

Controlling the Risk of Spread of Blood Borne Viruses from Staff to Patients

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Name	Designation	Date Response Received
All clinical team	Occupational Health Governance group	20 th October 2021
Dr Peter Flegg	Consultant Infectious Diseases	
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1 Introduction / Purpose

Certain Blood-borne viruses (BBV) can be transmitted from infected health care workers (HCW) to patients, and from patients to susceptible health care workers during clinical procedures. The main viruses of concern are Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV).

This policy sets out the Trust's approach to managing the risks of transmission of BBV from staff to patients.

The objectives are to:

- Outline the main areas of risk of transmission of BBV
- Outline the procedures for establishing the carrier status and immune status for HCW who may undertake clinical activities deemed to be "at risk"
- Outline the procedures for immunization of HCW who have direct clinical contact
- Outline the restrictions on clinical practice of staff who may be carriers of a BBV

This policy should be used in conjunction with the Trust's current policy on needlestick and other body fluid contamination incidents (1).

2 General Principles / Target Audience

This policy applies to all clinical staff (including students and honorary staff) whose duties may include performing Exposure Prone Procedures (EPPs) within the Blackpool Teaching Hospitals NHS Foundation Trust as well as locums or agency staff performing EPPs.

3 Definitions and Abbreviations

BBV	Blood Borne Virus
cART	Combination antiretroviral therapy
CCDC	Consultant in Communicable Disease Control
Elite controller	A person living with HIV who is not receiving antiretroviral therapy and who has maintained their viral load below the limits of assay detection for at least 12months, based on at least three separate viral load measurements
EPP	Exposure Prone Procedure
DPH	Director of Public Health
GDC	General Dental Council
GMC	General Medical Council
GUM	Genito-Urinary Medicine
HCW	Health Care Worker
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HBsAg	Hepatitis B surface antigen
HBeAg	Hepatitis B e antigen

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Identity Validated	Proof of a person's identity is required by photographic ID, usually a passport or drivers license
NMC	National Midwifery Council
UKAP	United Kingdom Advisory Panel
UKAP-OHR	UKAP-Occupational Health Monitoring Register of Blood Borne Virus Infected HCWs

4 Responsibilities (Ownership and Accountability)

4.1 Managers

It is the responsibility of Managers to identify tasks undertaken within their area of responsibility that might be considered to be EPP. This is especially important because of staff transferring between jobs where the preceding post may not have involved EPPs. In these instances Managers must inform the Occupational Health department so that appropriate screening can take place before EPPs commence.

It is the responsibility of Managers to ensure that staff do not engage in EPPs unless they have first been tested for infectivity with such BBV as are considered to constitute a risk to patients, and their immunity (if appropriate) to such virus infections has been validated.

It is the responsibility of Managers to ensure that staff comply with the requirements for screening, vaccination, testing of immunity and any restrictions on working practices.

4.2 Occupational Health

It is the responsibility of the Occupational Health Department to provide facilities for screening, vaccination, testing of immunity and counselling in relation to immune status and infectivity for individual members of staff and to notify Managers of staff who fail to comply with this Policy.

4.3 Members of Staff

It is the responsibility of members of staff who are aware that they may have exposed themselves to BBV either in the UK or abroad, and either through work or non-work activities, to report this immediately to Occupational Health, so risk assessments can decide whether it may be appropriate for further screening for BBV should take place.

As well as occupational risk (see 5.5.3 below), staff need to be aware that they may have put themselves at risk by having unprotected sex and/or intravenous drug use (these are not exhaustive lists). Staff have a professional and an ethical duty to report any potential risk that they may have placed themselves in. Staff should ask for assistance from the Occupational Health Clinical staff and should not rely on their own judgement as to whether they may or may not pose a risk to themselves or their patients. This is in concurrence with guidance from the GMC and NMC.

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5 Procedure

5.1 Exposure Prone Procedures must not be performed by a HCW who is:

- HIV positive and who has not complied with the new guidance (see section 5.9)
- Hepatitis B surface antigen (HBsAg) positive with a positive test for e markers (e-antigen positive)
- Hepatitis B surface antigen (HBsAg) positive with a negative test for e markers if the HCW has a viral load greater than 1000 genome equivalents/ml (10^3)
- Hepatitis C virus RNA positive.

5.2 Non-Exposure Prone Procedures

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 hand from sharp instruments and/or tissues, are considered not to be exposure prone. Examples of such procedures 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)
- Minor surface suturing
- The incision of abscesses
- Routine vaginal or rectal examinations
- Simple endoscopic procedures

Non-exposure prone procedures require good infection control procedures to be followed at all times.

5.3 Surveillance of HCW for BBVs

5.3.1 All staff, students and visiting HCW with patient contact

All staff, students and visiting HCW with patient contact will be asked to complete a health questionnaire prior to employment or commencing their duties, which includes questions about HBV, HCV, and HIV.

5.3.2 HCWs who are new to the NHS

HCWs who are new to the NHS will be offered screening tests for HCV and HIV. Those who are required to undertake EPPs will be tested for infectivity with HBV, HCV and HIV, unless they can show evidence of previous clearance by a UK Occupational Health or student health department, with confirmation of identity validation.

