NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Needle stick Injuries and Accidents Involving Exposure to Blood and Body Fluids in Staff

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1 Introduction / Purpose

To outline the procedure to be followed in the case of needle stick injuries, and accidents involving exposure to blood and body fluids involving staff.

2 General Principles / Target Audience

All Staff, students and contractors working within Blackpool Teaching Hospitals NHS Foundation Trust, and also including General Practitioners, Dentists, and other healthcare workers in the community for whom the Occupational Health Department (OHD) provides a service to.

This policy does not cover members of the public, or other occupations who may be at risk of needle stick through the course of their duties (e.g. police, fire service), as the OHD does not provide a service to them.

3 Definitions and Abbreviations

A+E	Accident and Emergency
Anti-HBs	Antibodies formed after vaccination with hepatitis B vaccine
BBV	Blood Borne Virus e.g. Hepatitis B, Hepatitis C and HIV
d.o.b	date of birth
Exposure Incident	See section 3.2.1
GU	Genito-Urinary
HBIG	Hep B Immunoglobulin
HBsAg	Hepatitis B Surface Antigen
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
Needlestick	See section 3.2.1
OHD	Occupational Health Department
PEP	Post-exposure Prophylaxis

4 Responsibilities (Ownership and Accountability)

4.1 Managers

It is the responsibility of managers at all levels to:

- Bring this procedure to the attention of all Health Care Workers (HCWs) and others who may be at risk of infection in the course of their duties
- Report all incidents in line with Trust Risk Management Policies.

4.2 All Staff

It is the responsibility of all members of staff, students and contractors and others to whom the policy applies to:

- Follow Trust Policies and guidance on safe working practices (including the adoption of Universal Precautions and the safe disposal of sharps).
- Comply with Trust Policies and OHD procedures on vaccination against Hepatitis B, and on health surveillance for other Blood Borne Virus' (BBVs)
- Report immediately to their line manager (or if a contractor, the manager responsible for the work area) any needle stick or contamination accident, or any situation in which a contamination accident might have occurred ('near-miss').
- Assist colleagues who have experienced a needle stick or contamination incident to minimise any delay in conducting a risk assessment and actions arising from the incident.

Attend their follow up appointments in the OHD and to the follow the advice given by the clinical staff in the OHD.

5 Procedure

FOR IMMEDIATE GUIDANCE ON WHAT TO DO FOLLOWING A NEEDLESTICK INJURY OR ACCIDENT INVOLVING EXPOSURE TO BLOOD OR BODY FLUIDS, GO TO APPENDIX 1 TOWARDS THE END OF THIS DOCUMENT
FOR Accident and Emergency (A+E) STAFF Go to Appendix 1 and 7 and use sections 5.1. and 5.4 to help you.
IF YOU WORK IN THE NORTHERN LOCALITY OF OUR COMMUNITY SERVICES then you should contact and / or attend University of Morecambe Bay Trust Occupational Health department which is located at Lancaster Royal Infirmary during their working hours which are 08.30 or 16.30 hours. **If the injury occurs out of the hours then you should attend A+E at Lancaster Royal Infirmary.** **Please note the contact details for these departments are different to those for Blackpool Occupational Health. The contact numbers for Lancaster are telephone 01524 512290 and fax 01524 512295.**

Occupational Health Department postal address –

2, North Park Dr, Blackpool, FY3 8NQ,
Tel: 01253 957950 (Option 2)
Email: bfwh.occupational.health@nhs.net

5.1 Risk Assessment

The risk of acquiring a blood-borne virus infection through occupational exposure is low, however certain blood-borne viruses (BBVs) can be transmitted from patients to susceptible (non-immune) Health Care Workers (HCWs) and others from accidental exposures (e.g. a needle stick, splash from body fluids).

Generalised estimated risks of transmission are shown in Table 1 below. Note the risks from a splash accident are much less than those where blood or body fluid has been "percutaneous". This is estimated as being reduced by a further factor of 10.

Table 1: Risk of seroconversion from a source patient positive for a BBV following a percutaneous exposure (e.g. needle stick injury).

Virus Type	**Risk of seroconversion**
Hepatitis B Virus (HBV)	30%
Hepatitis C Virus (HCV)	1.8% - 10% (estimated rates of transmission vary)
HIV	0.3%

5.1.1 What constitutes a needle stick or blood and body fluid exposure incident?

Any injury with:

- a sharp instrument, needle, blade, razor, broken glass
- a spicule of bone or tooth
- any other item causing a puncture wound or laceration that might be contaminated with blood or body fluids
- any splash of blood or body fluids into the eyes, mouth or onto broken skin
- any human scratch that breaks the skin and may be contaminated with a patients' blood or body fluids
- any bite where the skin is broken.

The main risk for transmission of BBV is from blood but other fluids and tissues may transmit infection including

- Amniotic fluid
- Breast milk
- Cerebrospinal fluid
- Exudates or other tissue fluid from burns or skin lesions
- Peritoneal, pericardial or pleural fluid
- Semen
- Synovial fluid
- Unfixed tissues and organs
- Vaginal secretions

- Other bodily fluid such as urine, faeces, vomit, and sputum is not normally considered a risk unless visibly stained with blood.
- Saliva would be a risk if visibly stained with blood (e.g. during dental work).

5.1.2 A risk of transmission exists

- if the injured person suffers a penetrating injury with a sharp object that has been in contact with a patient's blood or body fluid. This is a percutaneous injury.
- if the person has sustained a splash of blood or body fluids into eyes, nose, mouth or onto broken skin (e.g. eczema). This is a mucocutaneous injury.
- has sustained a bite which breaks the skin
- has received a scratch that breaks the skin and is contaminated with the patient's blood or body fluids.

If none of these apply then there can be no significant risk of transmission. If in doubt then contact the OHD (in hours 08.15 to 17.00 Telephone 01253 95 7950) or A+E (out of hours) for advice.

5.1.3 Risks of transmission from a source patient who is positive for a BBV increase with

- a penetrating injury that is deep
- hollow bore needles (because there is a larger volume of blood than on a solid needle)
- where the needle / sharp is visibly blood-stained
- needles that have been in an artery or vein
- a patient who is terminally ill with human immunodeficiency virus (HIV) / acquired immune deficiency syndrome (AIDS) or not on treatment.

Factors which put a source patient into a "high-risk" group for all BBV infections are described in Table 2 below.

Table 2.

- Known HIV antibody positive
- Known Hepatitis C antibody positive
- Known Hepatitis B surface antigen (HBsAg) positive
- (Hepatitis B and C are in themselves risk factors for somebody being HIV positive
- Current of past intravenous drug user
- Sex Worker
- Homosexual/bisexual male
- Originates form a country with a high prevalence of HIV in particular sub-Saharan Africa
- Admits to unprotected sex (recent or distant) with someone known to have HIV, Hepatitis B or C

5.1.4 Reduction of Risks

5.1.4.1 HIV

The risk of acquiring HIV following a high-risk HIV exposure can be reduced by taking post-exposure prophylaxis (PEP) **as soon as possible preferably within the first hour** following the injury. It is vital therefore that there is no delay in attending A+E to receive this treatment. (The OHD is not currently able to provide PEP).

