## CONTENTS

| 1. Executive summary | 3 |
| 2. Status and Scope of Policy | 4 |
| 3. Introduction | 4 |
| 4. Definitions | 5 |
| 5. Purpose of this Policy | 6 |
| 6. Key Elements | 6 |
| 7. Responsibilities | 8 |
| 8. Confidentiality | 8 |
| 9. Review of this policy | 8 |
| 10. Bibliography | 9 |

### Appendices:

- **Annex 1**
  Standard Operational Procedure for incidents involving potential exposure to blood borne viruses through needlestick injuries & other non-sexual exposures. 10

- **Annex 2**
  Operational Procedures for ‘Working with Blood borne Viruses Policy’ 32

- **Annex 3**
  Hepatitis B 39

- **Annex 4**
  Hepatitis C 45

- **Annex 5**
  HIV 49

- **Annex 6**
  Requirements for Identified Validated Samples (IVS) 54

- **Annex 7**
  Lothian Policy for reporting blood borne virus-infected healthcare workers and initiating patient notification exercises 55
1. **Executive summary**

**Aim of the policy**
The overall aim of the policy is to control the risk to patients and staff from health care workers (HCW) infected with blood borne viruses (BBV), to control the risk to HCW from patients and to reinforce good practice. It documents the process by which NHS Lothian ensures compliance with the Scottish Government’s guidance on health clearance for HCW for BBV (hepatitis B, hepatitis C and HIV).

**Who it applies to**
- This policy relates to all NHS Lothian HCW with direct patient contact.
- The policy requires specific action from management (including service managers, clinical directors and departmental heads), Human Resources, Recruitment Departments, and Occupational Health and Safety.
- In addition, the following will be responsible for implementation of the policy in relation to themselves, their staff and students: agencies, education and training establishments and other NHS employers providing staff and students to work at NHS Lothian sites; General Practitioners, General Dental Practitioners, and other independent practitioners including the Spire Murrayfield Hospital.

**Key points of the policy**
- Clarification of roles and responsibilities for delivery of this policy. All HCW involved in clinical roles have a professional duty to protect patients and should be aware of the procedures outlined in this policy. Individuals who believe they may have been exposed to a BBV must seek medical advice.
- The establishment of BBV fitness criteria and associated testing regimes for staff employed in, or applying for, posts involving Exposure Prone Procedures (EPP - defined as those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient’s open tissues to the blood of the worker). This involves the establishment and operation of:
  - Detailed lists of posts assessed as involving EPP and staff employed within these posts.
  - Effective recruitment and pre-employment procedures ensuring no staff commence EPP work prior to confirmation that the BBV status is compatible with the policy.
  - Effective ongoing monitoring, surveillance, self-reporting and staff support systems to ensure BBV status of staff in EPP posts continues to be in accordance with the policy.
- The establishment of policy for the ongoing management and support of BBV-infected HCW, according to the NHS Lothian Redeployment policy.
- The establishment of policy for reporting procedures and risk assessment where a BBV-infected HCW is found to have performed EPP.
- Details of the current “Standard operating procedure for dealing with incidents involving potential exposure to blood borne viruses” (needlestick injury policy) including rapid access for reporting, effective access to post-exposure prophylaxis and follow-up according to agreed guidelines.

**Minimum implementation standards**
Department heads must assess this policy for relevance to their employees. Where the policy has relevance i.e. where employees have direct patient contact, the policy should be read and understood by the employees.
2. Status and Scope of Policy

2.1 This policy updates and replaces the previous Lothian policies for infected healthcare workers namely ‘Protecting healthcare workers and patients from Hepatitis B – Action Plan and Supplement’ (October 2000) and ‘Hepatitis C Infected Health Care Workers Action Plan’ (December 2003). It also implements the following guidance:

- ‘Practice of exposure prone medical procedures by healthcare workers living with HIV or Hepatitis B’ issued as SGHD/CMO (2014)2;

2.2 The aim of this policy is to control the risk to patients and staff from Health Care Workers (HCW) infected, or potentially infected, with blood borne viruses (BBVs), by documenting NHS Lothian requirements and systems for the management of such HCWs. It also aims to control the risk to HCW from patients and reinforce good practice. It represents the definitive plan for implementing, within Lothian, the Scottish Executive requirements for protecting patients from Hepatitis B, C and HIV as outlined in most recent guidance documents. In addition, the policy maintains the confidentiality and safe working of staff infected with BBVs and Annex 1 details the NHS Lothian procedure for dealing with incidents involving potential exposure to blood borne viruses.

2.3 This policy covers NHS Lothian employees, including bank and locum staff and workers who may be coming from high prevalence areas. Agencies supplying staff to NHS Lothian must also comply in full. Education and training establishments and other NHS employers providing staff or students to work at NHS Lothian sites must ensure their staff or students are compliant with no less rigorous standards. General Practitioners, General Dental Practitioners, the Spire Murrayfield Hospital and independent practitioners will be responsible for implementation in relation to themselves and their staff and students, liaising with the Lothian NHS Occupational Health Service (OHS), as required.

3. Introduction

3.1 The BBVs covered by this policy are Human Immunodeficiency Virus (HIV) Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV). The transmission of these viruses to patients from infected staff is an identified risk, which needs to be controlled. However, there is a greater risk to HCWs from the body fluids of infected patients.

3.2 Basic control of infection measures provide an important element of BBV infection control, and must be followed by all HCW.

3.3 After examining the risks, expert UK and Scottish Executive guidance suggest that formal pre-employment and “in post” clearance for BBV carriage should be limited to those HCWs involved in carrying out EPPs.
3.4 This policy operates in conjunction with the NHS Lothian Immunisation Policy (in progress) and NHS Lothian Procedure for dealing with incidents involving potential exposure to blood borne viruses (Annex 1).

4. Definitions

4.1 HCWs are persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a healthcare setting.

4.2 For considerations of Health Clearance, in terms of blood borne virus, the Scottish Government advice relates to HCWs with direct patient contact: defined as ‘staff who have regular clinical contact with patients and who are directly involved in patient care’. These include doctors, dentists, midwives, nurses, clinical support workers, paramedics and ambulance drivers, occupational therapists, physiotherapists and radiographers. Students and trainees in these disciplines and volunteers who are working with patients must also be included.

4.3 Non-clinical staff are workers who have social or professional contact with patients, but are not directly involved in patient care. This group includes receptionists, ward clerks, porters and cleaners.

4.4 Exposure Prone Procedures (EPP) are defined as follows\(^1\):

a) Those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient’s open tissues to the blood of the worker (bleed-back). These include procedures where the worker’s gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. sharp 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.

b) Procedures where the hands and fingertips of the worker are visible and outside the patient’s body at all times, and internal examinations or procedures that do not involve possible injury to the worker’s gloved hands from sharp instruments and/or tissues, are considered not to be exposure prone, provided routine infection control procedures are adhered to at all times. Examples of such procedures include:
   - taking blood (venepuncture)
   - setting up and maintaining intravenous 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 external abscesses
   - routine vaginal or rectal examinations
   - simple endoscopic procedures

Examples of UKAP’s advice on which procedures are, and are not, exposure prone are available\(^1\).
5. **Purpose of this policy**

5.1 To establish BBV fitness criteria and associated testing regimes for staff employed in, or applying for, posts involving EPP (Annexes 2-6).

5.2 To establish responsibilities within NHS Lothian for the delivery of this policy (Annex 2).

5.3 To establish NHS Lothian policy for the ongoing management and support of BBV-infected HCWs, according to the NHS Lothian Redeployment policy.

5.4 To ensure a policy for dealing with incidents involving potential exposure to blood borne viruses is maintained, which allows rapid access for reporting, effective access to PEP and follow-up according to agreed guidelines (Annex 1).

5.5 To establish Lothian policy for the reporting of BBV-infected healthcare workers who have performed EPP to the Director of Public Health (DPH), and outline the procedures for subsequent risk assessment and patient notification exercise if appropriate (Annex 7).

6. **Key elements**

The details of the procedures for this policy are contained in the annexes. The following section summarises the key elements:

6.1 **Lists of EPP posts**
Service Managers and Departmental Heads, in conjunction with the clinical director for the service, are responsible for the assessment of all their clinical posts and must maintain current lists of posts involving EPP. Posts should only be designated as involving EPP where they meet the definitions in 4.4 above. Over-designation of EPP posts leads to unjustified and inappropriate clinical investigations for screening for which there are ethical implications. Advice to managers is available from the Medical Director and from Consultant Occupational Physicians.

6.2 **Recruitment and pre-employment procedures**
Service Managers, Clinical Directors and Departmental Heads must ensure that individuals selected for EPP posts do not commence EPP until clearance is provided by the OHS via the relevant recruitment department.

6.3 **Redeployment procedures**
Where OHS assessments of existing staff determines that the worker is unfit for their employed role or identifies the need to modify practice, the Employee Relations advisor, in liaison with Partnership representatives, will work with the manager of the employee to arrange suitable alternative work which may involve referral to the NHS Lothian Redeployment Policy. Where the OHS assessment indicates occupational causation of the infection, it will be reported statutorily under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, and the employee will be retained in employment without detriment in pay and condition.
6.4 **Ongoing monitoring and surveillance**

a) Individuals who believe they may have been exposed to BBV infection, at work or in their personal life, must seek medical advice and if appropriate undergo diagnostic testing. Where such testing shows positive results, the worker must self-refer to Occupational Health for a review of their “fitness to work” assessment and may need to cease EPP.

b) Where accidental exposure to blood and body fluids occurs during work within NHS Lothian the "Standard Operating Procedure for incidents involving potential exposure to blood borne viruses through needlestick injuries and other non-sexual exposures" should be referred to (Annex 1). This policy outlines responsibilities and procedures for dealing with needlestick-type injuries in i) healthcare workers and ii) members of the public presenting to healthcare services. For healthcare workers this includes a risk assessment to be carried out by their line manager with the assistance of Occupational Health Nurses, who operate an on-call rota for this purpose. Onward referral can then be made for specialist advice as required.

c) Senior managers and departmental heads must ensure that they retain and maintain documented clearance for all staff carrying out EPP.

d) EPP staff subject to OHS follow-up requirements should attend for the required screening or immunisation when requested by the OHS. Where Occupational Health Clearance is withdrawn or where the review dates are exceeded without any clearance, the individual must cease EPP.

e) Clinicians should remind any BBV infected HCW under their care to refer themselves to OHS. If they become aware that an infected HCW is performing EPP or has done so in the past and has not followed the professional requirements of this policy to refer themselves to the OHS, or to modify their practice due to BBV infection, the clinician has a responsibility to inform Occupational Health. Occupational Health will risk assess the situation and notify the Medical Director/Nurse Director as appropriate. That Director will then consider who else should be notified.

f) The Medical Director/Nurse Director must ensure that NHS Lothian DPH is notified of any case where a HCW has performed EPP, when their BBV status does not meet the EPP standards as laid down in this policy. The responsibility for instituting and co-ordinating any patient notification exercise rests with the DPH (Annex 7).

g) HCW who have carried out EPP when their BBV status does not meet the requirements of this policy, have a personal responsibility to cease EPP and inform the OHS where they will get support and advice.
7 Responsibilities

7.1 The overall responsibility for the operation of this policy rests with the Medical Director, who is required to ensure that the key elements are subject to regular audit.

7.2 The Director of Human Resources has the responsibility to ensure that the policy is published and is known by NHS Lothian HCWs.

7.3 Staff should be aware of the relevant regulatory bodies’ statements on professional responsibilities:
- General Medical Council 2006. Good Medical Practice. www.gmc-uk.org
- General Dental Council. www.gdc-uk.org

8. Confidentiality

HCWs’ BBV status is subject to the same rights of medical confidentiality as any patient in receipt of medical care or investigation. Every effort should be made to avoid disclosure of the affected worker’s identity, or information that would allow deductive disclosure.