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5.3.3 HCWs who are returning to the UK and who may have been exposed to BBVs

HCWs who are returning to the UK and who may have been exposed to BBVs, must inform the Occupational Health Department and will be offered screening for BBVs, according to individual risk assessment. Those who will undertake EPPs will be obliged to follow the recommendations of the Occupational Health Department in relation to screening. Examples include those returning from research electives, work with medical charities, sabbatical, tours of active duty in the armed forces, exchanges, locum and agency work.

5.3.4 HCWs who decline to be tested for HBV, HCV and/or HIV or who cannot provide satisfactory evidence of non-infectivity

HCWs who decline to be tested for HBV, HCV and/or HIV or who cannot provide satisfactory evidence of non-infectivity will not be cleared for EPPs.

5.4 Hepatitis B

5.4.1 Evidence of development of antibodies (HBsAb) after Hepatitis B vaccination

Evidence of development of antibodies (HBsAb) after Hepatitis B vaccination does not necessarily imply lack of infectivity. All prospective employees, students or others undertaking EPPs will be required to produce written proof of their Hepatitis B immunity and possible infectivity (carrier status) when they attend for pre-employment health assessment. This must be “identity validated”. If no such documentation is available then with their informed consent and with confirmation of identity, blood will be taken to assess their Hepatitis B immunity and carrier status.

5.4.2 Prospective employees with direct clinical contact or who may through the course of their duties

Prospective employees with direct clinical contact or who may through the course of their duties (e.g., porters, domestics Lab staff processing blood and other fluids that may contain BBV) be at risk of exposure to HBV will be offered Hepatitis B immunisation.

5.4.3 HCWs who have naturally acquired immunity

HCWs who have naturally acquired immunity will need to show that they are also Hepatitis B surface antigen negative before they can undertake EPPs.

5.4.4 HCWs who are Hepatitis surface antigen positive and e-antigen positive

HCWs who are Hepatitis surface antigen positive and e-antigen positive will not be passed as “fit” to undertake employment if their proposed job involves EPPs.

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5.4.5 HCWs who are Hepatitis B surface antigen positive and e-antigen negative

HCWs who are Hepatitis B surface antigen positive and e-antigen negative require a pre-employment assessment of viral load. If this exceeds 1000 genome equivalents/ml they will not be passed fit to undertake EPPs. Those who have a viral load of ≤ 1000 genome equivalents/ml will be allowed to undertake EPPs but with annual follow up testing. These HCWs should cease to perform EPPs if their viral load is shown by testing to have risen above the specified level, or if investigation of a case of Hepatitis B in a patient indicates the possibility of a transmission from an HCW.

5.4.6 All serology reports

All serology reports must be from an NHS Trust laboratory or an independent UK / EC laboratory and contain the name of the HCW, date of birth, the date the blood was taken and the test result, along with confirmation that the sample was 'identity validated'.

5.4.7 Blood samples for serological testing

Blood samples for serological testing should only be taken by the staff in the Occupational Health Department, or someone appointed by Occupational Health. These should be 'identity validated'. Blood samples brought in by the HCW or requested by the HCW without the knowledge of the Occupational Health Department will not be accepted.

5.4.8 Staff who are HBcAb positive but HBsAg negative

Staff who are HBcAb positive but HBsAg negative and commence treatment with certain immunomodulating monoclonal antibody treatments may experience a flare up of HBV and HCV with concomitant viraemia. If during the course of treatment monitoring this occurs the HCW should cease EPP and a discussion with OHD Physician should take place.

5.5 Immunisation of staff against Hepatitis B

5.5.1 New Employees

HCWs who will be engaged in EPPs and who have completed a course of Hepatitis B vaccine will need to provide serological evidence of immune status and will be tested for possible infectivity (HBsAg), unless documentary evidence of a previous identity validated test already exists.

HCWs who cannot provide satisfactory documentary evidence will require to be tested before being allowed to perform EPPs.

HBsAg positive HCWs who perform EPPs will require an e antigen test, if this is positive they will not be able to perform EPPs. If the e antigen test is negative, a viral load estimation will be required. For an employee to perform EPPs the result of the viral load test needs to be less than or equal to 1000 genome equivalents/ml and the employee needs to be taking continuous antiviral therapy and agree to have regular monitoring of Hepatitis B viral load by Occupational Health.

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Locum doctors and agencies providing nursing and other health care staff will be required to provide evidence that they are compliant with Department of Health guidance. Those performing EPPs, who wish to start work urgently, will need to show to the satisfaction of the Occupational Health department and Trust that they are not carriers of Hepatitis B.

5.5.2 Staff in Post

Staff engaged in EPPs who are true vaccine non-responders (anti-HBs<10mIU/ml after boosters will be tested annually for HBsAg.

HCWs will be invited for boosters as required. Current guidelines suggest that a single booster after the initial course of vaccine is enough to confer life-long immunity, but further boosters may be offered after contamination incidents in accordance with the Trust's guidance on needlestick and body fluid contamination incidents.

Occupational Health will liaise with Managers to ensure compliance with vaccination and serological testing. Persistent failure to comply with Occupational Health advice will be reported to Managers within the individual's right to medical confidentiality.

HBsAg positive HBeAg negative workers currently performing EPPs should cease doing these procedures until their viral load test results have been received. As for new employees, staff will not be able to perform EPPs unless the viral load result is less than or equal to 1000 genome equivalents/ml, they are taking continuous antiviral therapy and they agree to have regular monitoring of Hepatitis B viral load by Occupational Health.