5.1.4.2 Hepatitis B

The risk of seroconversion is reduced as long as the member of staff has completed their full hepatitis B vaccination course and has had follow up blood tests to check that the anti-HBs level is satisfactory.

If the member of staff is a known 'non-responder' to hepatitis B vaccine they may require HBIG and should attend A+E (out of hours) or OHD (in hours) straight away.

If the member of staff has not yet completed their full course of vaccine then they must attend OHD (in hours) or A+E (out of hours) for a booster vaccine and a decision to be made as to whether HBIG is also required. See Appendix 4 for advice about HBV prophylaxis.

The decision as to whether HBIG is required will require the help of the Consultant Microbiologist on call.

5.1.4.3 Hepatitis C

There is neither vaccine, nor PEP available for Hepatitis C. However as long as the exposed member of staff attends their follow up appointments with OHD, if the follow up blood tests reveal that early acquisition has taken place, then early treatment will be very likely to clear the infection successfully.

5.2 Reporting Arrangements in Relation Inoculation Incidents

The injured person must report the incident to the person in charge of their work area immediately after having performed first aid. A risk assessment must be carried out jointly by the person to whom the incident is reported to along with the injured person, as soon as possible by completing the forms in Appendix 2, and referring to section 3.2 to help.

- If the line manager or supervisor is not immediately available, the injured person must contact the OHD in hours (08.15 to 17.00) otherwise A+E (out of hours) for advice.
- If the source patient is suspected to be HIV positive then immediate risk assessment is essential as PEP may be necessary and this should be given within 1 hour of the injury. The injured party must attend A+E immediately with the completed risk assessment forms (Appendix 2) and inform the triage nurse that they have had a high-risk needle stick or exposure incident. The OHD cannot currently give PEP.

5.3 Process for the Management of an Inoculation Incident (Including Prophylaxis)

5.3.1 Action for OHD Staff

Appendix 1 will have informed the injured member of staff whether or not they need to attend A+E immediately for PEP and/or HBIG. Each scenario points the injured member of staff to a Plan illustrated in flow charts in Appendix 3.

Plans C and E will tell them what to do if the risk assessment shows that they do not require immediate clinical input in the form of PEP or HBIG and will direct them to Occupational Health. Plans A, B and D will mean that they will go to A+E to be seen immediately as they may require PEP or HBIG and/or a hepatitis B booster.

- Ensure first aid has been done – if not do it without delay
- Review the risk assessment on the completed Appendix 2 that the injured party will have brought with them
- Is PEP required?
- Follow the appropriate action plan (if high-risk for HIV and person has attended OHD, then telephone A+E to advise triage nurse that they are being sent across for PEP)
- Is HBIG required? (See Appendix 4)
- Is a hepatitis B booster required? (see Appendix 4)
- Take storage bloods from the injured person (see section 5.5)
- Check that source bloods have been taken, or are going to be taken by colleagues of the injured person. (see section 5.6)
- Make sure that follow up arrangements are in place for the injured party.

5.4 Action for A+E Staff

Appendix 1 will have informed the injured member of staff whether or not they need to attend A+E immediately. For each needle stick scenario there is a course of action to help you manage it without missing anything. Each scenario points the injured member of staff to a Plan illustrated in flow charts in Appendix 3.

Plans A, B and D will mean that they come to A+E to be seen immediately as they may require PEP or HBIG and/or a hepatitis B booster.

Plans C and E will tell them what to do if the risk assessment shows that they do not require immediate clinical input in the form of PEP or HBIG and will direct them to Occupational Health.

Use the appropriate Plan in Appendix 3 depending upon the risk assessment which the injured person will have brought to A+E with them (Appendix 2).

You can use Appendix 7 checklist for help with this, so you don't miss anything

- Ensure first aid has been done – if not do it without delay
- Review the risk assessment on the completed Appendix 2 that the injured party will have brought with them
- Is PEP required? Staff will need to read Appendix 8 and sign consent form in Appendix 9.
- If PEP is prescribed, in office hours, contact Consultant in Infectious Diseases or Consultant in GU Medicine/BBV team via switchboard to arrange follow up for PEP.
- Is HBIG required? (see Appendix 4) A+E can organise this with Consultant Microbiologist
- Is a hepatitis B booster required? (see Appendix 4)
- Take storage bloods from the injured person (see section 5.5)
- Check that source bloods have been taken, or are going to be taken by colleagues of the injured person. (see section 5.5.7)

Make sure that Appendix 2 forms are emailed / taken to OHD by the next working day so that follow-up arrangements can be made for the injured person. **The onus to do this is on the injured person, but they may be anxious, so remind them**.

5.5 Storage Bloods

Storage blood must be taken from the injured member of staff.

Take a 7.5ml clotted sample (brown topped bottle) of venous blood. Use a virology form, and put the following information in the clinical features box:

- “**Staff member – needle stick accident. Blood is for storage**.” **ALSO** put the source patients name and date of birth (d.o.b.) too if this is known. This is so that the laboratory and the OHD can link the two samples together.

THE BLOOD TEST REQUEST SHOULD BE AS THOUGH IT WERE FROM OCCUPATIONAL HEALTH EVEN THOUGH TAKEN IN A+E OR ON THE WARD.

5.6 Source Patient Bloods

5.6.1 It is very important that blood is taken from the source patient with consent and tested for all of HIV antibody, Hepatitis B surface antigen and Hepatitis C antibody. If consent is denied it cannot be taken.

5.6.2 Source patient testing is the responsibility of the nurse/clinician (consultant or junior doctor) involved in the care of the patient and NOT the injured HCW.

If the patient has left the hospital, the GP must be contacted and asked to help with the risk assessment process including obtaining a blood sample and record in the patient’s case notes. This may be difficult and can delay matters which is why it is recommended for the risk assessment to be carried out immediately while the patient is still available on the premises.

5.6.3 It is essential to obtain fully informed consent from the source patient to be able to test their blood for BBVs. Use Appendix 5 and the information sheet in Appendix 6 to help you.

5.6.4 In the case of a child, consent should be sought from the person with parental responsibility.

5.6.5 Blood must not be taken from a patient who cannot competently give consent, therefore if the patient is deceased or unconscious, or confused, blood cannot be taken. It is against the law (Human Tissue Act 2006). In such circumstances the incident must be managed according to the risk assessment.

5.6.6 Source patient venous blood is taken in a 7.5ml clotted sample (brown topped bottle). Use a virology form, and put the following information in the clinical features box:

- ”Source Patient for needlestick accident. Please test for HBsAg, AND HIV AND HCV Antibodies.” ALSO put the injured person’s name and d.o.b. too so that the laboratory and OHD can link the two samples together.
- **THE BLOOD TEST REQUEST MUST BE FROM THE CLINICIAN IN CHARGE OF THE SOURCE PATIENT’S CARE and COPIED INTO OCCUPATIONAL HEALTH**.