9. Review of this policy

It is recommended that this policy is reviewed and appropriately amended if necessary at two yearly intervals, or earlier if required.
10. Bibliography


STANDARD OPERATING PROCEDURE FOR INCIDENTS INVOLVING POTENTIAL EXPOSURE TO BLOOD BORNE VIRUSES THROUGH NEEDLESTICK INJURIES & OTHER NON-SEXUAL EXPOSURES

Standard Operating Procedure

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<tr>
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<td>July 2016</td>
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<tr>
<td>AUTHOR OF SOP</td>
<td>Public Health Consultant</td>
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 Definitions and abbreviations

<table>
<thead>
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<th>Definition</th>
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<tr>
<td>Anti HBS</td>
<td>Anti Hepatitis B Surface Antigen Antibody</td>
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<tr>
<td>BBV</td>
<td>Blood-Borne Viruses - refers collectively to human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV)</td>
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<td>CSHC</td>
<td>Chalmers Sexual Health Centre</td>
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<tr>
<td>GUM</td>
<td>Genito-Urinary Medicine</td>
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<td>HBIG</td>
<td>Hepatitis B Immunoglobulin</td>
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<td>Hepatitis C Virus</td>
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<td>Health Care Worker</td>
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<td>Human Immunodeficiency Virus</td>
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<td>Occupational Health Service</td>
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<tr>
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<td>Polymerase Chain Reaction</td>
</tr>
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<td>Post Exposure Prophylaxis</td>
</tr>
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<td>Royal Hospital for Sick Children</td>
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<tr>
<td>RIDU</td>
<td>Regional Infectious Diseases Unit</td>
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<tr>
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<td>Royal Infirmary of Edinburgh</td>
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<tr>
<td>SJH</td>
<td>St John’s Hospital</td>
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<td>WGH</td>
<td>Western General Hospital</td>
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Contents
1. Introduction
2. Immediate Action
3. Risk assessment of exposure
4. What to do if significant exposure has occurred
5. Post exposure prophylaxis against HIV
6. Post Exposure Prophylaxis against Hepatitis B
7. Follow up relating to Hepatitis C
8. General notes on follow up
9. References

Appendix 1 - Background information that may inform risk assessment
Appendix 2 - BBV risk assessment flowchart
Appendix 3 – Blood-borne virus exposure: Risk assessment record form
Appendix 4 - Current recommended HIV Post-Exposure Prophylaxis
Appendix 5 - Post-Exposure Prophylaxis: Patient Information Leaflet
Appendix 6 – NHS Lothian Testing for Blood-borne Viruses Leaflet
1. **Introduction**

This document gives practical step by step guidance on what to do after potential exposure to blood-borne viruses (BBV) following a needle-stick or other non-sexual incident. It is a standardised operating procedure (SOP) established as part of the NHS Lothian “Working with Blood-Borne Viruses Policy”. It deals with occupational injuries sustained by NHS health-care workers (HCW), third sector workers in voluntary agencies providing BBV testing using dry blood spot tests, as well as non-occupational injuries. The Occupational Health Service (OHS) does not get involved in non-occupational injuries or injuries to third sector workers.

Individuals presenting after **sexual exposure or assault** should be assessed according to the Lothian Guidelines for Post-Exposure Prophylaxis for Sexual Exposure to BBVs (PEPSE) (revised July 2014), available on the intranet.

2. **Immediate Action**

2.1 **Wound care**

Wash injury thoroughly with warm running water and soap

Encourage bleeding

Cover with a waterproof plaster

Exposed mucous membranes, including conjunctivae, should be irrigated copiously with saline eye wash after removal of contact lenses.

2.2 **Informing people in case of NHS health care worker (HCW) injuries**

**The injured person**

- Report injury to line manager (Consultant on duty in the case of medical staff)
- Contact Occupational Health Service (OHS) on 0131 537 9369 or extension 49369 (on aircall via Astley Ainslie switchboard 0131 537 6000 outwith normal hours of 08.00 to 16.00, Monday to Friday).

**The line manager**

- Clarify that a needle-stick or other significant exposure injury has occurred
- Ensure that the individual has reported to OHS for advice and follow-up
- Carry out a risk assessment with assistance from OHS (see section 3 below). For Regional Infectious Diseases Unit (RIDU) and Chalmers Sexual Health Centre (CSHC) staff, the risk assessment will be carried out by the consultant on-call, but the OHS nurse must also be informed in every case.
- There is a legal requirement for line management to accurately record all injuries occurring within the organisation. An incident form should be filled out in all cases. Confidentiality is paramount and the name of the injured party should not be included in any formal reports. Access to named information on the Datix system is password protected and restricted to key members of staff. The Datix reporting system should be used where available. All details should be filled in as usual, but the source patient should be identified by initials and case note number only, and the injured person should be referred to by initials and date of birth only. The full name of the injured person should be written / kept at ward / department level only.
- If appropriate, ensure that blood is obtained from the source patient for testing for BBVs (see section 4.5)
3. Risk Assessment of Exposure

3.1 Who does risk assessment when a HCW has been injured?
The line manager does this with assistance from the on-call OHS nurse. If the injury
is sustained by a single-handed HCW (e.g. salaried dental practitioner), this person
should contact the on-call OHS nurse (if covered by this service) or the duty
Infectious Diseases (ID) consultant for advice.

3.2 Who does risk assessment when a third sector worker or member of the public
has been injured?
This is done by the doctor to whom the injured person presents e.g. a doctor in A&E
or a GP. Expert advice is available from GUM and ID consultants on call in CSHC or
RIDU (via switchboard - Tel No. 0131-536-1000). Both units provide on-call advice
Monday - Friday, 09.00 – 17.00. Out-of-hours cover is provided solely by ID
consultants at RIDU.

Children with needle-stick or exposure injuries are usually seen at the A&E
department at RHSC. Expert advice can be obtained (at any time) from Dr Laura
Jones, Consultant Paediatrician, who can be contacted via switchboard (0131 536
1000). In the event that Dr Jones cannot be contacted out-of-hours then contact the
Paediatric Infectious Disease on-call consultant in Glasgow Tel 0141 201 0000.

3.3 How to assess whether there has been significant exposure
The significance of the exposure depends on the type of exposure and the type of
body fluids involved.

Type of exposure: there are three types associated with significant risk.
Perforaneous injury (from needles, instruments, bone fragments, significant bites
which break the skin, etc)
Exposure of broken skin (abrasions, cuts, eczema etc)
Exposure of mucous membranes including the eyes

Type of body fluid: the following are potentially infectious for BBV.
Blood
Amniotic fluid
Cerebrospinal fluid
Human breast milk
Pericardial, peritoneal, synovial and pleural fluid
Saliva in association with dentistry (likely to be contaminated with blood, even when
not obviously so)
Unfixed human tissues and organs
Any other body fluid if visibly bloodstained
Exudative or other tissue fluid from burns or skin lesions
Genital tract secretions

Note that urine is not considered to be an infectious fluid (unless visibly blood
stained).

Transmission of HIV by human bite has been reported but is extremely rare. In
those rare cases where it has occurred there has been severe trauma with extensive
tissue damage and the presence of blood. Even if one party (biter or victim) is known
to be HIV positive, a significant exposure is unlikely.
Possible biting scenarios include:

**Known HIV positive person bites HIV negative person**: a significant exposure would require some form of mucosal trauma to the mouth of the biter and severe trauma with extensive tissue damage to the victim.

**HIV negative person bites known HIV positive person**: significant oral exposure would occur if there was significant bleeding from the victim into the mouth of the biter and some form of mucosal trauma to the mouth of the biter.

If neither party is known to be HIV positive then a bite would not constitute a significant risk for HIV transmission.

### 3.4 Outcome of the initial risk assessment

If risk assessment indicates that no significant exposure has occurred, then no further action is required. If risk assessment indicates that significant exposure has occurred, go to Section 4.0.

### 4. What to do if significant exposure has occurred

#### 4.1 Assess the risk of transmission

Assess the nature of exposure and the source status. This will inform your course of action. See appendix 1, also flowchart in Appendix 2.

<table>
<thead>
<tr>
<th>Nature of exposure</th>
<th>Source status</th>
<th>Recommended action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not significant</strong></td>
<td>Not relevant</td>
<td>No action required</td>
</tr>
<tr>
<td><strong>Significant exposure</strong></td>
<td>Known sero-negative for BBVs within last month</td>
<td>Decide whether to <strong>seek source blood testing</strong> based on likelihood of BBV infection occurring since last test. If so, treat as “BBV status unknown” below. Blood for storage: required HIV: PEP not required. HBV: See Section 6.0 Follow-up: Not required***</td>
</tr>
<tr>
<td></td>
<td>Source identity unknown. BBV status unknown.</td>
<td>Blood for storage: required HIV: PEP not required**. HBV: See Section 6.0. Offer injured party testing*</td>
</tr>
<tr>
<td></td>
<td>Source identity known. BBV status unknown.</td>
<td>Blood for storage: required HIV: PEP usually not required, but may be started pending source testing. HBV: See Section 6.0. Offer injured party testing* Seek source blood testing **</td>
</tr>
<tr>
<td>Source known HIV, HBV and/or HCV positive</td>
<td></td>
<td>Blood for storage: required HIV: PEP recommended if source HIV positive. HBV: See Section 6.0 Recommend injured party testing*</td>
</tr>
</tbody>
</table>

*Staff at RIDU are always prepared to discuss unusual cases and to offer follow-up counselling.
**The seroprevalence of HIV in injecting drug users in Scotland is estimated to be <0.5%. Transmission by needlestick is unusual, even if the source is HIV positive. Therefore people sustaining a needlestick injury from a discarded needle or a source of unknown status should not be offered PEP.**

4.2 Record keeping

In every case fill in a Risk Assessment Record Form (Appendix 3). Copies are available with the 3 day starter packs (see section 5.3 for starter pack locations) and clinical managers should ensure that forms are available to health care workers in all clinical situations in NHS Lothian.

For healthcare workers, the form should be emailed to Occupational Health Department occupational.health@nhslothian.scot.nhs.uk

For third sector workers and members of the public, the risk assessment form should be filed with the clinical case notes.

Where injured party testing and follow up is required there are 3 options:

Option 1:
Contact the on-call RIDU middle grade doctor via WGH switchboard. This doctor is available 09:00 to 21:00 every day.

Outwith these hours, obtain a contact number for the injured person and contact the on-call ID middle grade doctor the next morning. Email the risk assessment form to wgh.infectiousdiseases@nhslothian.scot.nhs.uk

Option 2:
Contact the on-call GUM middle grade doctor at Chalmers Sexual Health Centre via the help line 0131 536 1070 selecting option 3 to speak to a professional member of staff, or telephone the doctors’ station on extension 61585. A GUM doctor is available in the clinic 08:30 to 16.30, Monday to Friday. Email the risk assessment record form to Chalmers.ClinicalAdv@nhslothian.scot.nhs.uk marked as URGENT. The injured person should be asked to present to the main reception of Chalmers Sexual Health Centre at 9am on the next working day or as agreed with the on-call doctor.

Option 3:
For paediatrics contact Dr Laura Jones at RHSC. The HCW / member of the public should be informed where to attend for follow up, and asked to attend as agreed with the on-call doctor at the receiving unit.

4.3 General guidance on the BBV testing service

RIE Laboratory Medicine (Virology) offers a 7-day routine laboratory service within normal working hours. Furthermore, the Department offers an urgent BBV testing service around the clock. The service is supported by a Consultant Virologist at all times. However, urgent test requests should only be made when required by the initial risk assessment where it indicates a real risk of BBV infection in the source (see appendix 1). In other situations, the source patient tests may be performed the next morning in a non-urgent manner.

Verbal requests for urgent tests should be made directly to Virology (through RIE switchboard; 0131 536 1000) – either to the Duty Virologist (within normal working hours Monday-Friday) or the Biomedical Scientist on-call (out-with normal working hours).
Urgent tests are turned around within two hours from arrival at RIE provided details have been conveyed to Virology. However, data obtained from source testing may not always be available rapidly enough to influence a decision on starting HIV PEP, although it will be helpful in informing a decision to stop PEP promptly and/or reassure the injured person.