5.6 Hepatitis C

HCWs who are new to the NHS will be offered screening for HCV. Those who are required to undertake EPPs (and existing staff who are moving to a post requiring EPPs) will be required to be tested for Hepatitis C antibody and will not be cleared for duty until the results are known.

HCWs who know, or who believe that they may be infected with Hepatitis C (i.e., have antibodies to Hepatitis C virus) and who are to carry out EPPs must be tested for the presence of Hepatitis C virus RNA. Those found to be Hepatitis C virus RNA positive will not be allowed to carry out EPPs. However, HCWs who have been treated successfully with antiviral therapy can resume EPPs if they remain Hepatitis C virus RNA negative 6 months after cessation of treatment. For confirmation of their negative status, they need to show that they are Hepatitis C virus RNA negative a further 6 months later (i.e., 12 months after cessation of treatment).

The Department of Health guidance on HCV and HCWs indicates that testing for Hepatitis C antibodies (and Hepatitis C RNA if necessary) should take place prior to embarking on a career relying on the performance of EPPs. For doctors in training grades, this usually means prior to entering training in a surgical specialty.

Blackpool Teaching Hospitals NHS Foundation Trust have a responsibility to patients, and to health care workers considering a career in a specialty relying on EPPs. The Trust requires all FY1 doctors to be tested for Hepatitis C antibodies (and Hepatitis C RNA if necessary) unless they have been tested previously as a student and can provide

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satisfactory identity-validated confirmation. Those found to be positive will be tested for Hepatitis C RNA and counselled on careers in specialties not involving EPPs. They will not be permitted to undertake EPPs unless they can demonstrate a sustained response to treatment.

5.7 HIV

5.7.1 Routine Testing

All HCWs who are new to the NHS will be offered HIV testing. Those who are entering an EPP specialty or job will not be cleared as fit for duty until the results of screening are known. All Foundation Year 1 doctors will be tested for HIV (unless they can demonstrate that they have been tested previously at medical school) and will only be cleared for non-EPP duties until the results of testing are known. Only identity-validated samples/results will be acceptable.

Existing HCWs do not need to be tested routinely for HIV status, but all HCWs who know or suspect that they are infected with HIV must promptly seek appropriate expert medical and Occupational Health advice. Those who perform EPPs must seek further expert advice on modification and limitation of their working practices to avoid EPPs, while appropriate measures are put in place to support and manage the health care worker following the new guidance.

5.7.2 Management of HIV infected HCWs

HIV infected HCWs must meet the following criteria before they can perform EPPs:

Either

- a) be on effective combination antiretroviral therapy (cART), **and**
- b) have a plasma viral load <200 copies/ml

OR

- c) be an elite controller

And

- d) be subject to plasma viral load monitoring every three months **and**
- e) be under joint supervision of a consultant occupational physician and their treating physician, **and**
- f) be registered with the UKAP Occupational Health Monitoring Register (UKAP-OHR).

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5.7.3 Initial health clearance for HIV infected HCWs who wish to perform EPPS

For HCWs wishing to perform EPPs, two Identified Validated blood samples (IVS) test results taken no less than three months apart and with viral load levels below 200 copies/ml are required to ensure viral load stability. At this point, a decision should be made as to whether health clearance could be given for the HCW to commence or resume EPP activities.

For HCWs currently restricted from EPPs who are on combination cART with undetectable viral load (below 200 copies/ml), one IVS at least 12 weeks since their last undetectable viral load is sufficient proof on which to grant clearance for conducting EPPs.

The decision to clear the individual HCWs for work involving EPPs is the responsibility of the consultant occupational physician in consultation with the treating physician. UKAP may be consulted on the application of the policy, as needed).

5.7.4 Viral load monitoring and ongoing clearance for HIV infected HCWs performing EPPs

HIV infected HCWs who are cleared to perform EPPs are subject to viral load testing every three months while continuing to perform such procedures. The three-month period should be taken from the date the previous IVS was drawn, and not from the date the result was received.

If a HCWs plasma viral load rises above 1000 copies/ml, they should be restricted immediately from carrying out EPPs until their viral load returns to being consistently below 200 copies/ml in at least two tests done no less than three months apart. The significance of any increase in plasma viral load above 200 copies/ml and below 1000 copies/ml should be assessed jointly by the occupational health and treating physicians with input from appropriate local experts (e.g., consultant virologist or microbiologist).

The table below sets out the expected course of action for viral load test results below and above the level for EPP clearance (200 copies/ml) check

Viral load count test result	Action
<50 copies/ml or below	No action – retest in 3 months
50-200 copies/ml	A case-by-case approach based on clinical judgement would be taken which may result in no action (as above) or a second test may be done 10 days later to verify the first result. Further action would be informed by the test result.

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Viral load count test result	Action
>200 copies/ml but <1000 copies/ml	A second test should automatically be done 10 days later on a new blood sample to verify the first result. If the count was still in excess of 200 copies/ml the HCW would cease conducting EPPs until their count, in two consecutive tests no less than three months apart, was reduced to < 200 copies/ml.
1000 copies/ml or above	<p>The HCW would cease conducting EPPs immediately. A second test must be done on a new blood sample 10 days later to verify the first result. If the count was still in excess of 1000 copies/ml, a full risk assessment should be initiated to determine the risk of HCW to patient transmission. At a minimum, this will include discussion between the consultant occupational physician and the treating physician on the significance of the result to the risk of transmission.</p> <p>Following a risk assessment exercise, a Patient Notification Exercise may be indicated. UKAP advice may be sought at this stage.</p>

5.7.5 Failure to attend or refusal to test

All HCWs performing EPPs should be advised by their consultant occupational physician and their treating physician of the importance of quarterly monitoring of their viral load and the implications of not doing so.