5.7 Follow Up Arrangements and Contact Information

- Occupational Health must be informed of all needle stick / contamination incidents, the onus for this being on the injured party.
- If the incident occurs out of normal working hours for OHD and the injured person has attended A+E because of the result of the risk assessment, they must contact OHD the next working day (Telephone 01253 95 7950).
- If the incident occurs in normal working hours (weekdays 08.15 to 17.00 hours), but the risk assessment has indicated they must go to A+E first because it is a high-risk injury for HIV transmission, then the injured person must contact OHD the same day or at the latest, the next working day.
- If the risk assessment indicates that they do not need to attend A+E then they must contact OHD the same day, preferably by telephoning the OHD to make arrangements to be seen the same day.
- For those prescribed the initial starter pack of PEP by A+E, if in office hours contact infectious diseases consultant or Genito-Urinary (GU) medicine consultant/BBV team via switchboard to arrange follow up of PEP. If unable to make contact, then the injured person MUST contact Occupational Health on the next working day so we can help to arrange this.
- It is vital that the appropriate follow-up arrangements are made and recorded on Occupational Health records.

5.8 Follow Up Blood Test in Occupational Health

For incidents where the source is unknown, or is not tested and the risk assessment decides is low risk, and where the injured staff member is a known responder to HBV (anti-HBs levels >100mIU/ml).

Time	HIV	Hepatitis C	Hepatitis B
6 weeks	Antibody	PCR	Not required
3 months	Antibody	PCR+Antibody	Not required
6 months	Antibody	Antibody	Not required

For incidents where the source is unknown, or is not tested and the risk assessment decides is low risk, and where the injured staff member is a NON-Responder to HBV, or is not fully immunised, or has a low response to HBV (anti-HBs levels <100mIU/ml).

Time	HIV	Hepatitis C	Hepatitis B
6 weeks	Antibody	PCR	HBsAg
3 months	Antibody	PCR+Antibody	HBsAg
6 months	Antibody	Antibody	HBsAg

For incidents where the source has been tested and is known to be negative for all three of HIV, HCV and HBV.

Time	HIV	Hepatitis C	Hepatitis B
6 months	Antibody	Antibody	Not required as long as known responder to HBV

For incidents where the source is known to be positive and/or tests positive for HIV and/or Hepatitis C and/or Hepatitis B or the risk assessment shows a high risk, then the relevant combination of tests must be done* (see over page for info about HBsAg).

Time	HIV	Hepatitis C	Hepatitis B
6 weeks	Antibody	PCR	HBsAg may be required*
3 months	Antibody	PCR+Antibody	HBsAg may be required*
6 months	Antibody	Antibody	HBsAg may be required*

*HBsAg may be required if the injured member of staff has not shown a good immune response to their vaccination course (anti-HBs levels <100mIU/ml) or if they were only partway through their vaccine course at the time of injury and/or have required HBIG because they are a non-responder.

5.9 Staff Training

Staff training will be undertaken as outlined in the Mandatory Risk Management Training Policy (CORP/POL/354) (BTHFT - Procedure, 2015).

5.10 Process for Monitoring Compliance

The process for monitoring compliance with this procedure is outlined in Appendix 10.

6 References and Associated Documents

BTHFT - Procedure, 2015. *Mandatory Risk Management Training.* [Online]
Available at: http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-POL-354.docx
[Accessed 21 01 2020].

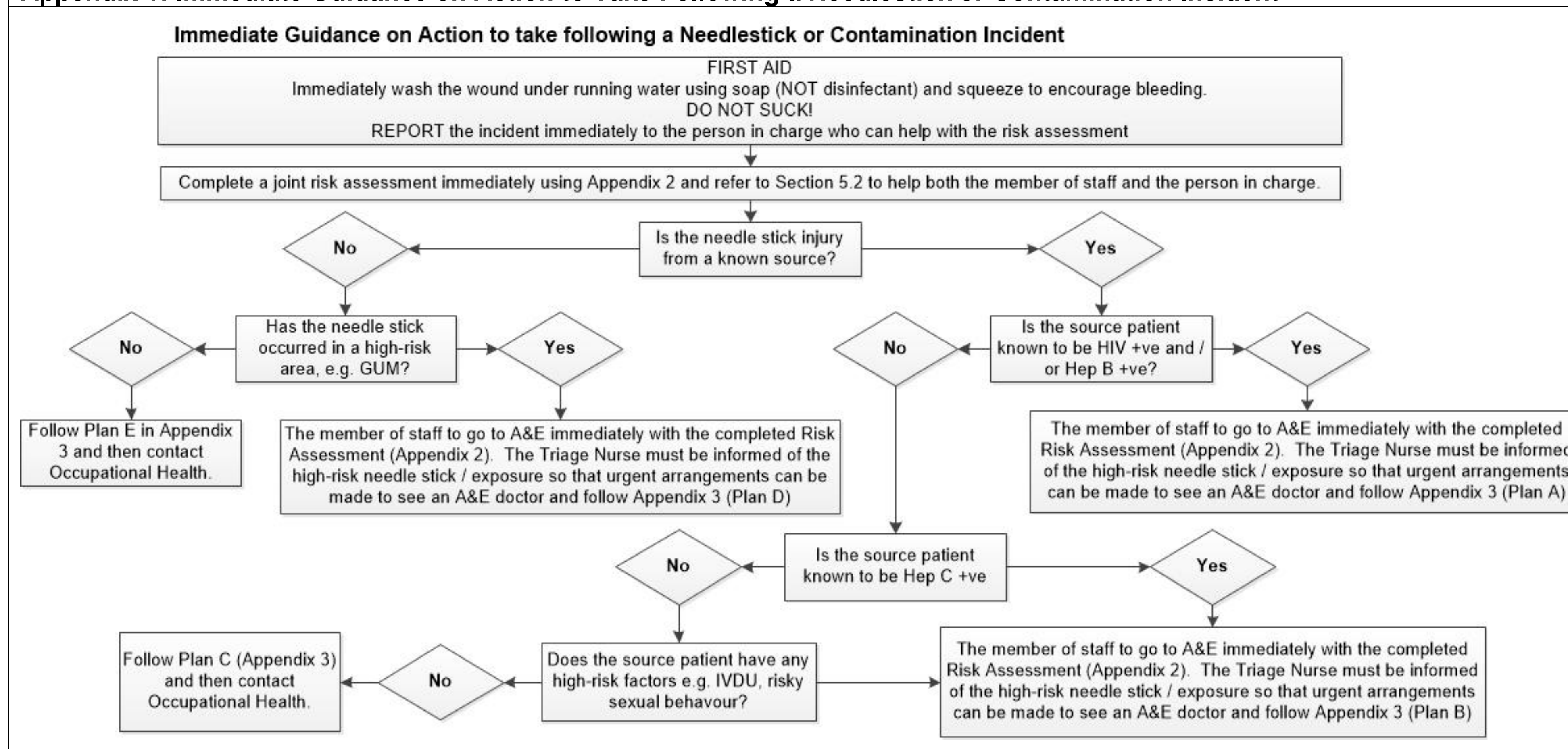
Crown, 2004. *Human Tissue Act 2004.* [Online]
Available at: http://www.legislation.gov.uk/ukpga/2004/30/contents
[Accessed 17 01 2020].

Department of Health and Social Care, Last updated 29 April 2015. *EAGA guidance on HIV post-exposure prophylaxis.* [Online]
Available at: https://www.gov.uk/government/publications/eaga-guidance-on-hiv-post-exposure-prophylaxis
[Accessed 22 07 2020].

Public Health England, Last updated 2 September 2014. *Immunisation against infectious disease (includes 'the Green Book').* [Online]
Available at: https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book
[Accessed 22 07 2020].