A request form should accompany the source patient’s 4.5 ml serum gel (brown cap) blood sample tube, include all of the patient’s and requestor’s details (including contact telephone and bleep numbers) and be marked as ‘Urgent: Exposure incident - source patient’ to aid rapid processing. Such samples may also be sent within the hospital system via TRAK provided all details are included. Either way, urgent requests must also be made verbally to Virology (as outlined above).

The test panel offered for source patient testing consists of the following tests: HIV antigen / antibody, HBV surface antigen, HBV core antibody, HCV antigen and HCV antibody. HBV surface antibody levels may be assessed at the same time if required.

4.4 Blood for storage (for the injured person)

In every case of significant exposure, take a baseline 4.5 ml anti-coagulated EDTA (red cap) blood sample from the injured person at the time of the incident and send it to RIE Laboratory Medicine (Virology) for testing or storage (samples will be kept for 2 years). Patients receiving HIV PEP (see below) will also require FBC, U&Es, phosphate and LFTs. In general, further EDTA blood samples should be obtained at 6 weeks (for significant exposure to HCV), 12 weeks and 24 weeks (for further details, please refer to sections 5.5, 5.6, 6.1 and 7.0 below).

4.5 BBV testing of the source person where their identity is known

It is the responsibility of the injured worker’s line manager to ensure that every effort is made to establish the sero-status of the source. A senior member of the clinical team responsible for the source patient should make arrangements to approach a source patient whose BBV sero-status is not known and ask for their informed agreement to testing. The injured HCW should not undertake this approach.

However, if the HCW sustaining the injury is single-handed, there may be no option but for them to approach the source patient themselves. In this case, if the source patient agrees to BBV testing, they could be referred to their General Practitioner or A&E for testing. The single handed practitioner should contact the GP / A&E to explain the situation.

A universal approach to asking source patients to agree to testing avoids the need to make difficult judgements, simplifies and normalises the process and avoids any appearance of discrimination against people perceived as belonging to groups associated with higher than average BBV prevalence. However, urgent out-of-hours determination of source sero-status may not be required if risk is low and, in this case, blood specimens can be taken and stored overnight for in-hours testing during the next day.

Similar to all other tests, pre-test discussion and informed consent is required, and such pre-test discussion can be provided by any competent HCW. Specialist pre-test counselling may sometimes be considered appropriate if the circumstances of the source patient are unusual or complex.
As part of pre-test discussion, or prior to asking about a history of possible exposure to BBV, the source patient should first be informed about the incident and the reason for the enquiry and request for a test. The difficulties of the exposed HCW’s situation should be discussed – either in terms of the worker not missing the opportunity to benefit from HIV PEP, or conversely, not being subjected unnecessarily to its potentially unpleasant short term and unknown long term side effects. Consent to HIV testing is rarely withheld in these circumstances, when the approach is made in a sensitive manner. Test results should be conveyed to the source patient.

If consent for testing is withheld or cannot be obtained from the source patient, for example because the source patient is unconscious, then testing cannot be carried out in light of the Expert Advisory Group on Aids (EAGA) guidelines, and a risk assessment has to be made without a test being performed.

Any source patient who is newly diagnosed with BBV infection as a result of this process will need immediate access to specialist post-test counselling and assurances about confidentiality. Source patients should also be informed promptly of negative results, with any post-test counselling appropriate to individual circumstances.

4.6 What to do if the identify of the source patient is NOT known

In general if the source patient cannot be identified, prophylaxis against HIV will not be recommended. But, in some cases there may be reason to give PEP where the exact identity of the source cannot be established. The on-call RIDU / GUM consultants are available to discuss difficult cases.

4.7 BBV testing of the injured person

Testing of the injured person for BBV should be considered in all cases. There is a professional obligation on certain healthcare workers to submit to testing when they have been at significant risk scenarios, there would be very strong advice that the individual should be tested. In a very low risk event, however, even if there was a significant injury, testing should be decided on a case by case basis and in consultation with the injured party, Occupational Health Service (in the case of healthcare worker), RIDU and the injured person’s attending physician. See Tables 3 and 4 for further details.

In the event of a subsequent BBV-positive test result, where an individual did not wish to be tested for a BBV at the time of injury, a stored baseline sample may allow the injured person to demonstrate seronegativity at the time of injury.

4.8 Checking vaccination status of injured person

Review the injured person’s HBV vaccination status, whatever the source status. Children will also be required to have their tetanus vaccination status checked.

4.9 Special circumstances

It is recognised that even in events where there is no significant injury or the risk is very low, patient concern and anxiety may determine the need for referral to CSHC/ RIDU for counselling and follow up.
Annex to the NHS Lothian Working with Blood Borne Viruses Policy

Individuals presenting after sexual exposure or assault should be assessed according to the Lothian Guidelines for Post Exposure Prophylaxis for Sexual Exposure to BBVs (PEPSE), available on the intranet.

5. **Post exposure prophylaxis against HIV**
   5.1 **Timing of initiation of PEP against HIV**
   PEP against HIV should be started as early as possible, ideally within 1 hour of a significant exposure. If it is known (or seems very likely) that the source is HIV positive, it may be appropriate to start PEP immediately pending the outcome of a more thorough risk assessment. Patients presenting more than 48 hours after significant exposure should be discussed with the on-call RIDU / GUM consultants. Where laboratory staff working with drug-resistant virus are exposed, an immediate expert opinion must be obtained from RIDU or GUM.

   5.2 **Supplying PEP against HIV**
   The evaluation of the injured person should include a medical history. Details of any existing medication should be established (including oral contraception, herbal remedies, medication purchased over the counter at pharmacies, prescribed drugs of addiction and recreational drugs). Females should be asked specifically about the possibility of pregnancy. In cases of doubt, the on-call ID or GUM consultant should be contacted. The current recommended regime for PEP in NHS Lothian is detailed in Appendix 4.

   Sexually active females who may be pregnant and are offered PEP should be discussed with the on-call ID or GUM consultant. Pregnancy is not a contraindication to PEP, but may affect the decision process. Urgent pregnancy testing should be arranged for any woman who cannot rule out the possibility of pregnancy to allow the injured person to reach an informed decision.

5.3 **Starter packs**
Starter packs containing a three day supply of medication are available at the following locations:
RIE A&E department
St John’s Hospital A&E department
Royal Sick Children’s Hospital emergency cupboard (Ward 6)
Roodlands Hospital back up cupboard (Ward 1)
Chalmers Sexual Health Centre
Regional Infectious Diseases Unit (WGH)

Starter packs also contain:
A patient information leaflet (Appendix 5)
A spare copy of the risk assessment sheet (Appendix 3)
A copy of NHS Lothian Testing for Blood Borne Viruses Leaflet (Appendix 6)

Clinical directors and/or professional leads in charge of these departments must ensure that staff are familiar with the contents of this SOP, are aware of the location of starter packs, and are adequately trained in the implementation of this SOP.

A full PEP course is 4 weeks (28 days).
5.4 **Patient information**

The doctor providing PEP should make sure the injured person has a copy of the NHS Lothian Post Exposure Prophylaxis Patient Information Leaflet (Appendix 5). Copies of this are available in the starter packs and at CSHC / RIDU. Patients should be informed that antiviral drugs are not licensed for prophylactic use, but that there is extensive experience of their use in this way. There are only prescribed when the potential benefits outweigh any potential risks.

5.5 **Follow up for HIV in patients starting PEP**

Patients starting PEP should attend for medical and counselling follow-up with a consultant in RIDU or GUM within 48 hours so that a decision can be made on continuing therapy, and so that any additional concerns can be addressed.

Follow-up for HIV is described in detail in Appendix 5, ‘Post Exposure Prophylaxis: patient information leaflet’. HIV follow up testing should be done at 4 weeks and 12 weeks after completion of PEP (i.e. 8 and 16 weeks after exposure).

For children, follow-up should be with Dr. Laura Jones at RHSC.

5.6 **Follow-up for HIV in patients not starting PEP**

Patients not taking PEP against HIV who are offered and agree to follow up testing should be tested at least 12 weeks after the exposure incident.

6. **PEP against Hepatitis B**

For HCWs and third sector workers providing BBV dry blood spot testing, the OHS nurse will arrange follow-up, and assess need for HBV vaccination. Most HCWs have been vaccinated against HBV and many will know whether they have responded to a HBV vaccine course. Irrespective of type of exposure: (1) all fully vaccinated HCWs (responders and non-responders alike) should be considered for HBV vaccine booster at time of exposure and (2) all non or partially vaccinated HCWs should embark on/complete their HBV vaccine course.

For details of HBV vaccination and Hepatitis B Immunoglobulin (HBIG) administration see Table 2.

Members of the public may be referred to their GP for completion of the vaccination course.

Those with significant exposure (as stated in paragraph 4.1 table 1) should be referred to RIDU/CSHS/Paediatrics for follow-up (see para 4.2).
### Table 2: Use of HBV vaccine and HBIG

<table>
<thead>
<tr>
<th>HBV status of exposed person</th>
<th>Significant exposure</th>
<th>Source patient is known to be actively infected with HBV</th>
<th>Source patient is unknown</th>
<th>Source patient is known NOT to be infected with HBV</th>
</tr>
</thead>
</table>
| Less than or equal to 1 dose of HBV vaccine pre-exposure | HBIG* x 1
Initiate accelerated** course of HBV vaccination | Initiate accelerated** course of HBV vaccination | Initiate accelerated* course of HBV vaccination |
| Greater than or equal to 2 doses of HBV vaccine pre-exposure (anti-HBs level unknown) | Give one dose of HBV vaccine now followed by a second dose one month later; check anti-HBS level | Give one dose of HBV vaccine now (finish course of HBV vaccine); check anti-HBS level | Give one dose of HBV vaccine now (finish course of HBV vaccine); check anti-HBS level |
| Known past HBV infection | No HBV prophylaxis | No HBV prophylaxis | No HBV prophylaxis |
| Known responder to HBV vaccination (anti-HBs >10mIU/ml) | Consider booster dose of HBV vaccine | Consider booster dose of HBV vaccine | Consider booster dose of HBV vaccine |
| Known non-responder to HBV vaccine (anti-HBs <10mIU/ml) | HBIG x 1
Consider booster dose of HBV vaccine
A second dose of HBIG should be given at one month | HBIG x 1
Consider booster dose of HBV vaccine
A second dose of HBIG should be given at one month | Consider booster dose of HBV vaccine |

*HBIG should be given as soon as possible after significant exposure and ideally within 48hrs although it should still be considered up to a week post-exposure. Hepatitis B immunoglobulin is held in the emergency cupboard fridge at the RIE. Dose: Adult and Child over 10 yrs, 500 international units by IM injection – see current BNF for paediatric doses / contact Dr. Laura Jones at RHSC.

**HBV accelerated vaccination: Doses at 0, 1 and 2 months with a booster dose at 12 months. See current BNF for adult and paediatric doses.

HBIG and HBV vaccinations should be administered at different sites if being given at the same time.

### 6.1 Follow up for Hepatitis B

Where people have received a course of vaccine following their significant exposure, follow-up for HBV is usually required for at least 6 months. However, individuals who are pre-exposure HBV vaccine responders with anti-HBs titres >100mUL/ml 2-3 months after a full vaccine course do not need follow up testing for HBV.
Table 3: Tests for HBV following significant exposure.

<table>
<thead>
<tr>
<th>Blood test</th>
<th>Three months post exposure</th>
<th>Six months post exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B surface antigen</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis B core antibody</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

7. **Follow up relating to Hepatitis C**

There is no vaccination or post-exposure prophylaxis for HCV but HCWs who develop symptoms of acute HCV should receive early treatment. Follow-up for HCV is required for at least 6 months.

Table 4: Tests for HCV following significant exposure*.

<table>
<thead>
<tr>
<th>Blood test</th>
<th>6 weeks post exposure</th>
<th>12 weeks post exposure</th>
<th>24 weeks post exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV Antibody</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>HCV RNA (PCR)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

* Positive results will prompt repeat testing and referral to RIDU.