Where a HCW does not attend their appointments, or refuses to have their viral load tested, the consultant occupational physician should inform the HCWs manager that they are no longer cleared to perform EPPs, until it has been established that the HCW is continuing with cART and their viral load (measured within the past three months) does not exceed 200 copies/ml.

5.7.6 Resuming EPPs

Resumption of EPP activities following a period of interruption (for whatever reason) requires demonstration of consistent viral load suppression to very low or undetectable levels i.e. at least two viral loads below 200 copies/ml, no less than three months apart.

5.7.7 Elite controllers

Elite controllers compromise a small proportion (0.2-0.55%) of all people living with HIV, who are not receiving antiretroviral therapy and have maintained their viral load below the limits of assay detection for at least 12 months, based on at least three separate viral load measurements.

A HCW who meets the definition of being an elite controller can be cleared for EPP activities without being on treatment but remains subject to three-monthly viral load

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monitoring to ensure they maintain their viral load below 200 copies/ml and to identify any rebound promptly. Any such cases should be referred to UKAP for advice on a case-by-case basis.

5.7.8 Occupational Health Monitoring Arrangements for HIV infected HCWs

Suitable arrangements must be in place for agency or locum staff to ensure that they have a designated occupational physician responsible for their monitoring in accordance with the guidance.

All HIV infected HCWs who perform EPPs should have their viral load measured every three months using a blood IVS. This would usually be carried out by the Occupational Health Service but where this would give rise to duplication of testing, local arrangements should be made between the treating physician and the occupational health service to ensure that blood drawn for HIV infected HCWs for viral load measurements in GUM or infectious diseases settings follow the principles of IVS.

ALL HIV infected HCWs including locum and agency staff who wish to perform EPPs and who meet the criteria for clearance must have the outcome of their monitoring promptly reported by the relevant occupational health department to a central confidential register, the UKAP-Occupational Health Monitoring Register of Blood Borne Virus Infected HCWs (UKAP-OHR) [UK Advisory Panel for Healthcare Workers Living with Bloodborne Viruses \(UKAP\) - GOV.UK \(www.gov.uk\)](http://www.gov.uk) (2)

Each HCW must be recorded on the register by their designated consultant occupational physician. The ongoing viral load monitoring data will be updated by occupational health providers on a regular basis via a web-based data entry system. Action taken as a result of an increase in viral load should be reported using the register to record that, restrictions on practice are put in place appropriately and, where necessary risk assessments and patient notification exercises are carried out.

The UKAP-OHR will be securely and confidentially administered. Access to the individual records of HCWs on the register will be strictly limited to the designated consultant occupational physicians responsible for the care, monitoring, management and EPP clearance of the HCW, and those who have delegated authority for this within occupational health, and to those few authorised individuals, managing the register on behalf of UKAP.

Decisions to clear individual HCWs for EPP work will ultimately remain the responsibility of the occupational health physician.

The roles and responsibilities of the respective individuals involved in the monitoring process for HIV infected HCWs performing EPPs are set out in the table below

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A. Health Care Worker
<p>MUST be under the care of a designated consultant occupational physician</p> <p>MUST accept that it is a condition of undertaking EPPs that they consent to ongoing monitoring while they continue to practise EPPs including:</p> <ol style="list-style-type: none"> 1. The registration of their details and monitoring data on the UKAP-OHR 2. The release of monitoring information to the consultant occupational physician and the treating physician 3. To provide an IVS for viral load monitoring at the appointed times 4. To seek advice if change in health condition may affect their fitness to practise or impair their health 5. To notify OH when they are changing their practice or place of employment. <p>Thus, HCWs must agree that by seeking to and undertaking EPPs, they are giving implied consent to 1 and 2 above and they are undertaking to satisfy 3, 4 and 5 as well.</p>
B. Consultant Occupational Physician
<p>The consultant occupational physician IS RESPONSIBLE for the monitoring of the infected HCW including:</p> <ol style="list-style-type: none"> 1. Ensuring the testing protocol and timings are followed 2. Reacting promptly to any alerts received via UKAP-OHR 3. Taking appropriate action when those who should present for tests do not do so, e.g., notifying the relevant manager of the HCWs non-attendance and restriction from EPPs practice 4. Taking IVS samples and ensuring samples are sent to laboratories 5. Interpreting the viral load results in relation to clearance to perform EPPs 6. Ensuring that the UKAP-OHR is updated in a timely manner 7. Advising the HCW and the employer on an ongoing basis, on whether the HCW is fit to perform EPPS 8. Timely liaison with treating physicians
C. Treating Physician
<p>The treating physician IS RESPONSIBLE for;</p> <ol style="list-style-type: none"> 1. The clinical management and support for the seropositive HCW 2. Advising and maintaining timely communications with the consultant occupational physician responsible for monitoring the infected HCW

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5.7.9 Testing arrangements

Laboratory testing should be undertaken by a Clinical Pathology Accreditation (UK) Limited accredited virology laboratory.