Human Tissue Act 2006

Appendix 1: Immediate Guidance on Action to Take Following a Needlestick or Contamination Incident



Appendix 2: Exposure Risk Assessment Record

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This section to be completed by the injured person (Please PRINT in block capitals and CIRCLE relevant alternative answers)

Surname…………………………………….. Forenames……………………………….M/F

Date of birth……………………………….. Address…………………………………………..

Job Title…………………………………. Department/Ward………………..……………….…..

Email (if we are unable to contact you by phone)………………………………………………………………

Contact telephone numbers Mobile………………….……… Work…………………..
Home……………………………… Bleep…………………

Date of incident……………………………..… Time of incident …..………………..…………
Place of incident……………………………………………………………………..………..

Type of exposure Blood Yes/No Other (please state)……………………
Type of injury If needle Hollow bore (e.g. green needle, venflon)
Solid bore (e.g. suture, lancet)

OR Splash/Scratch/Bite or Other (describe)………………………………………………..

Give a short description of the incident. What happened? How it happened? Why it happened?
…………………………………………………………………………………………………
…………………………………………………………………………………………………
………………………………………………………………………………………

Have you completed a full (3 doses) of hepatitis B vaccine? Yes/No
Approximate date this was completed?………………………
Were you confirmed as immune after the antibody blood test? Yes/No/Don't know
Are you a known non-responder to hepatitis B vaccine? Yes/No

Signature……………………………………………….……… Date……………………..………

This section to be completed jointly by injured person and person in charge of work area, or other suitably experienced person

Is the source patient known? Yes/No Hospital number…………………………
If known give details of source patient.
Surname…………………………………….. Forenames……………………………………..

Date of birth………………………………. Male/Female

SAMPLE

Appendix 2: Exposure Risk Assessment Record

Look at Appendix 1 NOW to see what action is to be followed and make arrangements for source patient testing with consent (See section 3.7 and appendices 5 and 6)
With consent (see section 3.7 and appendices 5+6) test source patient for;

HIV antibody **and** Hepatitis B surface antigen **and** Hepatitis C antibody

If source patient blood cannot, or has not been obtained please explain why
…………………………………………………………………………………………………
………………………………………………………………………………………………

If source is unknown, refer to Appendix 1 for further action.

For completion by A+E or Occupational Health

Date of assessment…………………………….. Time……………………………

Name of assessor………………………………….. Job title……………………………..

Risk Assessment HIGH RISK LOW RISK

Storage Bloods taken from injured person Yes/No If No why?................................
Storage blood form labelled correctly Yes/No (see section 3.6)

Treatment given
Hepatitis B vaccine booster Yes/No Batch no………………………
Hepatitis B Immunoglobulin Yes/No Batch no…………………….
PEP prescribed (A+E only) Yes/No

If PEP is prescribed, what follow up arrangements have been made with the infectious disease consultant or GU medicine consultant/BBV team? E.g. time and date of appointment.
……………………………………………………………………………………………..
If they are not available during office hours via switchboard, have you instructed the injured person to contact Occupational Health on the next working day?
Yes/No

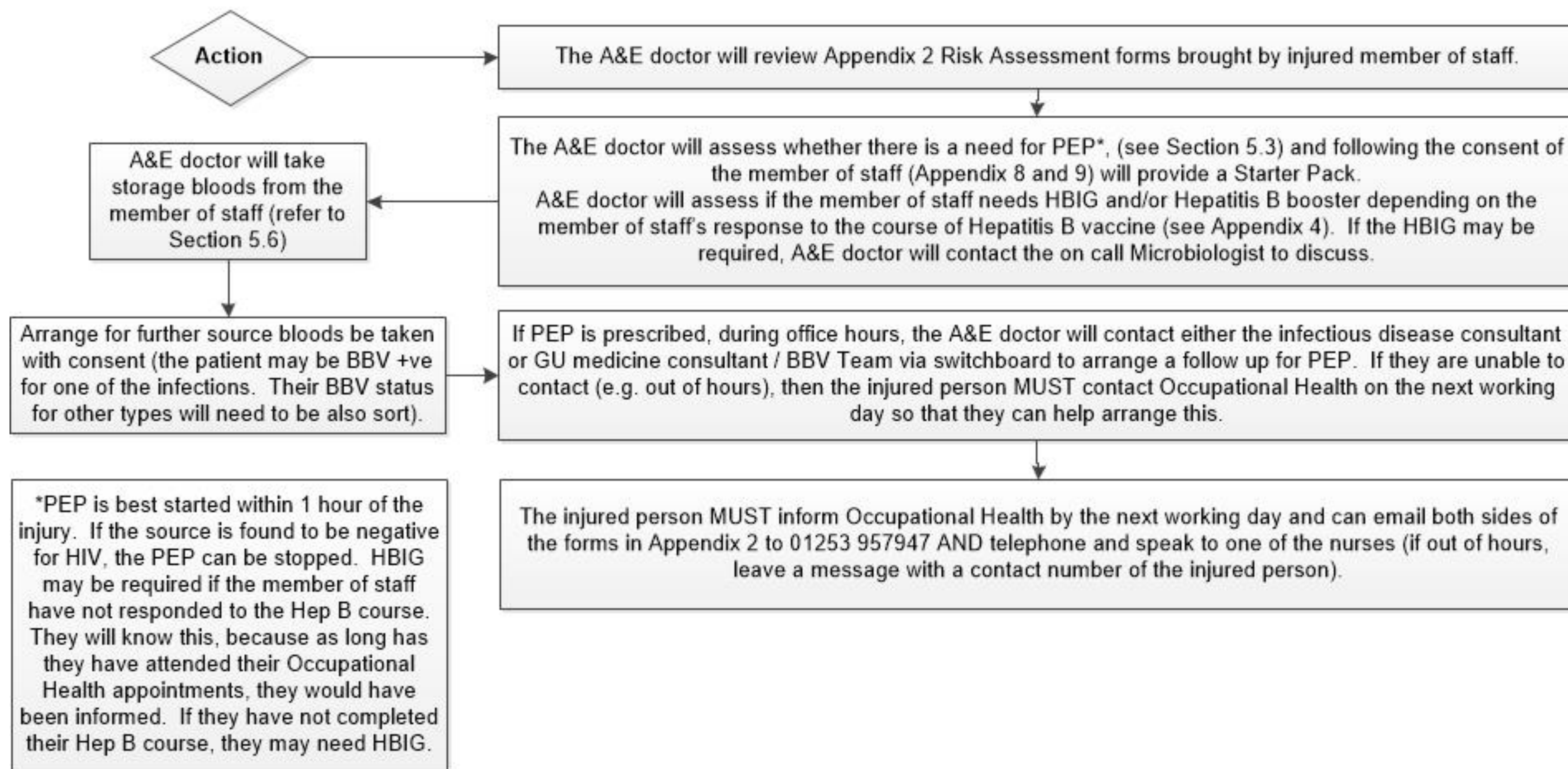
Please make sure that this form (2 sides) is delivered or faxed to the Occupational Health Department, by the next working day so that the appropriate follow up arrangements can be made.

