

Referred to ED? Yes / No - If Yes, Recipient must ring ED Minors Nurse Ext 52045 to notify them of their imminent arrival and pass this completed form to the Recipient to take with them.

If not referred to ED - in order to comply with PHNT policy and to ensure the Recipient’s SH&WB records are updated and to plan their future care - please forward this form to: The Nurse Manager, Staff Health and Wellbeing Department, Kingston House, Derriford Residences, Derriford Hospital, Plymouth. PL6 8DH

Signature: ……………………………….. Date: ……………….. Time: …………… am / pm

Name in CAPITALS:……………………………… Designation: ……………………………

Part 2 - 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 / administered: Yes / No / Declined

Referral to GUM advised: Yes / No / Declined

In order to comply with PHNT policy and to ensure the Recipient’s SH&WB records are updated and to plan their future care this form or a copy of it must be sent to: The Nurse Manager, Staff Health and Wellbeing Department, Kingston House, Derriford Residences, Derriford Hospital, Plymouth. PL6 8DH

Signature: ……………………………………..Date: …………………….. Time: …………….

Name in CAPITALS:……………………………………….. Designation: …………………………...
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

<table>
<thead>
<tr>
<th>a) Recipient’s name:</th>
<th>DoB:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Incident:</th>
<th>Time of incident:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where Incident occurred:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>d) Source Known?</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, please complete this section.</td>
<td></td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

f) **Source Risk factors already known to clinical team**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**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 an 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: ....................... Time: .................
Name in CAPITALS: ........................................ Designation: ........................................
Source Consent Form – Testing for BBVs

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

<table>
<thead>
<tr>
<th>Source name:</th>
<th>DoB:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital No.</th>
<th>Ward / Dept.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I understand an incident has occurred where another person (a member of Trust 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:

…………………………………………
(Enter the name of the doctor or health advisor here)

I consent to my blood being tested for the following blood borne viruses:

Hepatitis B
Hepatitis C
HIV

I understand the results of these tests will be treated strictly as Medical in Confidence. Only for the purposes of determining any appropriate treatment will the results be shared with the affected member of staff confidentially via the Trust’s staff health & wellbeing department.

Signature: ………………………………………… *Source/Guardian if applicable

*Name of Guardian/Parent: …………………………………………………………………

Date: ……………………

Witnessed by (signature): …………………………………………………

Print name: …………………………………………………………………

Date: ………………………

Please store this form in the patient’s case notes

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.

How does this affect you?

It is Trust 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. This will help ensure that the injury sustained by the health care worker can be managed appropriately.

- If you test negative for these viruses, it will help reduce anxiety in the injured health care worker and assure you.
- If you test positive for these viruses it will enable appropriate treatment to be given to both you and the injured health care worker as soon as possible.

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
- Seek your agreement to test for Hepatitis B, Hepatitis C and HIV
- Make it clear you have the right to decline the test
- 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
- 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).

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 Trust’s Staff Health & Wellbeing Department.

Medical Confidentiality will be maintained at all times

Many thanks for your co-operation.
Completing the **Member of Staff's Laboratory Request Form**

**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
Completing the **SOURCE** Laboratory Request Form  

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).

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

#### Appendix H

**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.**

<table>
<thead>
<tr>
<th>Headings</th>
<th>Key points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sharps Guidelines and protocol</strong> (24-hour cover)</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Source patient</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Transmission rate:</strong> Low</td>
<td>3:1000 percutaneous. &lt;1:1000 mucocutaneous. No risk where intact skin is exposed to HIV-infected blood.</td>
</tr>
<tr>
<td><strong>Drugs (starter pack triple therapy HIV PEP)</strong></td>
<td>One Truvada tablet (300mg tenofovir and 200mg emtricitabine- FTC) once a day. PLUS Two Kaletra film-coated tablets (200mg Lopinavir and 50mg Ritonavir) twice a day. No antiretroviral drug has been licensed for HIV PEP, so must be prescribed on an 'off-label' basis only.</td>
</tr>
<tr>
<td><strong>Timing of HIV PEP</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Follow-up</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

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.
HIV Post Exposure Prophylaxis (PEP) Information Leaflet

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.

<table>
<thead>
<tr>
<th>HBV status of person exposed</th>
<th>Significant Exposure</th>
<th>Non-significant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HBsAg positive source</td>
<td>Unknown source</td>
</tr>
<tr>
<td>1 dose HB vaccine pre-exposure</td>
<td>Accelerated course of HB vaccine*</td>
<td>Accelerated course of HB vaccine*</td>
</tr>
<tr>
<td>2 doses HB Vaccine pre-exposure (anti-HBs not known)</td>
<td>One dose of HB vaccine followed by second dose one month later</td>
<td>One dose of HB vaccine</td>
</tr>
<tr>
<td>Known responder to HBV vaccine (anti-HBs 10 mIU/ml)</td>
<td>Consider booster dose of HB vaccine</td>
<td>Consider booster dose of HB vaccine</td>
</tr>
<tr>
<td>Known non-responder to HB vaccine (anti-HBs &lt;10 mIU/ml 2-4 months post-vaccination)</td>
<td>HBIG x 1 Consider booster dose of HB vaccine</td>
<td>HBIG x 1 Consider booster dose of HB vaccine</td>
</tr>
</tbody>
</table>

*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 SH&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 PCH’s SH&WB Department or the Occupational Health Department of your new Trust.