The use of personal identifiers in requests for laboratory test should be avoided and care taken to ensure that the number of people who know the HCWs identity is kept to a minimum. However full person identifiers must always be used when sending results to the national UKAP-OHR.

Where coding is used, the occupational physician who maintains a full identity record should liaise with the lead consultant microbiologist/virologist in the local laboratory to ensure a consistent coding system unique to that laboratory is used, and that serial samples from the same HCW are identifiable as such.

5.7.10 Breaks in Monitoring

HIV infected HCWs who take a career break from performing EPPs may wish to continue three monthly monitoring during this period to facilitate a return to EPP activities. Individuals with a break in their monitoring record must meet the criteria for initial clearance before returning to EPP activities.

5.7.11 Patient Notification Exercises

Patient notification exercises for patients who have undergone EPP by an untreated HIV infected HCW would take place according to current guidance on HIV infected HCWs.

Patient notification exercises connected with HIV infected HCWs on cART would only be considered in circumstances in which their viral load had risen above 1000 copies/ml. The need for patient notification would be determined by a risk assessment on a case-by-case basis in line with the principles in existing guidance, and the UKAP should be consulted for advice.

5.7.12 Management of patients following exposure to blood and body fluid of HIV infected HCW

If an infected HCW becomes aware of accidentally exposing a patient to their blood, (e.g., sharps injury whilst operating) the HCW MUST report the incident in the usual way. A detailed risk assessment should be performed with the assistance of the HCWs consultant occupational physician and treating physician, focussing on the HCWs adherence to treatment, viral load and any factors that may raise the HCWs viral load.

If the exposure was judged to be significant (i.e., blood from the HCW may have breached the patient's tissues), and the HCW has a stable low viral load (less than 200 copies/ml), neither PEP nor follow-up HIV testing of the patient is necessary. There is no reason to advise patients of a possible exposure where the HCW was complying with the policy (i.e., had a viral load less than 200 copies/ml) and was cleared for EPP work, as the risk of PEP treatment far outweighs any risk of transmission.

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Where there is a concern that the viral load might be detectable (above 200 copies/ml), the HCWs viral load should be tested immediately, PEP should be offered to the patient pending the result, and the reasons for this explained to the patient. PEP can be discontinued if the viral load is less than 200 copies/ml, the patient reassured, and no HIV testing would be required. If the level is greater than 200 copies/ml, PEP should be continued for four weeks and the patient tested at three months post PEP completion.

5.8 Work Restrictions

5.8.1 HCW with Serological Markers - Positive

HCWs with the following serological markers will be excluded from performing EPPs:

- HIV antibody subject to provisions described in section 3.9 above.
- HBeAg positive.
- HBsAg positive and HBeAg negative with a viral load >1000 genome equivalents/ml. Those with a viral load \leq 1000 genome equivalents /ml can continue unrestricted practice but will have their viral load re-tested annually to assess their fitness to continue unrestricted practice.
- Hepatitis B core antibody IgM fraction (indicating current infection).
- Hepatitis C positive antibody **and** hepatitis C RNA positive

5.8.2 Restrictions

Restrictions will also be applied in the following circumstances:

- Conclusive evidence of transmission of infection from a HCW to a patient.
- HBsAg positive and HBeAg negative status who refuse to have viral load testing.
- HBsAg positive undergoing treatment with interferon or antiviral therapy and for up to a year following cessation of treatment when their viral load will determine whether they can continue unrestricted practice.
- Loss of HBsAg status spontaneously (reversion from normal to carrier status) will also be tested every 12 months to assess fitness to continue EPPs.
- HBsAg positive workers who become immunosuppressed for any reason or have symptoms suggestive of reactivation of infection should cease EPPs immediately and have a viral load test to determine fitness to continue unrestricted practice.

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5.8.3 HCW with Serological Markers - Negative

HCWs with the following serological markers can continue working without any restriction in work practice, as long as there is adequate documentary evidence of lack of infectivity (e.g., HBsAg negative)

- Persistent poor responders to vaccination (anti-HBs = 10miu/ml – 99miu/ml despite boosters).
- True non-responders to vaccine (anti-HBs = less than 10miu/ml despite boosters).
- Those with naturally acquired immunity (anti-HBc, IgG fraction and HBsAg negative).

5.8.4 Serology results

Serology results may occasionally produce a “false positive”. This is where the test results maybe borderline, and the laboratory advises that it is likely to be a false positive. HCWs will not be allowed to continue EPPs until further testing has been done to exclude a positive result and a negative result has been confirmed by the laboratory.

5.9 Refusal of vaccination or failure to attend for vaccination and/or serology testing

5.9.1 HCWs at risk of acquiring Hepatitis B

HCWs at risk of acquiring Hepatitis B (and/or those whose work involves EPPs) and who fail to submit to vaccination (unless there are medical contraindications) will be advised that they are placing themselves and patients at risk. Failure to comply with advice may result in redeployment, restricted work practice or a variety of other adjustments to safeguard the health and safety and welfare of patients and colleagues. It may also lead to disciplinary action and may (in serious cases) amount to gross misconduct warranting dismissal and notification of the appropriate professional body (including General Medical Council, Nursing and Midwifery council, General Dental Council etc). However, prior to taking any action the HCW will be given the opportunity to discuss the matter in confidence with a Consultant Occupational Physician. Should they wish to, the HCW may clarify employment issues by involving the Human Resources and Organisational and Development department and seek advice from their Trade Union representative.