Fax no. 01253 957947

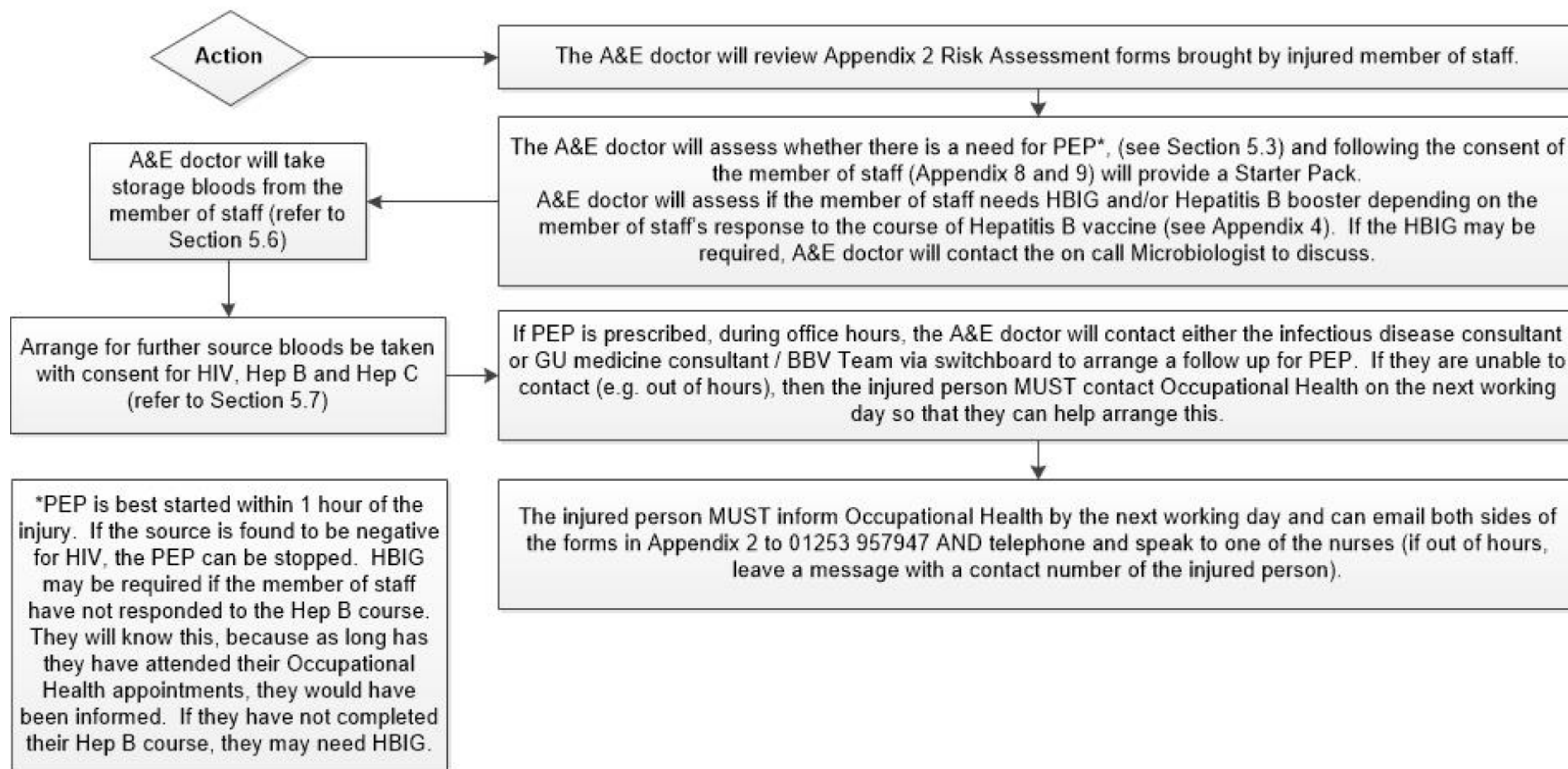
For completion by injured member of staff

1. How would you be able to prevent this incident from happening to yourself in the future?
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………..………………………………………………………………………

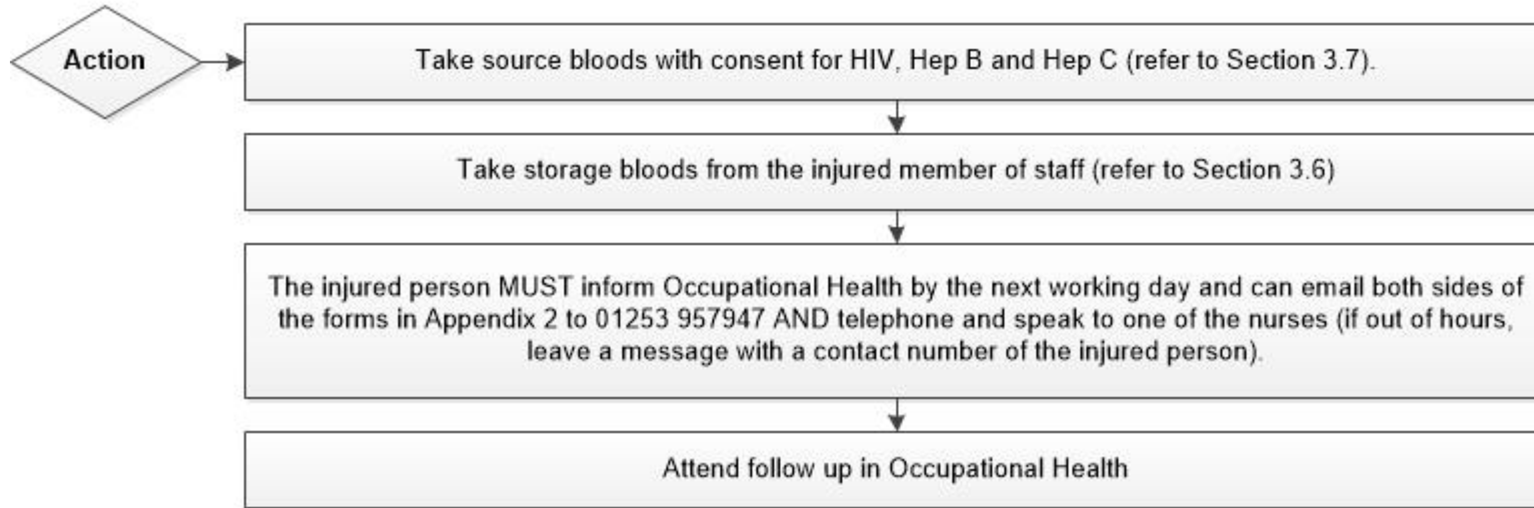
Appendix 3a: Plan A: Needlestick from a known HIV+ve and/or Hep B +VE source patient