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

Health Surveillance & Review

The SH&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.
Assessing Fitness for EPP Work – Staff who are BBV Positive

- **HBsAg Positive**
  - Check e Markers
    - eAg positive?
      - Yes → FI EPP
      - No → Viral Load HBV DNA (genome equiv/ml)
    - Yes → UR EPP
    - No → FI EPP
  - Arranged for annual recall

- **HCV Antibody Positive**
  - RNA positive?
    - Yes → FI EPP
    - No → UR EPP

- **HIV Positive**
  - FI EPP

Appendix L
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.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Core knowledge required</th>
<th>Core skills required</th>
<th>Mode of delivery</th>
<th>How can this training be accessed by part-timers; temporary; bank/agency staff; volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>All new staff (and existing staff moving between Departments)</td>
<td>Gain an awareness of the Management of Contamination Incidents SOP</td>
<td>undertake first aid and report to the Line Manager</td>
<td>Corporate Induction presentation (with handbook), Local Dept. induction</td>
<td>On initial appointment at Corporate and Local induction</td>
</tr>
<tr>
<td>• Any member of staff who may manage a Contamination Incident</td>
<td>Gain an understanding of:</td>
<td>prevent and manage a Contamination Incident</td>
<td>e-Learning</td>
<td>Existing staff should update on three yearly basis</td>
</tr>
<tr>
<td>• SHWB clinical staff</td>
<td>• The ways in which to prevent and reduce the incidence of Contamination Incidents</td>
<td></td>
<td>Corporate updates</td>
<td></td>
</tr>
<tr>
<td>• Infection Control</td>
<td>• The appropriate procedures to follow if Contamination Incidents occur</td>
<td></td>
<td>Instruction and Guidance from Staff Health &amp; Wellbeing Department / Health &amp; Safety Department</td>
<td></td>
</tr>
<tr>
<td>• Emergency Dept clinical staff</td>
<td>Update their understanding and awareness of:</td>
<td>prevent and manage a Contamination Incident</td>
<td>e-Learning</td>
<td>As and when identified</td>
</tr>
<tr>
<td>Groups of Staff (or individuals) identified by trend analysis of incidents</td>
<td>• The ways in which to prevent and reduce the incidence of Contamination Incidents</td>
<td></td>
<td>Corporate updates</td>
<td></td>
</tr>
<tr>
<td>Members of Staff who are appointed as Competent Persons by their Line Managers</td>
<td>Gain understanding and awareness of:</td>
<td>manage the responsibilities in the event of a Contamination Incident</td>
<td>The Health Advisors within the Department of GUM</td>
<td>As and when identified</td>
</tr>
</tbody>
</table>
## Review and Approval Checklist

<table>
<thead>
<tr>
<th>Review</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Is the title clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the style &amp; format comply?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rationale</strong></td>
<td>Are reasons for development of the document stated?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Development Process</strong></td>
<td>Is the method described in brief?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are people involved in the development identified?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has a reasonable attempt has been made to ensure relevant expertise has been used?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there evidence of consultation with stakeholders and users?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td>Is the objective of the document clear?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is the target population clear and unambiguous?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the intended outcomes described?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the statements clear and unambiguous?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evidence Base</strong></td>
<td>Is the type of evidence to support the document identified explicitly?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are key references cited and in full?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are supporting documents referenced?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Approval</strong></td>
<td>Does the document identify which committee/group will review it?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the document identify which Executive Director will ratify it?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dissemination &amp; Implementation</strong></td>
<td>Is there an outline/plan to identify how this will be done?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Does the plan include the necessary training/support to ensure compliance?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Document Control</strong></td>
<td>Does the document identify where it will be held?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Have archiving arrangements for superseded documents been addressed?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring Compliance &amp; Effectiveness</strong></td>
<td>Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is there a plan to review or audit compliance with the document?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Review Date</strong></td>
<td>Is the review date identified?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is the frequency of review identified? If so is it acceptable?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall Responsibility</strong></td>
<td>Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
All policies are required to be electronically signed by the Lead Director (the policy will not be accepted onto Healthnet until the e-signature is received).

The proof of signature for all policies is stored in the policies database.

The Lead Director approves this document and any attached appendices.

Signed:

Title: Director of Governance and Deputy Chief Executive

Date: 9th August 2012