8. **General notes on follow up**

8.1 **Health care workers (HCW)**

Following any occupational exposure to BBV, whether or not PEP was prescribed, HCWs should attend for OHS follow-up as requested by OHS staff and be prepared to report symptoms/signs of concern at any time. HCWs who carry out exposure prone procedures (EPP) do not need to modify their practice.

8.2 **Third sector workers and members of the public**

Follow up for third sector workers and members of the public who have been commenced on PEP is available at RIDU (WGH) or Chalmers Sexual Health Centre (Chalmers Street) by following the options outlined in para 4.2.
8.3 **Expert advice**

ID and GUM consultants are available to assist with risk assessment in complicated cases. Out-of-hours cover will be provided by the ID consultants but there is no need to contact them in the middle of the night if a decision to supply a starter pack has been made. It will usually be appropriate to obtain a contact number for the injured person and contact the on-call ID middle grade doctor the next morning.

Counselling staff at RIDU are happy to see HCW’s and members of the public who have been affected by BBV issues, even if the level of risk associated with this incident is negligible. They can be contacted on 0131 537 2864 or extension 32864.

In all cases no child should be started on PEP without prior discussion with Dr Laura Jones. Children whether receiving HIV PEP, HBV vaccinations or follow up testing should be referred to Dr Laura Jones. The referral letter should be sent to 10 Chalmers Crescent, Edinburgh EH9 1TS. The Paediatric Infectious Diseases Consultant on call in Glasgow (Tel 0141 201 0000) will provide cover for Laura Jones if she is unavailable.

8.4 **BBV testing information leaflet**

While waiting for test results and follow-up, it may be appropriate to give patients some basic written information. The information leaflet "Testing for Blood Borne Viruses" (Appendix 6) provides brief information on BBVs and issues to consider prior to being tested. Copies are available from the NHS Lothian Health Promotion Library at Astley Ainslie Hospital (Tel 0131 537 9337) and in starter packs.

9. **References**


Adapted from Department of Health. Immunisation against infectious disease 2006  


Post-exposure prophylaxis for Sexual Exposure to Blood-borne viruses (PEPSE) and other Non-Occupational Exposures to HIV  
SOP APPENDIX 1. Background information that may inform risk assessment

HIV

The risk of acquiring HIV infection following occupational exposure to HIV infected blood is low. Epidemiological studies have indicated that the average risk for HIV transmission after percutaneous exposure to HIV infected blood in health care settings is about 1 per 300 injuries (~0.3%). After a mucocutaneous exposure the average risk is estimated at less than 1 in 1,000 (<0.1%). Case control studies have identified factors associated with increased risk of occupationally acquired HIV infection including deep injury, visible blood on the device which caused the injury, injury with a needle which had been placed in a source patient’s artery or vein, terminal HIV-related illness in the source patient (a surrogate marker for high viral load).

Hepatitis B and C

Hepatitis B and C are more easily transmitted. Figures quoted for transmission are less than 1 in 50 for HCV, and 1 in 3 (~30%) for HBV from HepB eAg positive source.

Estimates of Blood-Borne Virus prevalence in Lothian (September 2013)

<table>
<thead>
<tr>
<th></th>
<th>HIV</th>
<th>HCV</th>
<th>HBV</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population</td>
<td>0.17% Lothian as at Dec 2012. 0.26% in 15-59 year olds. These are diagnosed prevalences; estimates taking into account undiagnosed will be higher</td>
<td>0.7% Lothian 2012</td>
<td>0.2% (chronic) Scotland over 15s;</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>5.5% MRC gay bar survey Edinburgh, 2012 (n=530) 3.1% England and Wales (not London), 2011</td>
<td>Audit by Lothian GUM in 2009 showed HCV prevalence no higher in MSM than in general population, unless HIV positive</td>
<td>Data not yet available from NaSH</td>
</tr>
<tr>
<td>People who inject or have ever injected drugs</td>
<td>0.4% in Lothian (unpub NESI 2011/12) c.f.1.2% England, Wales &amp; NI, 2011 (HIV in UK report, Public Health England) (0.9% outwith London)</td>
<td>33% in Lothian (n=385) 2010 NESI</td>
<td>0.74% (HBsAg) England, Wales &amp; NI, 2011 Shooting Up report.</td>
</tr>
<tr>
<td></td>
<td>HIV</td>
<td>HCV</td>
<td>HBV</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>People who inject</td>
<td>England &amp; Wales 1.5% (all) <strong>0.8%</strong> (after excluding other risk</td>
<td>England &amp; Wales 5.5% (all) <strong>4.7%</strong> (after excluding other risk</td>
<td>England &amp; Wales 8.8% (chronic, all) <strong>8.0%</strong> (after excluding other</td>
</tr>
<tr>
<td>image enhancing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black Africans</td>
<td>2.6% in men</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td></td>
<td>5.1% in women</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>England &amp; Wales, 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Asian</td>
<td></td>
<td><strong>0.59%</strong> (chronic) in South Asian women in Scotland aged 15-44</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Schnier et al, HPS, 2013)</td>
<td></td>
</tr>
<tr>
<td>East Asian</td>
<td></td>
<td><strong>10.3 – 11.6%</strong> (chronic) in East Asian in Scotland aged 15-44;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Schnier et al, HPS, 2013)</td>
<td></td>
</tr>
<tr>
<td>Prisoners HMP</td>
<td>No data</td>
<td>13% (all prisoners)</td>
<td>No data</td>
</tr>
<tr>
<td>Edinburgh</td>
<td></td>
<td>34% (ever injector prisoners)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2% (non-injector prisoners)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taylor et al, 2011</td>
<td></td>
</tr>
<tr>
<td>Prisoners HMP</td>
<td>No data</td>
<td>16% (all prisoners)</td>
<td>No data</td>
</tr>
<tr>
<td>Addiewell</td>
<td></td>
<td>46% (ever injector prisoners)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3% (non-injector prisoners)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taylor et al, 2011</td>
<td></td>
</tr>
</tbody>
</table>
Annex to NHS Lothian Working with Blood Borne Viruses Policy

BBV Risk Assessment flowchart

Possible BBV exposure

Wound care
- Wash injury thoroughly with warm running water and soap
- Encourage bleeding
- Cover with a waterproof plaster
- Exposed mucous membranes, including conjunctivae, should be irrigated copiously after removal of contact lenses

NHS Health Care Worker?
- Yes
  - Inform Occupational health Supervisor/manager
- No

Nature of injury:
- Percutaneous injury, exposure of broken skin or mucous membranes?
  - Yes
  - No significant exposure.
  - No
  - Yes

Serostatus of source known?
- Yes
  - Known HIV/HBV/HCV positive
  - Known HIV/HBV/HCV negative within last month
  - Is there reason to repeat test?
  - Blood for storage: required
    - HIV PEP recommended if source HIV positive.
    - HBV: See Section 6.0
    - Recommend injured party testing*
  - Blood for storage: required
    - HIV: PEP not required.
    - HBV: See Section 6.0
    - Follow-up: Not required

- No
  - Blood for storage: required
    - HIV: PEP usually not required, unless source high risk.
    - HBV: See Section 6.0
    - Offer injured party testing*
    - Seek source blood testing*

- One of these fluids?
  - Blood, amniotic fluid, CSF, milk, pericardial, peritoneal, synovial and pleural fluid, saliva in association with dentistry, unfixed tissues, other bloodstained fluid, exudative or other tissue fluid from burns or skin lesions, genital tract secretions

Identity of source known?
- Yes
  - Blood for storage: required
    - HIV: PEP not required**.
    - HBV: See Section 6.0
    - Offer injured party testing*

- No
  - Blood for storage: required
    - HIV: PEP not required**.
    - HBV: See Section 6.0
    - Offer injured party testing*

*Staff at RIDU are always prepared to discuss unusual cases and to offer follow-up counselling.
**The seroprevalence of HIV in injecting drug users in Scotland is estimated to be <0.5%. Transmission by needlestick is unusual, even if the source is HIV positive. Therefore people sustaining a needlestick injury from a discarded needle or a source of unknown status should not be offered PEP.
SOP APPENDIX 3: Blood-borne virus exposure: Risk assessment record form

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Date of Incident</td>
</tr>
<tr>
<td>Hospital Number</td>
<td>Time of Incident</td>
</tr>
<tr>
<td>GP</td>
<td>Nature of Incident</td>
</tr>
<tr>
<td>GP address</td>
<td>Is the injured person a health care worker? Yes / No</td>
</tr>
</tbody>
</table>

**Result of risk assessment:**

See "NHS Lothian Standard Operating Procedure for incidents involving potential exposure to blood borne viruses" main document and flowchart (Appendix 2)

<table>
<thead>
<tr>
<th>*Serum stored (everyone)</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum tested</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIV risk discussed</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis C risk discussed</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Hepatitis B risk discussed</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required</th>
<th>Given</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBV immunoglobulin</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>HBV vaccination</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>HIV PEP</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

**If HIV PEP is required**

Confirm that you have discussed the following:

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative risk of HIV infection</td>
</tr>
<tr>
<td>Side-effects of drugs (see patient info leaflet)</td>
</tr>
<tr>
<td>Possibility of pregnancy</td>
</tr>
<tr>
<td>Pregnancy Test</td>
</tr>
</tbody>
</table>

...and done the following:

<table>
<thead>
<tr>
<th>Required</th>
<th>Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient information leaflet given</td>
<td>Yes / No</td>
</tr>
<tr>
<td>FBC, LFTs</td>
<td>Yes / No</td>
</tr>
<tr>
<td>PEP 3 day starter pack supplied</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

**Follow-up**

<table>
<thead>
<tr>
<th>Follow up offered or recommended</th>
<th>Yes / No</th>
</tr>
</thead>
</table>

If yes, what arrangements have been made so far?

See "NHS Lothian Standard Operating Procedure for incidents involving potential exposure to blood borne viruses" main document

**Signed** | **Date/Time**

**Printed Name** | **Designation**

For all significant exposure cases, email completed form to either RIDU email: wgh.infectiousdiseases@nhslothian.scot.nhs.uk or Chalmers Sexual Health Centre email: Chalmers.ClinicalAdv@nhslothian.scot.nhs.uk – marked as URGENT or send to Dr Laura Jones (Paediatrics). For advice tel RIDU 0131 537 2878, Chalmers tel 0131 5361070 Also send to Occupational Health: occupational.health@nhslothian.scot.nhs.uk for all injured health care workers.

* Patients receiving HIV PEP will also require FBC, U&Es, phosphate and LFTs
SOP APPENDIX 4: Current recommended HIV Post-Exposure Prophylaxis

The following regimen is currently recommended for post-exposure prophylaxis in adults in Lothian (from April 2014):

Truvada tablets: (tenofovir disoproxil 245mg and emtricitabine 200mg):
ONE tablet ONCE a day at the same time each day (with food)

And

Raltegravir
ONE tablet TWICE a day (every twelve hours) with food.

Both medications are continued for 4 weeks (28 days) in total.

For children, please consult Consultant Paediatrician for dosages (available via RHSC switchboard).
SOP APPENDIX 5: Post-Exposure Prophylaxis [PEP]: Patient information leaflet

Information about drugs to reduce the risk of acquiring HIV

About this factsheet
This leaflet gives information about the risk of acquiring HIV from a needlestick or similar injury. If you have just had a needlestick injury, it is likely that by now you will have been assessed by a doctor or an Occupational Health nurse, and have been offered drugs to reduce the risk of acquiring HIV. That person should have given you specific information about your situation. If there are things you need to know that are not covered in this leaflet, you should ask the person who has assessed you.

What is the risk of acquiring HIV from a needlestick injury?
The risk of acquiring HIV from a needlestick injury from someone who is known to have HIV is very low - about 3 in 1,000. This means that for every 1,000 people who sustain a needlestick injury, only 3 will acquire HIV. This is the average risk. The risk is higher if the patient has acquired HIV very recently (i.e. seroconverting) or has had HIV for a long time and is not on treatment. Other factors, such as the amount of blood involved and the depth of the needlestick injury also affect the risk. Splashing of blood onto mucous membranes (e.g. the eye) or onto broken skin can transmit infection but the risk is much lower than with a needlestick. Splashing of blood onto intact skin does not transmit HIV infection.