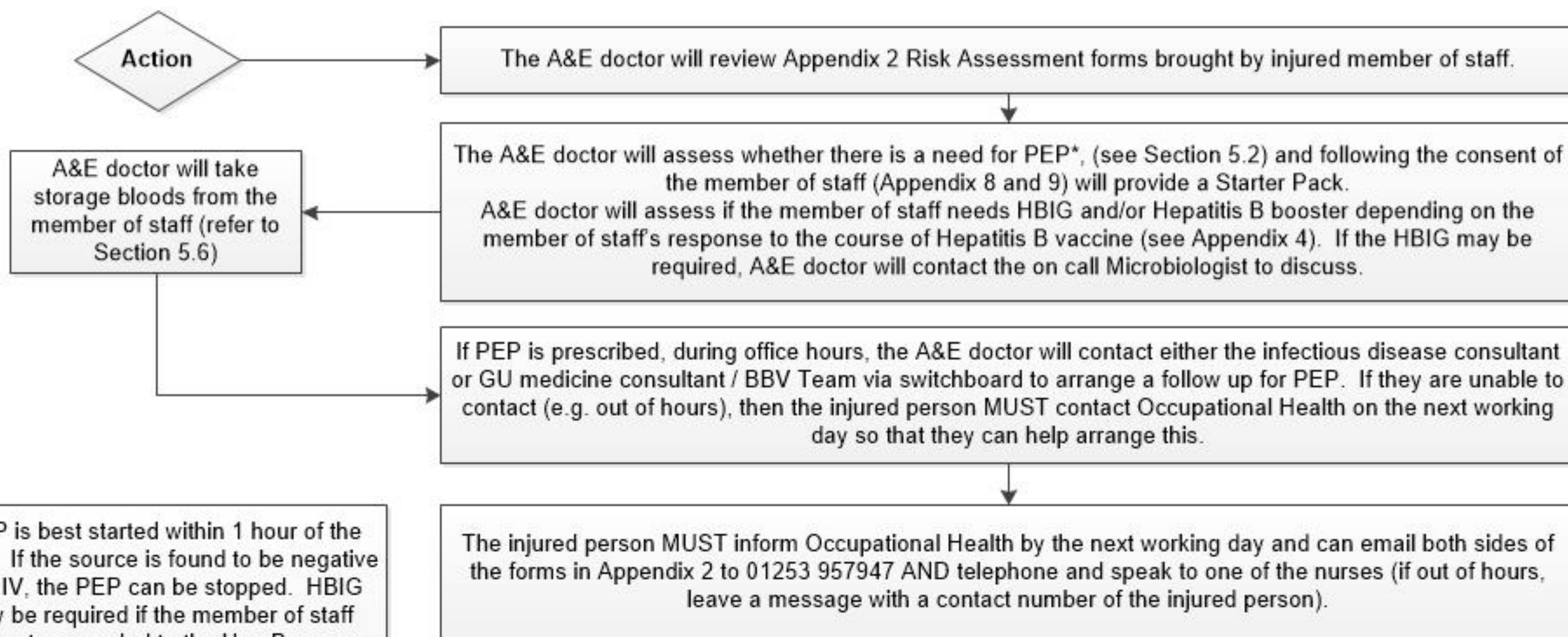
Appendix 3b: Plan B: Needlestick from a known source with risk factors for BBV or is known to be HCV +VE



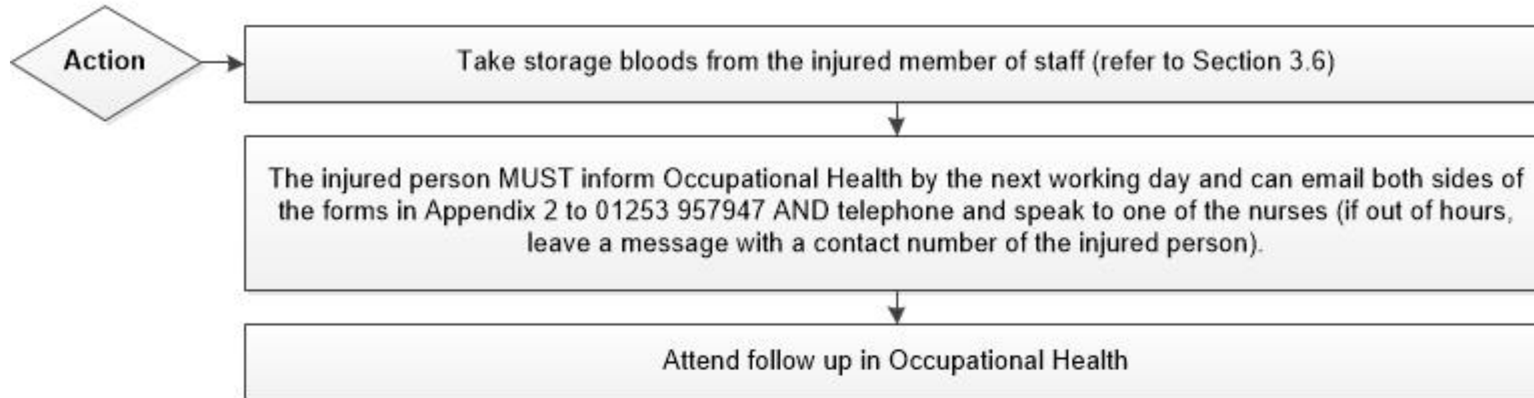
Appendix 3c: Plan C: Needlestick from a known source patient with no known risk factors



Appendix 3d: Plan D: Needlestick from an unknown source patient but in a high-risk area



Appendix 3e: Plan E: Needlestick from an unknown source patient



Appendix 4: HBV Prophylaxis for reported exposure incidents (source Green Book)

HBV status of injured person	HBV status of source patient		
	HBsAg positive source	Unknown Source	HBsAg negative source
≤ 1 dose HB vaccine pre-exposure**	Accelerated course of HB vaccine* and HBIG x1	Accelerated course of HB vaccine	Initiate course of HB vaccine
≥ 2 doses HB vaccine pre-exposure (anti-HBs not known)**	One dose of HB vaccine followed by second dose one month later	One dose of vaccine	Finish course of HB vaccine
Known responder to HB vaccine (anti-HBs> 10mlIU/ml)**	Consider booster dose of vaccine (give if over 12 months from completing full HB vaccine course)	Consider booster dose of vaccine (give if over 12 months from completing full HB vaccine course)	Consider booster dose of vaccine (give if over 12 months from completing full HB vaccine course)
Known non-responder to HB vaccine (anti-HBs<10mlU/ml)** All non-responders will know they are non-responders as they will have been advised during their OH attendances	HBIG x1 Consider booster dose of HB vaccine Second dose of HBIG should be given at one month**	HBIG x1 Consider booster dose of HB vaccine Second dose of HBIG should be given at one month**	No HBIG Consider booster dose of vaccine

- An accelerated course of vaccine consists of doses spaced at zero, one and two months.
- ** All injured staff will require follow-up in OHD either for further HBIG and HB vaccine and for follow up bloods therefore if the injured person has attended A+E, they MUST contact OHD on the next working day.
  HBIG must be given as soon as possible following an incident if it is assessed as being required
  Contact the Consultant Microbiologist on call for advice if HBIG may be required.

Appendix 5: Obtaining blood from a source patient

Guidance for the clinician in charge of the patient

Pre-blood test discussion

Before taking blood from the ‘source’ patient, the clinician or Ward Manager involved should be clear about their own responsibilities in respect of obtaining informed consent, documenting the consent in the patient’s notes and subsequently informing the patient of the results of the test.