5.10 Duties of all HCWs

Colleagues who know, or have good reason to believe, that a Hepatitis B, Hepatitis C or HIV infected HCW has not followed advice to modify their practice, should inform an appropriate person in the HCWs employing or contracting authority (e.g., Trust Medical Director or deputy, or Trust Nursing Director etc) or where appropriate the relevant regulatory body. Whenever possible the HCW should be informed before the information is given to an employer or regulatory body.

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5.11 Patient Notification Exercises

Where it is believed that patients have undergone EPPs performed by a HCW who is HIV positive (and there is cause for concern based on a risk assessment under the new guidance). HBeAg positive or HBeAg negative with a viral load greater than 1000 genome equivalents/ml, or where transmission of Hepatitis C virus may have occurred from an infected HCW, the Director of Public Health or Consultant in Communicable Disease Control will determine whether a patient notification exercise is necessary. The UK Advisory Panel can be consulted should any doubts occur in the procedure to be followed. (The new guidance for HIV infected HCWs advises that the need for a patient notification exercise would be determined by risk assessment on a case-by-case basis and UKAP should be consulted for advice). The Consultant Occupational Physician and/or Consultant Microbiologist will make sure that the DPC and/or CCDC are informed of concerns regarding positive results in HCWs who perform EPPs, if the DPC and/or CCDC are not already aware.

5.12 Managing an Infected Health Care Worker

Please Note HCWs will receive the same rights of confidentiality as any patient seeking or receiving medical care. Whilst their manager will be advised that a change in duties should take place, the infectious status will not be disclosed without the HCWs consent. Any breach of confidentiality will be treated in accordance with the Trust's Disciplinary Policy and Rules (3; 4).

- HCWs will be assured that their status and rights as employees are safeguarded and that the Trust will make every effort to arrange suitable alternative work if necessary and where possible.
- Where alternative employment is not readily available in the Trust, reasonable steps will be taken to look for suitable employment elsewhere. In the case of medical/dental staff the relevant Postgraduate Deans will be approached (with consent of the HCW) to provide advice about retraining.
- Referral to a Specialist for further clinical management will be offered to the HCW either directly, or via the General Practitioner.
- The Consultant Occupational Physician or a Deputy will act as an advocate for the infected HCW on issues of retraining and redeployment.
- In the first instance, temporary redeployment may have to be considered. If permanent redeployment becomes necessary, this may involve a move to a post that does not involve EPPs.
- The final decision about the type of work that may be undertaken by an infected HCW will be made on an individual basis taking into account the specific working practices of the HCW. In case of continuing doubt about the tasks that the infected HCW may or may not perform, the Consultant Occupational Physician may contact the UK Advisory Council (UKAP) (2) or advice while ensuring the anonymity of the HCW concerned.

(Address UKAP Secretariat, 61 Colindale Avenue,, London NW9 5EQ, telephone number 020 8327 6074).

Email ukap@phe.gov.uk – checked 13th October 2021

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- Occupational Physicians who are aware that infected HCWs under their care have not followed advice to modify their work practice must inform the GMC, GDC or NMC and where possible would attempt to inform the HCW before doing so.
- Compensation for occupationally infected HCWs is available from The Industrial Injuries Disablement Benefit Scheme (Prescribed Disease B8 (5)). To qualify the claimant must have worked in an environment where they have had contact with human blood, or blood products, or a source of viral Hepatitis. Leaflets and advice on the scheme can be obtained from the local Benefits Agency Offices.

The NHS Injury Benefits Scheme (6), provides temporary or permanent benefits for all NHS employees who lose remuneration because of an injury or disease attributable to their NHS employment. Details of the scheme can be obtained from the NHS Pension Agency, Injury Benefits Manager, 200-220 Broadway, Fleetwood, Lancs FY7 8LG.

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Appendix 1: Exposure Prone Procedures

Examples of advice given by UKAP

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

The following advice has been given by UKAP, however local risk assessment is still necessary as local procedures and HCWs individual practice may differ.

Accident and Emergency (A&E)

A&E staff who are restricted from performing exposure prone procedures (EPPs) should not provide pre-hospital trauma care.

These staff should not physically examine or otherwise handle acute trauma patients with open tissues because of the unpredictable risk of injury from sharp tissues such as fractured bones. Cover from colleagues who are allowed to perform EPPs would be needed at all times to avoid this eventuality.

Other EPPs which may arise in an A&E setting would include: rectal examination in presence of suspected pelvic fracture; deep suturing to arrest haemorrhage; internal cardiac massage. (See also **Anaesthetics, Biting, Paramedics and Resuscitation**)

Anaesthetics

Procedures performed purely percutaneously are not exposure prone, nor have endotracheal intubation nor the use of a laryngeal mask been considered so.

The only procedures currently performed by anaesthetists which would constitute EPPs are:

- the placement of portacaths (very rarely done) which involves excavating a small pouch under the skin and may sometimes require manoeuvres which are not under direct vision;
- the insertion of chest drains in accident and emergency trauma cases such as patients with multiple rib fractures.