The risk from other injuries such as bites is difficult to assess - this really needs to be discussed with your doctor on an individual basis, but the risk is likely to be very low.

HIV and AIDS
HIV is the virus that causes AIDS. HIV damages the body’s immune (defence) system and leaves the patient open to infection - this is the disease called AIDS. Nearly everyone who is infected with HIV will develop AIDS at some point if not started on antiretroviral therapy.

An HIV infected person can transmit the infection to others by sexual intercourse, through blood transmission, during a pregnancy or through breast feeding.

HIV infection can usually be detected in the blood within four weeks after it is acquired but it may take up to 12 weeks for infection to show in the blood after a course of Post-Exposure Prophylaxis medication [PEP]. The tests we use to tell if you have been infected are described below.

Will taking PEP medication prevent you from acquiring HIV?
We know that taking one antiretroviral drug reduces the risk of transmission by about 80% - that is, from 3 in 1,000 on average to about 0.6 in 1,000 (6 in 10,000). We strongly believe that taking three drugs together will reduce the risk even further.

Taking PEP does not completely abolish the risk of acquiring HIV; cases of HIV transmission have occurred in some people in spite of taking these drugs.
It is important to practise safe sex for 12 weeks after the course of PEP is complete, or for 12 weeks after the incident, if PEP was not started i.e. until you have had a second (confirmatory) negative HIV test.

What do I need to take and for how long?
We recommend taking Truvada, one tablet once a day, and Raltegravir one tablet twice a day for four weeks. Truvada contains two active drugs so this is triple drug therapy.
Neither of these drugs interacts significantly with other medications, but you should let the doctor know if you are taking anything else, or have any other health problems.

**What tests will be done?**

HIV blood tests will be done at 4 & 12 weeks after the injury or 4 & 12 weeks after you finish the course of treatment. It is not possible to declare you “all clear” until 12 weeks after you finish the course of treatment. If you decide to take the tablets, the doctor will also take other blood tests at regular intervals to make sure that the drugs are not upsetting you.

During this period we recommend that you practise safe sex, and you should not donate blood. Health care workers who carry out exposure prone procedures do not need to modify their practice.

**What should you do if you are/may be pregnant?**

These drugs have been used during pregnancy in patients with HIV in order to reduce the risk of the baby acquiring HIV. If you are or think you may be pregnant, you must discuss this with the doctor or Occupational Health nurse who has assessed you.

They will probably want to discuss your treatment with an HIV specialist at either RIDU (Western General Hospital) or at Chalmers Sexual Health Centre. Until you have been given the all-clear by your HIV specialist, you need to practise safe sex, and so you should not become pregnant during this time.

**What to do if you need more information**

Until you have had your first follow-up appointment you should contact the Occupational Health Service or doctor who assessed you for advice or information. Once you have been seen at RIDU (Western General Hospital) or at Chalmers Sexual Health Centre the doctor there will give you information about contact numbers and other services.

April 1st 2014
Are there reasons not to have a test?
In most cases it is much better to know if you have a BBV infection so you can be monitored and have any necessary treatment.

If you are depressed or really feel you could not cope with a positive result it may be better to get help with this before you take the test – but most people cope with the diagnosis even if they thought they could not.

If you have a positive test you may find it harder to get life insurance, for example with a mortgage, but it is not impossible. A negative test should not affect your ability to get insurance.

Going for BBV tests
You can have confidential testing for BBV with your GP at the Sexual Health centre or at a BBV testing clinic. It can be stressful to go alone – think about taking a friend you trust for support, especially when you are going to get the result.

Think about who you would tell if you got a positive result – and who you would not tell. If you tell people you are going for a test they will probably ask about the result.

All services are confidential and will not disclose your result without your consent. In most cases you will be given the result in person – positive or negative. It is important to return to your GP or hospital to discuss your results.

Contact details
Appointments
Chalmers Sexual Health Centre
Chalmers Sexual Health Centre
2a Chalmers Street, Edinburgh
0131 536 1070
For information on clinics held throughout Edinburgh and the Lothians access:
www.lothiansexualhealth.scot.nhs.uk
HIV Counselling Clinic
Western General Hospital
Edinburgh
0131 537 2864

Blood Borne Virus Testing Clinics
Testing at various sites across Lothian. For details and appointments call the Community Blood Borne Virus Nurse Team on 0131 537 2843/50
Advice and Information
C Plus (Hepatitis C Care and Support)
22 Laurie Street, Edinburgh EH16 7AD
0131 478 7929
Waverley Care Community Projects
1-3 Mansfield Place, Edinburgh EH13 6NB
Tel: 0131 558 1425
NHS 24 (Health advice and information service)
Tel: 08454 24 24 24 or visit the website at
www.nhs24.com

To order additional copies of this leaflet, contact the Health Promotion Resources Centre on 0131 537 3333.
What are Blood Borne Viruses (BBV)?

There are three main blood borne viruses – HIV, Hepatitis B, and Hepatitis C. They are passed between people through:

- sharing of any injecting equipment including spoons, filters and water
- unprotected sex – heterosexual or homosexual
- unsterile medical treatment or unsterile body piercing/tattoos
- blood to blood contact from an infected individual e.g. in a fight.

They can also be passed from an infected mother to her baby. Treatment can greatly reduce the risk of HIV and Hepatitis B in the baby. The risk of Hepatitis C is low.

HIV and Hepatitis B are more common in men who have sex with men and in people who have lived abroad, especially in Southern Africa, the Far East and Eastern Europe. Hepatitis C is common in drug users who have ever injected. Hepatitis C is less likely to be transmitted through sex.

How do the viruses affect people?

After HIV infection someone can have a flu-like illness and then remain well for many years. The virus gradually destroys the body’s defences – the immune system – making it difficult to fight off infections. Severe damage to immunity is called AIDS (Acquired Immune Deficiency Syndrome).

Hepatitis B infection can cause a mild or severe inflammation of the liver (hepatitis) with jaundice. Sometimes this can be fatal. About 20% of people infected will have a long term infection. This gradually damages the liver causing scarring (cirrhosis) and sometimes liver cancer.

Hepatitis C infection is usually silent for many years. It also causes cirrhosis of the liver and the risk of cancer. People with the infection may feel very tired and have poor concentration. They may have a flu-like illness. If cirrhosis of the liver develops, people can be very ill and die.

What are the BBV tests?

Each virus has its own blood tests that tell us different things about the infections.

HIV

The first test is an antibody test detecting the body’s immune reaction to the virus. If this test for HIV is positive it means that you are infected with the virus. Other tests called the CD4 count and the viral load will be then taken to see if the immune system has been damaged yet and how much virus is in the blood.

Hepatitis C

The first test is also an antibody test. If this is positive another test is carried out to see if the virus is still present in the body.

Up to 80% of infected people can become long term carriers of this virus with risk of liver damage.

Hepatitis B

A blood test works out if there is an ongoing infection. This can also show if the person has fought off the infection and is now protected against future Hepatitis B infection.

Some of these viruses take 3–6 months to show up in the blood – if you have been at risk during this time you may be advised to get a repeat test even if your first result is negative. If you put yourself at risk again you should have a further test.

Why have a test?

Untreated all three viruses can cause serious illness and death after a long infection. In the early stages many people feel well and do not realise that they are infected.

There is now treatment for Hepatitis B and C that can often cure the infection, and treatment for HIV that can control it. The treatments can be difficult to take and can have side-effects. For HIV, treatment will be lifelong. Treatments are improving all the time.

Knowing about an infection allows you to protect your health – for example by stopping drinking alcohol if you have Hepatitis B or C. You can also protect others from getting the infection from you, by avoiding unsafe sex and not sharing injecting equipment. Women can also make choices about pregnancy and protecting their unborn child from HIV and Hepatitis B.
Annex 2 – Operational procedures for ‘Working with Blood borne viruses Policy’

CONTENTS

1. Key deliverables
2. Recruitment and Pre-Employment Procedures
3. Ongoing Monitoring and Surveillance
4. Confidentiality
Annex 2

Operational Procedures for 'Working with Blood borne Viruses Policy'

1. Key Deliverables

1.1 The implementation of this policy achieves 3 separate but related deliverables:
   a. The establishment and maintenance of detailed lists of NHS Lothian posts assessed as involving EPP and lists identifying current staff employed within those posts;
   b. The establishment and operation of effective recruitment and pre-employment procedures, ensuring that no staff commence EPP work in NHS Lothian prior to confirmation that their BBV status is compatible with this policy;
   c. The establishment and operation of effective ongoing monitoring surveillance, self reporting and staff support systems, to ensure that BBV status of staff in relevant posts continues to be in accordance with this policy.

1.2 Service Managers, Clinical Directors and Departmental Heads are responsible for the assessment of all their clinical posts and must maintain current lists of posts involving EPP. The ethical implications of carrying out unjustified and inappropriate clinical investigations for screening determine that posts should only be designated as involving EPP where they meet the agreed definitions (point 4.4 in Main Policy). Advice to managers is available from the Medical Director and from Consultant Occupational Physicians.

1.3 Senior Managers, Clinical Directors and Department Heads should advise the HR Department of changes in their EPP post lists as they occur. The full departmental list of EPP posts is to be re-submitted to the HR Department annually.

1.4 The HR Department must maintain a current and comprehensive list of NHS Lothian EPP Posts, as well as a list of staff appointed to those posts. The full list of staff appointed in roles involving EPP is to be re-submitted to the Occupational Health Service (OHS) annually, with changes being reported as they occur.

1.5 The OHS must maintain a current list of staff appointed in EPP posts.
2. Recruitment and Pre-Employment Procedures

2.1 Senior Managers, Clinical Directors and Departmental Heads must inform the appropriate recruitment department, with sufficient notice, when new staff (new, permanent, temporary, locum, agency or bank) are required to fill EPP posts. They must also ensure that individuals selected for EPP posts do not commence EPP until clearance is provided by the OHS Service via the relevant recruitment section.

2.2 The recruitment process must:
   a. Inform all prospective clinical HCW of NHS Lothian policy for staff who believe they may have been exposed to BBV (point 3.1 below);
   b. Inform all prospective EPP staff of NHS Lothian policy for pre-employment BBV screening requirements, which they must complete prior to commencing EPP.
   c. Provide Service Managers and Departmental Heads with information from OHS identifying the fitness status of prospective HCW for EPP work, including the need for temporary or permanent restrictions or modifications covering that individual’s employment.

2.3 Prospective EPP staff must comply in full with BBV screening requirements of this policy; failure to do so will determine that the individual will not be employed or allowed to work with NHS Lothian. If appointed, disciplinary action may result if it is discovered that test result misrepresented their BBV status.

2.4 The OHS must:
   a. Assess the BBV status of all prospective EPP staff notified to the service by the recruitment process. Assessment is based on examination of results of previous tests, by conducting tests using identified validated samples or by a mixture of both.
   b. Inform the HCW of the results of their evaluation, including the provision of advice on the implications for future employment.

   In addition:
   (i) Where the HCW is already employed by NHS Lothian in another post, the OHS will review their continued fitness for this post based on the new information;
   (ii) When the pre-employment testing was carried out by NHS Lothian OHS, the service is responsible for advising the HCW on the need for further specialist or GP referral.