The following check list is intended to help the person obtaining the sample (and consent) to ensure that all important issues are discussed with the patient:

- Identify your own role
- Stress the confidentiality
- Explain why a blood sample is being requested (that a member of staff or other person has sustained a contamination accident)
- Explain which ‘diseases’ and viruses are being tested for (i.e. Hepatitis B and C and HIV).
- Explain to the source patient that if their blood tests were found to be positive for any of these infections then their clinical care for these illnesses would be given by either the GU medicine consultant/BBV team, or infectious disease consultant.

Appendix 6 may be used to aid you in this and may be given to the patient to read to explain what is being asked of them and why.

The responsibility for acting on the results obtained from a source patient in terms of treatment and onward referral to an infectious diseases consultant or consultant in GU medicine, remain with the clinician caring for the source patient.

Source patient venous blood is taken in a 7.5ml clotted sample (brown topped bottle). Use a virology form, and put the following information in the clinical features box:

- **”Source Patient for needlestick accident. Please test for HBsAg, AND HIV AND HCV Antibodies.”** ***ALSO*** put the injured person’s name and d.o.b. too so that the laboratory and OHD can link the two samples together.

THE BLOOD TEST REQUEST MUST BE FROM THE CLINICIAN IN CHARGE OF THE SOURCE PATIENT’S CARE and COPIED INTO OCCUPATIONAL HEALTH.

Appendix 6: Source Patient Information Sheet

Accidental Exposure of Health Care Workers to Blood or Body Fluids

SOURCE PATIENT INFORMATION SHEET

You have been involved in an incident where one of the Health Care Staff has accidentally been exposed to your blood or another of your body fluids. If you are carrying an infection, then there is a chance that this could have been transmitted to your health care worker (it is possible to carry some viruses without any outward signs of infection).

It is usual practice for Health Care Workers who have been exposed in this way to have tests and treatments to ensure that they do not become infected with one of the more serious viruses such as Hepatitis B, C or HIV (the AIDS virus). These treatments are often complicated and can result in unpleasant side effects for the health care worker concerned over a period of several weeks.

Guidance from the Government's Department of Health recommends that in the situation described above, all patients are asked to give a blood sample. This blood can then be tested for Hepatitis B & C viruses and HIV. The result of the test would help decide which treatment your health care worker might need to take as a precaution against becoming infected. If your blood test results are negative, then your health care worker need not undergo treatment (or may be able to stop treatment if they have already started).

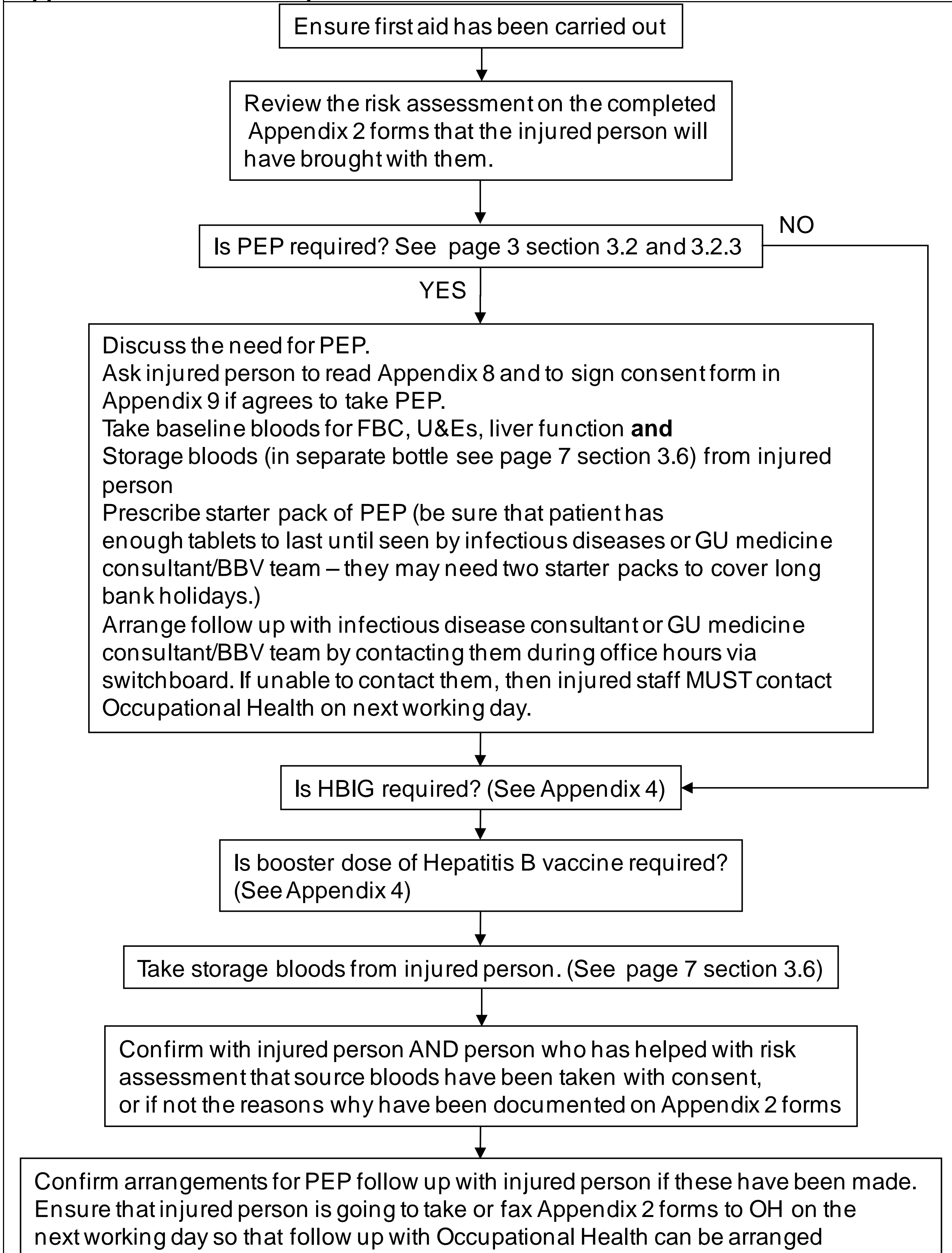
This request for a blood test from you is routine, and is asked for in all cases of accidental exposure to blood. It is not being requested from you because your doctors suspect that you have a virus infection - indeed if this were the case they would have discussed the matter with you before now. The test is being performed to help protect the health of your health care worker, and help them avoid taking an unnecessary course of treatment or having to have unnecessary tests.

One of the clinical staff will discuss with you about obtaining a blood sample, and will be able to answer any other questions you may have. You will be told the results of your blood test and what it means by the doctors caring for you. The results will also be made available to the medical specialist in Occupational Health who is looking after the health care worker involved in the accident. This doctor can then decide whether treatment or further tests are needed for your health care worker.

Simply having a blood test for Hepatitis B, C or HIV in circumstances such as these will have no effect on your ability to get life insurance or a mortgage if the result proves to be negative. Should, however, you be found to have one of these viruses this may have implications for your future health and the medical team who are caring for you will offer appropriate counselling and medical advice.

We thank you for your co-operation.

Appendix 7: Checklist Help for A+E Clinician



Appendix 8: HIV Exposure — Your questions answered

What is my risk of catching HIV?