The insertion of a chest drain may be considered to be exposure prone for example where a finger is inserted into the chest cavity, as may be necessary e.g., with a flail chest, and where the health care worker could be injured by the broken ribs.

Modern techniques for skin tunnelling make it possible for these to be done in a non-exposure prone way and involve wire guided techniques and putting steel or plastic trochars from the entry site to the exit site where they are retrieved in full vision.

Biting

Current advice is that HCW carrying a BBV do not need to be restricted from working with patients who may bite, as the risk of transmission from HCW to patient is negligible. However, transmission of BBVs from a biting patient to a HCW is a significant risk and must be dealt with according to the Trusts Needle stick and Body Fluid incident Policy (1).

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Bone Marrow transplants

Not exposure prone.

Cardiology

Percutaneous procedures including angiography / cardiac catheterisation are not exposure prone. Implantation of permanent pacemakers (for which a skin tunnelling technique is used to site the pacemaker device subcutaneously) may or may not be exposure prone. This will depend on whether the operator's fingers are or are not concealed from view in the patient's tissues in the presence of sharp instruments during the procedure

Dentistry and orthodontics (including hygienists)

The majority of procedures in dentistry are exposure prone, with the exception of: examination using a mouth mirror only; taking extra-oral radiographs; visual and digital examination of the head and neck; visual and digital examination of the edentulous mouth; taking impressions of edentulous patients; and the construction and fitting of full dentures.

However, taking impressions from dentate or partially dentate patients would be considered exposure prone, as would the fitting of partial dentures and fixed or removable orthodontic appliances, where clasps and other pieces of metal could result in injury to the dentist.

Ear, Nose and Throat Surgery (Otolaryngology)

ENT surgical procedures generally should be regarded as exposure prone with the exception of simple ear or nasal procedures, and procedures performed using endoscopes (flexible and rigid) **provided fingertips are always visible**. Non-exposure prone ear procedures include stapedectomy / stapedotomy, insertion of ventilation tubes and insertion of a titanium screw for a bone anchored hearing aid.

Endoscopy

Simple endoscopic procedures (e.g., gastroscopy, bronchoscopy) have not been considered exposure prone. In general, there is a risk that surgical endoscopic procedures (e.g. cystoscopy, laparoscopy - see below) may escalate due to complications which may not have been foreseen and may necessitate an open EPP. The need for cover from a colleague who is allowed to perform EPPs should be considered as a contingency.

General Practice

EPPs are rare in General Practice. Possible areas where they may be encountered are obstetrics, trauma and resuscitation situations. (see relevant sections.)

Gynaecology (see also Laparoscopy)

Open surgical procedures are exposure prone. Many minor gynaecological procedures are not considered exposure prone, examples include dilatation and curettage (D&C), suction termination of pregnancy, colposcopy, surgical insertion of depot contraceptive implants / devices, fitting intrauterine contraceptive devices (coils), and vaginal egg collection **provided fingers remain visible at all times when sharp instruments are in use**.

Performing **cone biopsies** with a scalpel (and with the necessary suturing of the cervix) would be exposure prone. Cone biopsies performed with a loop or laser would not in themselves be classified as exposure prone, but if local anaesthetic was administered to the cervix other than under direct vision i.e., with fingers concealed in the vagina, then the latter would be an exposure prone procedure.

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Appendix 1: Exposure Prone Procedures

Intensive Care

Intensive care does not generally involve EPPs on the part of medical or nursing staff

Laparoscopy

Mostly non-exposure prone because fingers are never concealed in the patient's tissues. Exceptions are, exposure prone if main trocar inserted using an open procedure, as for example in a patient who has had previous abdominal surgery. Also, exposure prone if rectus sheath closed at port sites using J-needle, and fingers rather than needle holders and forceps are used.

In general, there is a risk that a therapeutic, rather than a diagnostic, laparoscopy may escalate due to complications which may not have been foreseen necessitating an open exposure prone procedure. Cover from colleagues who are allowed to perform EPPs would be needed at all times to avoid this eventuality.

Midwifery / Obstetrics

Simple vaginal delivery, amniotomy using a plastic device, attachment of fetal scalp electrodes, infiltration of local anaesthetic prior to an episiotomy and the use of scissors to make an episiotomy cut are not exposure prone.

The only exposure prone procedures routinely undertaken by midwives are repairs following episiotomies and perineal tears.

Needlestick / Occupational Exposure to HIV

Health care workers need not refrain from performing exposure prone procedures pending follow up of occupational exposure to an HIV infected source. The combined risks of contracting HIV infection from the source patient, and then transmitting this to another patient during an exposure prone procedure is so low as to be considered negligible. However, in the event of the worker being diagnosed HIV positive, such procedures must cease in accordance with this guidance.

Nursing

General nursing procedures do not include EPPs. The duties of operating theatre nurses should be considered individually. Theatre scrub nurses do not generally undertake exposure prone procedures. However, it is possible that nurses acting as first assistant may perform EPPs (see also **Accident and Emergency, Renal Medicine / Nursing, and Resuscitation**).

Obstetrics / Midwifery

See section on **Midwifery**. Obstetricians perform surgical procedures, many of which will be exposure prone according to the criteria.

Operating Department Assistant/Technician

General duties do not normally include exposure prone procedures.