2.5 Where any restrictions recommended by Occupational Health cannot be accommodated within the job profile of the EPP post, an offer of employment is not confirmed. Candidates who are not offered EPP posts, based on pre-employment screening, have the opportunity to apply and be considered for advertised non-EPP roles through the normal recruitment process.
2.6 Specific Groups:

a) **Locum and agency healthcare workers**
Before commencing EPP duties, all HCWs working on a temporary or intermittent basis must provide evidence of satisfactory BBV status to their Service Manager, Clinical Director or Departmental Head.

b) **Visiting Professionals**
Clinical Directors are responsible for ensuring that any visiting professional who wishes to take part in clinical work involving EPPs must comply with this policy.

c) **Doctors appointed through the South East Scotland Committee for Post Graduate Medical and Dental Education**
The Post Graduate Dean’s Office is responsible for ensuring that the procedures in this policy are followed for all doctors in training.

d) **Medical Students**
It is the responsibility of the Medical School to ensure that students comply with the procedures in this policy.

e) **Other healthcare students**
It is the responsibility of the relevant university or college to ensure that students comply with the procedures in this policy.

f) **Healthcare workers applying for posts with Honorary NHS Contracts**
New HCWs with honorary NHS contracts must follow the procedures for new appointments as outlined in this policy.

g) **Independent contractors**
General Practitioners, General Dental Practitioners, private hospitals, hospices and nursing homes, independent midwifery services, podiatric surgeons, ambulance services and other independent practitioners will be responsible for implementation in relation to themselves and their staff and students, liaising with the Lothian NHS Occupational Health Service, as required.

h) **Healthcare workers recruited from abroad**
For healthcare workers recruited from abroad, only results from UK accredited laboratories can be accepted for compliance with this policy.
3 Ongoing Monitoring and Surveillance

3.1. All HCW involved in clinical roles, including those carrying out EPP, have a professional duty to protect patients. Individuals who believe they may have been exposed to BBV infection, at work or in their personal life, must seek medical advice and if appropriate undergo diagnostic testing. Where such testing shows positive results, the worker must self-refer to OHS for a review of their “fitness to work” assessment and may need to cease EPP. Failure to comply with this policy may result in disciplinary action.

3.2. Where accidental exposure to blood and body fluids occurs during work within NHS Lothian the NHS Lothian “Standard Operating Procedure for incidents involving potential exposure to blood borne viruses through needlestick and other non-sexual exposures” (Annex 1) should be referred to.

3.3. EPP staff subject to OHS follow-up requirements must present themselves for the required immunisation or screening when requested by the OHS. Failure to do so may result in disciplinary action. When the HCW is aware that they will be away from the area at the time that follow-up tests will be required, it is their responsibility to liaise with the OHS to arrange alternative dates.

3.4 The OHS must:

a) Operate a system, which recalls EPP staff for follow up immunisation or testing as required by appendices 3-5.

b) Notify Service Managers of the outcome of these recall assessments in the format "fit for EPP / fit for EPP with review / unfit for EPP".

c) Inform the Medical Director, and Service Managers, of EPP staff who fail to attend for required follow up actions as required by appendices 3-5.

d) Reassess the BBV fitness status of healthcare workers presenting in accordance with paragraphs 3.1 and 3.2 above. Where this assessment determines the need to amend the individual’s fitness status, report the results to the Service Managers in the format listed at paragraph 3.4b above.

e) Provide advice and support to healthcare workers whose status changes as a result of these assessments.

3.5 Service Managers, Clinical Directors and Heads of Departments must:

a) Where OHS indicate that EPP staff have not attended for required follow up actions, Service Managers will ensure EPP work by those individuals does not proceed until appropriate follow up action is complete.

b) Where OHS assessments of existing staff determines that an EPP worker is now unfit for EPP work, Service Managers must ensure that such work stops.

Lothian NHS Board | Approved: September 14
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Revision due: September 16
c) Where OHS assessments of existing staff determines that the worker is unfit for their employed role or identifies the need to modify practice, the Employee Relations advisor, in liaison with Partnership representatives, will work with the manager of the employee to arrange suitable alternative work which may involve referral to the NHS Lothian Redeployment Policy. Where the OHS assessment indicates occupational causation of the infection, it will be reported statutorily under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, and the employee will be retained in employment without detriment in pay and condition.

d) Where the change in blood borne virus status:
   i) Results in sickness absence
   ii) Occurs as a result of a work related incident

Service Managers, with support from HR, will advise staff on any entitlement under the NHS injury benefits scheme.

3.6 Clinicians should remind any BBV infected HCW under their care to refer themselves to OHS. If they become aware that an infected HCW is performing EPP or has done so in the past and has not followed the professional requirements of this policy to refer themselves to the OHS, or to modify their practice due to BBV infection, the clinician has a responsibility to inform the OHS. Similarly, if the Health Protection Team identify a HCW who has a BBV and has performed EPP, they have a duty to report this to the OHS.

3.7 OHS will risk assess the situation and notify the Medical Director/Nurse Director as appropriate. That Director will then consider who else should be notified. In the case of students, the principal of the relevant college should be informed, and for doctors in training, the Postgraduate Dean. Consideration should be given to whether the GMC, GDC, NMC need to be informed.

3.8 The Medical Director/Nurse Director must ensure that NHS Lothian Director of Public Health (DPH) is notified of any case where a HCW has performed EPP, when their BBV status does not meet the EPP standards as laid down in this policy. The responsibility for instituting and co-ordinating any patient notification exercise rests with the DPH (Annex 7).

3.9 HCW who have carried out EPP when their BBV status does not meet the requirements of this policy, have a personal responsibility to cease EPP and inform the OHS where they will get support and advice.
4. **Confidentiality**

4.1 HCWs’ BBV status is subject to the same rights of medical confidentiality as any patient and client in receipt of medical care or investigation.

4.2 Medical in confidence information is maintained in the individual’s Occupational Health record, and is not normally released without the consent of the HCW or a court order.

4.3 The results of OHS assessments are passed to management without clinical information (see 3.4b above). Situations may arise where it could be useful for a HCW to be able to discuss their BBV status in detail with the Medical Director, their line manager and an identified HR representative. In these situations OH clinical information on BBV status will normally only be passed to these individuals with the HCWs consent.

4.4 In exceptional circumstances of patient risk or public safety, it may be necessary for DPH or physicians treating patients to have access to confidential information. This can sometimes be accomplished by anonymising the data, so that it is in no way tied to the name of the HCW. Individuals making a disclosure of confidential information are required to justify their decision. This duty does not end with the death of the worker.
Annex 3 – Hepatitis B

CONTENTS

1. NHS Lothian Policy for the Management of Hepatitis B Virus
2. Hepatitis B Virus Immunisation
3. Exposure Prone Procedure Restrictions
4. Pre-Employment Screening for Exposure Prone Procedure Posts
5. Staff Currently in Employment
6. HBeAg Positive HCWs in EPP Posts
7. HBsAg Positive HBeAg Negative HCWs in EPP Posts
8. Non-Responders to Hepatitis B Vaccine
9. Responsibilities of clinicians
Annex 3

Hepatitis B

1. NHS Lothian Policy for the Management of Hepatitis B Virus

Hepatitis B Virus Markers

The infectivity of those infected with HBV will vary depending on circulating antigens and antibodies. There are 3 markers that are important in determining whether someone who is infected with HBV can perform EPPs. These are:

1.1 Hepatitis B e Antigen (HBeAg)
HBeAg is associated with the presence of infectious virus. While carriers of HBV are HBeAg positive their blood contains a high concentration of virus and is likely to transmit infection. Some carriers may have persistent HBeAg whilst others may develop antibodies to it after a variable period. This usually leads to a reduction in the level of infectivity.

1.2 Hepatitis B Surface Antigen (HBsAg)
HBsAg is found during the latter part of the incubation period and acute phase of Hepatitis B Infection. Its persistence is associated with failure to clear virus from the body, though the level of infectivity is considered to be low when the patient is HBeAg negative and anti-e positive.

1.3 Hepatitis B Viral Load (Hepatitis B DNA quantification)
Some individuals infected with Hepatitis B may carry a genetic variant, which does not produce Hepatitis B e-antigen, but is still capable of assembling infectious viral particles. In such cases the person will be Hepatitis B surface antigen positive but have no e antigen markers. Viral load testing should take place for individuals in this category to determine their infectivity.

2. Hepatitis B Virus Immunisation

The NHS Lothian policy on HBV immunisation is contained in the Immunisation Policy (in progress).

2.1 All HCWs subject to immunisation by NHS Lothian will have their carrier status assessed at the time of first injection.

2.2 It should be borne in mind that HCWs are at greater risk of acquiring HBV in the health care setting than patients. Therefore, all staff whose duties may bring them into contact with blood or blood stained fluid or tissues are strongly advised to be immunised against Hepatitis B. In certain areas, eg renal dialysis where there is a high risk of contact with BBV, staff who are not immunised may be restricted from working in those areas.
3 Exposure Prone Procedure Restrictions

Service Managers, Clinical Directors and Department Heads are responsible for identifying posts and staff performing EPP.

3.1 Exposure prone procedures must **not** be performed by a HCW who is:

- HBeAg positive.
- HBsAg positive, HBeAg negative, not undergoing treatment, and with a viral load greater than $10^3$ (i.e. 1000) genome equivalents per ml.
- HBsAg positive, HBeAg negative with no record of viral load testing in the previous 12 months.
- Infected with Hepatitis B, HBeAg negative, now on treatment, whose pre-treatment viral load was above $10^3$ genome equivalents per ml.

3.2 **Before carrying out EPPs all HCW must:**

- Show evidence of adequate immunity to Hepatitis B either from immunisation or previous infection
- Be HBsAg negative if non-responder to the vaccine or if vaccination is contraindicated (annual testing of the HBV immune status of non-responders in EPP posts will be carried out by the OHS)
- Be HBsAg positive, HBeAg negative with a viral load less than $10^3$ genome equivalents per ml (annual testing of viral load will be carried out by the OHS)
- Be HBsAg positive, HBeAg negative, under treatment, whose pre-treatment viral load was between $10^3$ and $10^5$ genome equivalents per ml, and now with a viral load below $10^3$ genome equivalents per ml

3.3 For most staff this will involve immunisation with a satisfactory antibody response.

3.4 Any member of staff, including those who refuse testing, who cannot satisfy any of the above criteria, must not perform EPPs.

3.5 The virological criteria for fitness to undertake EPPs are kept under review by the Expert Advisory Groups on Hepatitis and HIV and these may change in the future. The policy of the NHS Lothian will be amended to incorporate any change.

4 Pre-Employment Screening for Exposure Prone Procedure Posts

4.1 All candidates for employment must be notified to the OHS giving adequate notice for pre-employment screening by the person undertaking the recruitment.
4.2 Evidence of satisfactory immunity to Hepatitis B or absence of HBeAg is a contractual condition of employment. Those staff who are already infected with HBV must have a viral load of less than $10^3$ genome equivalents per ml.

4.3 Prospective employees who fail to mount an immunological response to vaccination will require to be investigated for carrier status, prior to any job offer being made.

4.4 Prospective employees who are HBsAg carriers will all require to be further investigated to determine HBeAg and viral load status. If restriction from performing EPPs is not considered practicable the following will not be considered for employment to an EPP post:

   a) Individuals who are HBeAg carriers of the virus or
   b) Individuals who are HBsAg positive, HBeAg negative with a viral load greater than $10^3$ genome equivalents per ml.

4.5 It is the NHS Lothian policy that, unless there are medical contraindications, individuals employed in EPP posts are contractually required to be subject to HBV Immunisation.

4.6 Where there are medical contraindications to Hepatitis B immunisation the implications will be assessed by the Occupational Health Physician.

5 Staff Currently in Employment
As with some new starts, situations may arise where staff currently employed, i.e. EPP Posts, will be required to undergo further or periodic testing. The OHS will notify the appropriate Manager of the individual's fitness restriction, indicating the appropriate review date. The OHS will programme the reviews, but Managers must ensure that EPP ceases if confirmation of future fitness is not received. Managers to seek further advice from HR regarding the ongoing management of the HCW.

6 HBeAg Positive HCWs in EPP Posts
6.1 HCWs in post who are found to be HBeAg positive must not perform Exposure Prone Procedures.

6.2 All healthcare workers who are HBsAg positive must cease EPPs until their HBeAg status has been established.

6.3 HBeAg positivity need not necessarily be life-long; spontaneous loss of HBeAg with the development of antibody, anti-HBe, occurs each year in about 5-15% of those infected as adults. HBeAg carriers infected as adults may respond well to treatment with interferon and carrier state may be reversed in up to 40% of those treated.