- Your risk of acquiring HIV infection following an injury with a needle carrying HIV-infected blood is about 1 in 300. The risk from a splash of HIV– infected blood or body fluids into your eyes or mouth, or onto cuts and grazes on your skin, is much less – about 1 in 1,000 or less.
- There is no evidence of risk where HIV-infected blood is in contact with intact skin.
- Your risk is therefore small, but it may be worth trying to reduce the risk by taking **Post-Exposure Prophylaxis (PEP)**

What is PEP?

- Treatment with anti-HIV drugs lowers the chances of catching HIV after a contamination accident. Studies suggest that health care workers who take anti-HIV drugs after a needlestick have an 80% lower chance of catching HIV
- Our policy is to recommend a combination of anti-HIV drugs to be taken after a 'high risk' contamination accident. A 'high risk' accident being one where the source patient is known to be HIV positive or there is a risk that they could be.

Will I need to take this treatment?

- We will try to give you as much information as possible, to help you decide whether to take the PEP treatment. In the end, the decision is yours. Whatever you decide, we will ask you to sign a form to indicate whether or not you wish to start PEP.

Is treatment always effective?

- No. There are cases where HIV infection has developed despite the use of anti-HIV drugs after exposure. However, combination of drugs we use are recommended by national advisors and we believe will substantially lower your risk of infection.

When should treatment be started?

- It is best to start the treatment as soon as possible after the exposure, ideally within an hour. If the treatment is delayed beyond a couple of hours, the risk of infection rises. Nevertheless, even if there has been a delay of up to 72 hours in seeking advice after the exposure, we would still offer PEP though it would be likely to be less effective.

If I'm not sure about the treatment, should I start it or can I wait and start it later?

- Most health care workers are understandably upset and anxious, and find it hard to make this sort of decision. Even if you are unsure, we suggest that you take the first few doses of the drugs as recommended.
- You will be offered an appointment to see a clinician with expertise in this area (either the Consultant in Infectious Diseases or Consultant in GU medicine/BBV team) as soon as possible after starting the drugs, and you can then take further advice on whether to continue the drugs. You can discuss the situation with your partner and family, and take a calmer look at the risks.
- If you decide not to start the medication now, there is little point in starting it later. It will be much less effective or may not be effective at all – you will just get the possible side effects.
- We recommend that you remain on treatment for four weeks. This is expected to provide protection during the 'window of opportunity' for HIV infection to become established

Appendix 8: HIV Exposure — Your questions answered

Which drugs are recommended?

Medicine	Morning	Evening
Truvada	Take one tablet	
Raltegravir 400mg	Take one tablet	Take one tablet

- We may want to change these drugs later on, but we would explain this to you at the time.

Does the treatment have side effects?

- Many people get some mild side effects, and occasionally the side effects will be a problem that might even keep you off work.
- It can cause headache, muscle pains (like 'flu), stomach upsets and skin rashes.
- To make the treatment as safe as possible, close follow up is required. The clinicians managing your PEP will decide if you need any other blood tests because you are taking PEP.
- More details about the drugs, how they must be taken and their side effects, are included in the packs.

What if I am pregnant?

- The available evidence suggests that the recommended drugs are safe in pregnancy and if PEP is necessary it needs to be given regardless of the stage of pregnancy.
- You must tell your doctor if you could be pregnant. You should take precautions to avoid becoming pregnant or fathering a child while taking the medicines.
- The medication will reduce the effectiveness of hormonal contraception; these methods should not be relied on while you are taking the medication, and you should use a barrier method (condoms) in addition.

Is it safe to have sex with my partner and to give blood?

- Although the risk of you catching HIV is very small, we advise that you don't do anything that might pass on HIV to someone else. This means you shouldn't have unprotected sex (i.e. always use a condom) and you shouldn't donate blood until the Occupational Health Department give you the 'all clear'. This will be after blood tests taken at six months.

Can I still continue to work?

- You may need time off if you get side effects and feel unwell.
- If you are employed in a job that requires you to undertake 'exposure prone procedures' (e.g. surgery) you can still work, but you should discuss your job in detail with the Occupational Health Department and HIV specialist. It is possible that you will be advised not to undertake certain tasks to avoid any risk of passing on HIV that you may have caught to a patient.

Who do I contact for further information?

- We will arrange for you see the Consultant in GU medicine/BBV team or Infectious diseases consultant as soon as possible, and you are welcome to contact Occupational Health if you are worried.

Appendix 9: Staff Consent Form for HIV Post-Exposure Prophylaxis

Blackpool Teaching Hospitals
NHS Foundation Trust

I have read and understand the contents of the information sheet "HIV exposure – your questions answered"

I agree / do not agree* to start PEP

* Delete as appropriate

Surname………………………………………….. First Name………………………………..

Date of birth ……………………………………………..

Ward/Department ……………………………………

Job Title ……………………………………………………….

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

SAMPLE

Please return this form with the completed Appendix 2 forms **by the following working day to**

Consultant Occupational Health Physician
Occupational Health Department
2, North Park Dr, Blackpool, FY3 8NQ
Blackpool Teaching Hospitals Foundation NHS Trust

Appendix 10: Process for Monitoring Compliance

	Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individual / group / committee	Frequency of monitoring	Responsible individual / group / committee for review of results	Responsible individual / group / committee for development of action plan	Responsible individual / group / committee for development of action plan
a)	Duties	Audit	Occupational Health Manager Occupational Health Team	Annual	Occupational Health Manager Occupational Health Team	Occupational Health Manager Health and Safety and Environmental Governance Committee	Occupational Health Manager Health and Safety and Environmental Governance Committee
b)	Reporting arrangements in relation to inoculation incidents	Audit	Occupational Health Manager Occupational Health Team	Annual	Occupational Health Manager Occupational Health Team	Occupational Health Manager Health and Safety and Environmental Governance Committee	Occupational Health Manager Health and Safety and Environmental Governance Committee
c)	Process for the management of an inoculation incident (including prophylaxis)	Audit	Occupational Health Manager Occupational Health Team	Annual	Occupational Health Manager Occupational Health Team	Occupational Health Manager Health and Safety and Environmental Governance Committee	Occupational Health Manager Health and Safety and Environmental Governance Committee
d)	Organisation's expectations in relation to staff training as identified in the training needs analysis	Audit	Occupational Health Manager Occupational Health Team	Annual	Occupational Health Manager Occupational Health Team	Occupational Health Manager Health and Safety and Environmental Governance Committee	Occupational Health Manager Health and Safety and Environmental Governance Committee

Appendix 11: Equality Impact Assessment Form

Department	Occupational Health	Service or Policy	CORP/PROC/100	Date Completed:	January 2015

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?	See Purpose			
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?	No			
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	No			
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			
Does the policy/development promote access to services and facilities for any group in particular?	No			

Appendix 11: Equality Impact Assessment Form

Does the service, leaflet or policy/development impact on the environment • During development • At implementation?	No			

ACTION:			
Please identify if you are now required to carry out a Full Equality Analysis	~~**Yes**~~	**No**	**(Please delete as appropriate)**

Name of Author: **Signature of Author:**	**Dr Sue Richardson**	**Date Signed:**	**January 2015**
Name of Lead Person: **Signature of Lead Person:**		**Date Signed:**	
Name of Manager: **Signature of Manager**		**Date Signed:**	