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Appendix 1: Exposure Prone Procedures

Ophthalmology

With the exception of orbital surgery which is usually performed by maxillo-facial surgeons (who perform many other EPPs), routine ophthalmological surgical procedures are not exposure prone as the operator's fingers are not concealed in the patient's tissues. Exceptions may occur in some acute trauma cases, which should be avoided by EPP restricted surgeons.

Orthopaedics

Some orthopaedic procedures are not exposure prone such as: Manipulation of joints with the skin intact; Arthroscopy, provided that if there is any possibility that an open procedure might become necessary, the procedure is undertaken by a colleague able to perform the appropriate open surgical procedure; Superficial surgery involving the soft tissues of the hand; Work on tendons using purely instrumental tunnelling techniques that do not involve fingers and sharp instruments together in the tunnel; Procedures for secondary reconstruction of the hand, provided that the operator's fingers are in full view; Carpal tunnel decompression provided fingers and sharp instruments are not together in the wound; Closed reductions of fractures and other percutaneous procedures.

Exposure prone procedures include: Open surgical procedures; Procedures involving the cutting or fixation of bones, including the use of K-wire fixation and osteotomies; Procedures involving the distant transfer of tissues from a second site (such as in a thumb reconstruction); Acute hand trauma; Nail avulsion of the toes for in-growing toenails and Zadek's procedure (this advice may not apply to other situations such as when nail avulsions are performed by podiatrists).

Paediatrics

Neither general nor neonatal/special care paediatrics has been considered likely to involve any EPPs. Paediatric surgeons do perform EPPs

Paramedics

In contrast to other emergency workers, a paramedic's primary function is to provide care to patients. Paramedics do not normally perform EPPs. However, paramedics who would be restricted from performing EPPs should not provide pre-hospital trauma care. (This advice is subject to review as the work undertaken by paramedics continues to develop).

Pathology

In the event of injury to an EPP restricted pathologist performing a post-mortem examination, the risk to other workers handling the same body subsequently is so remote that no restriction is recommended.

Podiatrists

Routine procedures undertaken by podiatrists who are not trained in and do not perform surgical techniques are not exposure prone. Procedures undertaken by podiatric surgeons include surgery on nails, bones and soft tissue of the foot and lower leg, and joint replacements. In a proportion of these procedures, part of the operator's fingers will be inside the wound and out of view, making them exposure prone procedures (see also Orthopaedics).

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Appendix 1: Exposure Prone Procedures

Radiology

All percutaneous procedures, including imaging of the vascular tree, biliary system and renal system, drainage procedures and biopsies as appropriate, are not EPPs

Renal Medicine

The working practices of those staff who supervise haemofiltration and haemodialysis circuits do not include EPPs. Obtaining vascular access is not EPP as long as the operators fingers remain visible at all times during the procedure. However, it is currently advised that HCWs who are HbeAg positive (or HbeAg negative, HBsAg positive with a Hepatitis B viral load exceeding 1000 genome equivalent/ml) should not undertake clinical duties on renal dialysis units.

Resuscitation

Resuscitation performed wearing appropriate protective equipment does not constitute an EPP. The Resuscitation Council (UK) recommends the use of a pocket mask when delivering cardio-pulmonary resuscitation. Pocket masks incorporate a filter and are single-use.

Surgery

Open surgical procedures are exposure prone. This applies equally to major organ retrieval because there is a very small, though remote, risk that major organs retrieved for transplant could be contaminated by a health care worker's blood during what are long retrieval operations while the patient's circulation remains intact. It is possible for some contaminated blood cells to remain following pre-transplantation preparatory procedures and for any virus to remain intact since organs are chilled to only 10°C.

Volunteer health care workers (including first aid)

The important issue is whether or not an infected health care worker undertakes EPPs. If this is the case, this guidance should be applied, whether or not the health care worker is paid for their work.

This information is not an exhaustive list and further advice as to whether a procedure is considered to be EPP can be obtained from UKAP.

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Appendix 2: Equality Impact Assessment Form					
Department	Occupational Health	Service or Policy	CORP/POL/227	Date Completed:	October 2021
GROUPS TO BE CONSIDERED Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.					
EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and social economic / deprivation.					
QUESTION	RESPONSE		IMPACT		
	Issue	Action	Positive	Negative	
What is the service, leaflet or policy development? What are its aims, who are the target audience?	This policy sets out the Trust's approach to managing the risks of transmission of BBV from staff to patients				
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion	No				
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	No				
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?	No				
How does the service, leaflet or policy/ development promote equality and diversity?	N/a				
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	No				
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups	Yes		Yes		
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites iii. Improve public spaces including creation of green spaces?	No				
Does the service, leaflet or policy/ development promote equity of lifelong learning?	No				
Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health?	No				
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?	No				
Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?	No				
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	No				

Appendix 2: Equality Impact Assessment Form				
Does the policy/development promote access to services and facilities for any group in particular?	No			
Does the service, leaflet or policy/development impact on the environment	No			
<ul style="list-style-type: none"> During development At implementation? 				
ACTION:				
Please identify if you are now required to carry out a Full Equality Analysis		Yes	No	(Please delete as appropriate)
Name of Author:	Kerrie Chesters + Clare Partington	Date Signed:		October 2021
Signature of Author:				
Name of Lead Person:	Kerrie Chesters	Date Signed:		October 2021
Signature of Lead Person:				
Name of Manager:	Susan Wild	Date Signed:		February 2022
Signature of Manager				