6.4 Advice regarding the duties that HBeAg positive HCWs may continue to perform must be sought from the Occupational Health Physician (OHP).
7 **HBsAg Positive HBeAg Negative HCWs in EPP Posts**

7.1 Healthcare workers in post who perform EPPs and are HBsAg positive but HBeAg negative must have their Hepatitis B viral load measured. Where a viral load in excess of $10^3$ genome equivalents per ml is detected then the HCW will not be permitted to perform EPPs.

7.2 Where the viral load is less than $10^3$ genome equivalents per ml the HCW may continue to perform EPPs. However, the HCW must have their viral load re-tested at 12 monthly intervals to ensure that it remains below the accepted limit. If subsequent testing shows that the individual’s viral load has risen above $10^3$ genome equivalents per ml then the HCW will not be permitted to perform EPPs.

7.3 If re-testing is not carried out within 12 months the infected healthcare worker will not be permitted to perform EPPs.

7.4 HCWs who are re-tested every 12 months do not require to be restricted from performing EPPs whilst awaiting viral load test results.

7.5 Testing of Hepatitis B viral load must only undertaken in a designated laboratory. The designated laboratory for NHS Lothian is the Specialist Virology Centre, RIE.

7.6 Two identified, validated samples (IVS) will be obtained one week apart from the healthcare worker and sent separately to Specialist Virology Centre, RIE. The samples will be obtained by an Occupational Health doctor or nurse, or where this is not feasible by a person expressly acting on behalf of the Occupational Health Service. The infected health care worker will not be allowed to submit their own samples.

7.7 If OHS clearance is provided for a HCW to undertake EPP while an antiviral treatment is given, the re-test requirements will be specified on a case by case basis.

8. **Non-Responders to Hepatitis B Vaccine**

8.1 Non-responders to Hepatitis B vaccine are individuals who have had an equivalent of 2 full courses of Hepatitis B vaccine and not produced a satisfactory antibody response (10-100mIU/ml).

8.2 Staff in post who are vaccine non-responders and who have no markers of previous HBV infection are at risk of acquiring infection. They may continue without restriction of practice, provided that BBV exposure incidents are reported, treated and followed-up.

8.3 Non-responders who perform EPP will be checked annually, by the Occupational Health Service, for Hepatitis B markers.
9. **Responsibilities of clinicians**

9.1 Clinicians should remind any BBV infected HCW under their care to refer themselves to OHS. If they become aware that an infected HCW is performing EPP or has done so in the past and has not followed the professional requirements of this policy to refer themselves to the OHS, or to modify their practice due to BBV infection, the clinician has a responsibility to inform the OHS.

9.2 OHS will risk assess the situation and notify the Medical Director/Nurse Director as appropriate. That Director will then consider who else should be notified. In the case of students, the principal of the relevant college should be informed, and for doctors in training, the Postgraduate Dean. Consideration should be given to whether the GMC, GDC, NMC need to be informed. Managers to seek further advice from HR regarding the ongoing management of the HCW.
Annex 4 – Hepatitis C

CONTENTS

1. NHS Lothian Policy for the Management of Hepatitis C Virus (HCV)

2. Staff who are to Commence Training or Employment Involving EPPs

3. HCV Testing

4. Occupational Health Advice for Hepatitis C Infected HCWs

5. Responsibilities of clinicians
Annex 4

Hepatitis C

1. **NHS Lothian Policy for the Management of Hepatitis C Virus (HCV)**

Transmission of Hepatitis C Virus from staff to patients has been documented in the UK.

1.1 All healthcare workers with direct clinical contact, who are new to the NHS, are offered pre-test discussion and Hepatitis C antibody testing by NHS Lothian. For non EPP workers, this is an offer only and there is no requirement on the worker to agree.

1.2 Healthcare workers with direct clinical care have a professional responsibility in terms of health and safety of their patients such that they should seek advice if they believe that they have been exposed to Hepatitis C infection.

1.3 **Staff in EPP Posts**

Healthcare workers currently in EPP posts who believe that they may have been exposed to Hepatitis C infection must promptly seek and follow confidential professional advice on whether they should be tested for Hepatitis C virus RNA. If they are found to be Hepatitis C RNA positive then they must cease all EPPs.

1.4 Healthcare workers who know themselves to be infected with Hepatitis C are required to report this and must be tested for HCV RNA. Those found to be RNA positive must cease all EPPs.

1.5 Where a member of staff undergoes a successful course of therapy and remains HCV RNA negative 6 months after completion of treatment then they may resume EPPs. A further test for HCV RNA must be taken after a further 6 months to confirm that the HCW remains HCV RNA negative.

2. **Staff who are to Commence Training or Employment Involving EPPs**

2.1 All staff to be employed in EPP posts for the first time (new starts or existing staff) require:

   a) to demonstrate that they have been tested for HCV and were:

   - HCV antibody negative
   - HCV antibody positive but HCV RNA negative at the time of testing.

   or

   b) to be tested for HCV antibody, and if found positive, to be tested for HCV RNA.

2.2 Any healthcare worker who prior to commencement of employment for an EPP post is found to be HCV RNA positive will not be employed in an EPP post.

2.3 Where a member of staff undergoes a successful course of therapy and remains HCV RNA negative 6 months after completion of treatment then
they may be employed. A further test for HCV RNA must be taken after a further 6 months to confirm that the HCW remains HCV RNA negative.

2.4 The timing of HCV testing prior to employment or training for EPP will be dependent upon the professional discipline. Some staff groups where EPPs are integral to the job should be tested prior to commencing appropriate professional training, e.g. dentists and midwives. Others will require testing following completion of basic training and prior to undertaking specialist roles which entail performing EPPs, e.g. GP trainees who will undertake minor surgery and nursing staff who are to be employed in Accident & Emergency departments or operating theatres.

2.5 In NHS Lothian, all staff to be employed in EPP posts must provide evidence of IVS (Identified Validated Sample) testing or be subject to such testing prior to taking up the post. The system of clearance is incorporated into the Fitness Screening by OHS.

3 HCV Testing
3.1 Prior to obtaining samples, the Occupational Health Service will explain to staff the testing arrangements and how a positive result may affect future employment requiring performance of EPPs.

3.2 Testing for HCV antibodies requires one IVS (EDTA blood) to be sent to Specialist Virology Centre, RIE. Should the testing indicate the presence of HCV antibodies then a further two IVSs (EDTA blood) must be obtained a week apart and sent to Specialist Virology Centre, RIE for HCV RNA testing.

3.3 The Occupational Health Service will inform the HCW of the results and the implications.

3.4 Healthcare workers already undertaking EPPs are not required to cease EPPs whilst awaiting results providing the testing is carried out promptly.

3.5 Any HCW who already knows that they are HCV positive or who are intending to undertake professional training for a career that involves EPP who refuses to be tested for Hepatitis C antibody, and if required HCV RNA, will not be permitted to undertake EPPs or be employed in an EPP post.

4. Occupational Health Advice for Hepatitis C Infected HCWs
Where a HCW is identified as being infected with Hepatitis C, they will be assessed by an accredited specialist Occupational Physician, who will discuss appropriate further clinical management with the HCW. Advice will also be given on minimising the risk of transmission in the health care setting and to close contacts.

5. Responsibilities of clinicians
5.1 Clinicians should remind any BBV infected HCW under their care to refer themselves to OHS. If they become aware that an infected HCW is performing EPP or has done so in the past and has not followed the professional requirements of this policy to refer themselves to the OHS,
or to modify their practice due to BBV infection, the clinician has a responsibility to inform OHS.

5.2 OHS will risk assess the situation and notify the Medical Director/Nurse Director as appropriate. That Director will then consider who else should be notified. In the case of students, the principal of the relevant college should be informed, and for doctors in training, the Postgraduate Dean. Consideration should be given to whether the GMC, GDC, NMC need to be informed. Managers to seek further advice from HR regarding the ongoing management of the HCW.
Annex 5 – HIV

CONTENTS

1. NHS Lothian Policy for the Management of HIV

2. Responsibility of HCW

3. Staff who commence training or employment involving EPP

4. Fitness of HIV HCW to undertake EPP

5. HIV testing

6. Responsibilities of clinicians
Annex 5

HIV

1. NHS Lothian Policy for the Management of HIV

1.1 Current evidence suggests that the likelihood of transmission of Human Immunodeficiency Virus (HIV) from an HIV infected HCW to a patient is extremely low. However, HCWs who are infected with HIV must be assessed with regard to the risk they constitute for patients. Within NHS Lothian this assessment will be carried out in the strictest confidence by an accredited specialist Occupational Physician.

   a) Advice will be given on minimising the risk of transmission in healthcare settings and to close contacts.

   b) The OHS may recommend appropriate re-deployment if required. Redeployment may be required to protect the HCW eg. if duties involve exposure to known or undiagnosed TB.

   c) The OHS will discuss appropriate further clinical management with the HCW and liaise with the HCW’s treating physician to arrange subsequent medical supervision.

1.2 Only HCW infected with HIV who meet strict clearance and follow up criteria may perform exposure prone procedures.

1.3 If there is doubt about whether an HIV infected HCW can safely be employed in a particular clinical area, the OHS will contact the special UK Advisory Panel that has been established specifically to give advice on such matters.

1.4 HIV infected HCWs who do not perform EPPs but who are involved in the clinical care of patients must remain under regular medical and occupational health supervision and receive appropriate advice if their circumstances change.

1.5 All healthcare workers with direct clinical contact, new to the NHS, are offered pre-test discussion and HIV testing at the pre-employment stage by NHS Lothian.

1.6 Staff in EPP posts

Healthcare workers currently in EPP posts who believe they may have been exposed to HIV must promptly seek and follow confidential professional advice on whether they should be tested for HIV. If found to be HIV positive, then they must cease all EPPs.

1.7 Healthcare workers who know themselves to be infected with HIV must cease EPPs until formal evaluation for clearance by a consultant occupational physician.
2. **Responsibility of HCW**

2.1 HCWs have a professional duty to protect patients. Those who believe they may have been exposed to infection with HIV in their personal life or during the course of their work must seek medical advice, and, if appropriate, diagnostic HIV testing. HCWs found to be infected must seek expert medical and occupational health advice. Those who perform or assist in EPPs must obtain further advice on their work practice, as it may need to be modified or restricted to protect their patients.

2.2 If exposure prone procedures are currently being performed these activities must cease whilst expert advice is sought.

2.3 NHS Lothian Director of Public Health (DPH) must be notified when an HIV infected HCW has performed EPPs. The HCW may, request that a physician acting on his/her behalf inform the DPH.

3 **Staff who commence training or employment involving EPPs**

3.1 All staff in NHS Lothian who are to be appointed to an EPP post for the first time (new starts or existing staff) are required to demonstrate that they have been tested negative for HIV.

3.2 Any healthcare worker who, prior to commencement of employment for an EPP post, is found to be HIV positive will be referred to a consultant occupational physician to assess their fitness.

3.3 The timing of HIV testing prior to employment or training for EPP will be dependent on the professional discipline. Some staff groups where EPPs are an integral part of the job are tested prior to commencing appropriate professional training. Others require testing following completion of basic training, and prior to undertaking specialist roles. In circumstances where individuals are to undertake EPP posts for NHS Lothian, where no previous testing has been performed, NHS Lothian OHS will carry out the testing.

3.4 In NHS Lothian, all staff to be employed in EPP posts must provide evidence of IVS (identified validated sample) testing, or be subject to such testing prior to taking up the post. The system of clearance is incorporated into the fitness screening by OHS.

4 **Fitness of HIV Infected Healthcare Workers to Undertake EPP**

4.1 In order to be cleared to perform EPP, HIV infected HCWs must meet, and maintain, the following criteria:

Either

a) be on effective combination antiviral therapy (cART) AND
b) have a plasma viral load of less than 200 copies per ml

or

c) be an ‘elite controller – defined as an individual with HIV not receiving cART who has maintained a viral load below the limits of detection for at least 12 months, based on at least 3 separate viral load measurements.
Annex to the NHS Lothian Working with Blood Borne Viruses Policy

Annex 5
HIV

AND

d) be subject to plasma viral load monitoring by IVS samples every 3 months and
e) be under joint supervision of a consultant occupational physician and
f) be registered with the UKAP occupational health monitoring register (UKAP – OHR).

4.2 Initial clearance of HIV infected HCWs to perform EPPs requires 2 IVS test samples no less than 3 months apart demonstrating viral load levels below 200 copies per ml. The decision to clear the HCW is the responsibility of the consultant occupational physician in consultation with the treating physician. UKAP may be consulted. Any HIV infected HCW cleared to undertake EPP must be entered on the UKAP – OHR by the consultant occupational physician.

4.3 Once cleared to undertake EPP, HIV infected HCWs must be subject to IVS viral load testing every 3 months (from the date of sample, not the date of receipt of results). The table below sets out the required actions based on viral load tests

<table>
<thead>
<tr>
<th>Viral load count test result</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50 copies/ml or below</td>
<td>No action – retest in three months</td>
</tr>
<tr>
<td>50-200 copies/ml</td>
<td>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.</td>
</tr>
<tr>
<td>&gt;200 copies/ml but &lt;1000 copies/ml</td>
<td>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 &lt;200 copies/ml.</td>
</tr>
<tr>
<td>1000 copies/ml or above</td>
<td>The HCW would <strong>cease conducting EPPs immediately</strong>. 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 HIV transmission. Following a risk assessment exercise, a Patient Notification Exercise (PNE) may be indicated. UKAP advice may be sought at this stage.</td>
</tr>
</tbody>
</table>

4.4 All HCWs performing EPP under these arrangements must be advised by their consultant occupational physician and treating physician of the importance of the 3 monthly monitoring. Where a HCW does not attend for...
monitoring or refused to have tests undertaken, consultant occupational physicians must inform NHS Lothian management that the individual is no longer cleared to perform EPP. Resumption of EPP activities (following a period of interruption) for whatever reason requires demonstration of a consistent viral load suppression to very low or undetectable levels (ie at least 2 viral samples below 200 copies/ml no less than 3 months apart).

4.5 The roles and responsibilities of the respective individuals involved in the monitoring process are set out in section 6 below.

5. HIV testing

5.1 Prior to obtaining samples, the Occupational Health Service will explain to staff the testing arrangements and how a positive result might affect their future employment requiring EPPs.

5.2 Testing for HIV requires IVS EDTA blood tube sent to the specialist virology centre at RIE (marked “EPP” to ensure that the sample is tested and not stored).

5.3 The OHS will inform the healthcare worker of the results and implications.

5.4 Healthcare workers undertaking EPP are not required to cease EPP while waiting for the results of testing.

6. Responsibilities of clinicians

6.1. Clinicians should remind any BBV infected HCW under their care to refer themselves to OHS. If they become aware that an infected HCW is performing EPP or has done so in the past and has not followed the professional requirements of this policy to refer themselves to the OHS, or to modify their practice due to BBV infection, the clinician has a responsibility to inform OHS.

6.2. OHS will risk assess the situation and notify the Medical Director/Nurse Director as appropriate. That Director will then consider who else should be notified. In the case of students, the principal of the relevant college should be informed, and for doctors in training, the Postgraduate Dean. Consideration should be given to whether the GMC, GDC, NMC need to be informed. Managers to seek further advice from HR regarding the ongoing management of the HCW.
Annex 6

Requirements for Identified Validated Samples (IVS)

1. An IVS Must Meet the Following Criteria:

   a) The individual taking the sample must be happy that the HCW is the individual presenting for the testing, by the examination of photographic proof of identity: i.e. Employee’s identity badge, new driving licence, passport etc.

   b) The sample is taken in an occupational health (OH) service centre, or in relation to HIV infected healthcare workers, in the facility of the treating physician. Samples being tested for HIV should be marked “EPP” to ensure that the sample is tested and not stored.

   c) Samples are delivered to the laboratory in the routine way, not transported by the HCW.

   d) When the sample results are received, they are checked as having been sent from the OH service, or from the treating physician.

   e) Within NHS Lothian, IVS sample laboratory reports are stamped as being “IVS” and signed by the checking OHS staff member on completion of steps above.

   f) It is NHS Lothian policy that from 1 January 2006 BBV serology and immunology results require to be IVS certified. HBV testing prior to 1 January 2006 which does not meet IVS standards remains acceptable. HCV and HIV testing requires to be IVS standard irrespective of sampling date.

2. Acceptance of Results

   NHS Lothian will carry out testing required by this policy unless satisfactory documented evidence is provided. Satisfactory documented evidence is a written confirmation of the results from an accredited laboratory, including the laboratory results provided by another OHS, or for non IVS results prior to 1 January 2006 by their General Practitioner or another medical authority. Original or photocopied laboratory results alone are not acceptable, without a signature from OHS or their medical authority confirming the identity of the individual tested.
Annex 7

NHS Lothian Policy for reporting blood borne virus-infected healthcare workers and initiating patient notification exercises

CONTENTS

1. Introduction

2. Responsibilities

3. Purpose of patient notification

4. Risk assessment of need of patient notification

5. Confidentiality

References
Annex 7

NHS Lothian Policy for reporting blood borne virus-infected healthcare workers and initiating patient notification exercises

1. **Introduction**

This Annex sets out Lothian policy for reporting BBV infected HCWs to the NHS Lothian Director of Public Health (DPH), and the process for initiating a patient notification exercise. It is based on procedures laid out in Scottish Executive guidance.

2. **Responsibilities**

2.1 Healthcare workers who have carried out EPP when their BBV status does not meet the requirements of this policy have a personal responsibility to inform Occupational Health.

2.2 Clinicians should remind any BBV infected HCW under their care to refer themselves to OHS. If they become aware that an infected HCW is performing EPP or has done so in the past and has not followed the professional requirements of this policy to refer themselves to the OHS, or to modify their practice due to BBV infection, the clinician has a responsibility to inform OHS.

2.3 OHS will risk assess the situation and notify the Medical Director/Nurse Director as appropriate. That Director will then consider who else should be notified. In the case of students, the principal of the relevant college should be informed, and for doctors in training, the Postgraduate Dean. Consideration should be given to whether the GMC, GDC, NMC need to be informed. Managers to seek further advice from HR regarding the ongoing management of the HCW.

2.4 Healthcare workers who have good reason to believe that a BBV infected HCW is practising in a way which places patients at risk, or has done so in the past, must inform an appropriate person (e.g. Consultant Occupational Health Physician) or where appropriate, the relevant regulatory authority. Wherever possible, the HCW should be informed before information is passed on to an employer or regulatory body.

2.5 If the Occupational Physician identifies either risk of ongoing transmission or risk to patients previously treated by the HCW, they should inform the Medical Director/Nurse Director.

2.6 The Medical Director/Nurse Director must notify DPH of any case where a HCW, whose BBV status does not meet the EPP standards as laid down in this policy, has performed EPP.

2.7 The responsibility for instituting and co-ordinating any patient notification exercise rests with the DPH. This decision will be taken in consultation with the Consultant in Public Health Medicine (Communicable Disease and Environmental Health)(CPHM(CD/EH)), Health Protection Scotland (HPS) and the United Kingdom Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP) as necessary. The Medical
3. **Purpose of patient notification**

3.1 The purpose of notification of patients identified as having been exposed to a risk of BBV infection by an infected HCW is:

- To provide the patients with information about the nature of the risk to which they have been exposed
- To detect BBV infection and provide care and advice on measures to prevent onward BBV transmission
- To collect valid data to augment existing estimates of the risk of BBV transmission from an infected HCW to patients during EPP.

3.2 The aim is to identify the patient population at distinct risk of exposure to the infected HCWs blood during EPP. These patients should be contacted, offered pre-test counselling and encouraged to have appropriate blood tests. The decision on whether and how far back the patient notification exercise should go, will be taken by the DPH on the basis of a risk assessment.

4. **Risk assessment of need of patient notification**

4.1 The need for patient notification should be decided on a case-by-case basis using three assessment criteria:

- evidence of possible BBV transmission
- nature and history of the infected HCWs clinical practice
- other relevant considerations e.g.
  - evidence of poor clinical practice in relation to infection control
  - physical/mental impairment
  - other relevant medical conditions e.g. weeping eczema

4.2 **Categories of bleed-back**

EPP have been classified into three levels of bleed-back, categories 1-3 of increasing risk, as follows:

- **Category 1**
  Procedures where the hands and fingertips of the worker are usually visible and outside the body most of the time and the possibility of injury to the worker’s gloved hands from sharp instruments and/or tissues is slight. This means that the risk of the HCW bleeding into a patient’s open tissues should be remote e.g. local anaesthetic injection in dentistry, removal of haemorrhoids.

- **Category 2**
  Procedures where the fingertips may not be visible at all times but injury to the worker’s gloved hands from sharp instruments and/or tissues is unlikely. If injury occurs it is likely to be noticed and acted upon quickly to avoid the HCWs blood contaminating a patient’s open tissues e.g. routine tooth extraction, appendicectomy.
### Category 3

Procedures where the fingertips are out of sight for a significant part of the procedure, or during certain critical stages, and in which there is a distinct risk of injury to the worker’s gloved hands from sharp instruments and/or tissues. In such circumstances it is possible that exposure of the patient’s open tissues to the HCWs blood may go unnoticed or would not be noticed immediately e.g. hysterectomy, caesarean section, open cardiac surgical procedures. A comprehensive categorisation of the most common clinical procedures depending upon the relative risk of bleed-back is being developed by UKAP.

#### 4.3 Current guidance for specific infections:

**Hepatitis B**

“Patient notification, with the offer of serological testing, should be undertaken only if there is evidence to suggest that transmission of infection from a health care worker to patient may have taken place, and should be considered if a review of surveillance data, or other local information, points to this possibility. Local responsibility for considering the need for patient notification exercises should rest with the Director of Public Health. If a patient notification exercise is considered necessary, UKAP should be consulted”.

**Hepatitis C**

“Whenever a transmission of hepatitis C from an infected health care worker to a patient is detected, notification of other patients of that health care worker who have undergone EPP, with the offer of serological testing, should normally follow.”.

“For hepatitis B and C, the policy is that if there is no evidence of healthcare worker to patient transmission, no patients need to be notified and offered testing”.

**HIV**

“Where there is evidence of HIV transmission from infected HCW to patient, notification of all patients who have undergone EPP by the HCW should take place. In the absence of evidence of HIV transmission, all patients who have undergone category 3 procedures by an HIV infected HCW should be notified. When only category 1 or 2 procedures have been carried out, patient notification will not be necessary, unless the other relevant considerations suggest that it is”.

“In the case of all three blood borne viruses, patients may need to be notified in the event of “other relevant considerations”.

#### 4.4 Additional information will be required to estimate when the HCW was infected, in order to decide how far back any patient notification exercise should go. The co-operation of the HCW will be necessary and should be sought in a sensitive manner preferably by their own physician.

#### 4.5 Communications

- When a patient notification exercise is to be undertaken, the DPH or delegated colleague (eg CPHM (CD/EH)) should inform UKAP. Guidance notes and proformas are available from UKAP.
Annex to the NHS Lothian Working with Blood Borne Viruses Policy

- If more than one NHS Board is involved, HPS should become involved.
- If there is doubt about the need for patient notification, UKAP should be consulted.
- UKAP should also be informed in writing of incidents where it is concluded that a patient notification is not warranted.

4.6 When it has been decided that a patient notification exercise is necessary, a small incident team should be set up locally. The number of individuals who know the identity of the infected HCW should be kept to a minimum at all stages.

5. Confidentiality

Every effort should be made to avoid disclosure of the infected worker’s identity or information that would allow deductive disclosure. The duties of confidentiality still apply even if the infected HCW has died or has already been identified publicly.

References


2. Scottish Executive Health Department. Hepatitis B Infected Health Care Workers. NHS HDL(2000)03
