## Prevention and Management of Potential Exposure to Blood Borne Viruses Including Needlestick and Sharps Injuries

**Lead Author:** Dr Eamonn Trainor  
**Additional author(s):** N/A  
**Division/ Department:** Clinical Support & Tertiary Medicine  
**Applies to:** Salford Royal Care Organisation  
**Date approved:** 19/06/2018  
**Expiry date:** June 2021

<table>
<thead>
<tr>
<th>Contents</th>
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<tbody>
<tr>
<td><strong>Section</strong></td>
</tr>
<tr>
<td>1</td>
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<tr>
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<td>12</td>
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<td>Appendix 1</td>
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<td>Appendix 3</td>
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It is your responsibility to check on the intranet that this printed copy is the latest version.
1. **What is this policy about?**

Occupational exposure to blood borne viruses is unnecessarily common and can ultimately result in a serious illness or death. In order to prevent such occurrences it is essential that all staff pay careful attention to the appropriate policy, procedure or protocol when handling sharp instruments, syringes, blood and other body fluids. Any significant exposure to blood and some other body fluids or tissue has the potential to transmit blood borne viruses, the most important of which are Hepatitis B (HBV), Hepatitis C (HCV), and HIV.

Where a possible exposure to blood borne viruses does take place it is the aim of this policy to ensure all staff within Salford Royal NHS Foundation Trust know how to manage the situation and act accordingly. All employees of the Trust should also be aware of the possible risks from occupational exposure to blood borne viruses and be aware of the importance of seeking advice following any needlestick or other exposures onto broken skin or mucous membranes.

The risk of becoming infected with a blood borne virus following percutaneous or mucocutaneous exposure varies with the circumstances and the particular virus involved. Four factors are proven to increase the risk of occupationally acquired blood borne virus infection:

- Deep injury
- Visible blood on the device which caused the injury
- Injury with a needle which has been placed in a donor’s artery or vein
- High virus load in the donor’s blood e.g. in advanced stage or undiagnosed HIV infection

The risk of infection following a significant **percutaneous injury** is approximately:

- HBV 30% (3 in 10)
- HCV 3% (3 in 100)
- HIV 0.3% (3 in 1000)

The risk of HBV and HIV infection is significantly reduced by immunisation against Hepatitis B and the use of post-exposure prophylaxis (PEP).
2. Where will this document be used?

2.1 All clinical staff
Laboratory staff
Health & Wellbeing staff
Healthcare students on placement at the Trust

3. Why is this document important?

3.1 First aid should be carried out immediately following any exposure to blood or a body fluid. Wash the area liberally with soap and water but without scrubbing. In the case of a puncture wound or needlestick injury, encourage the wound to bleed freely but do not suck the wound.

Following percutaneous or mucocutaneous exposure to blood or a body fluid, staff members should attend the Health and Wellbeing Department (8am-4pm Monday-Friday) or the Emergency Department (out of hours) immediately.

The ward manager, or deputy, should provide the Health and Wellbeing Department or Emergency Department with information to enable an informed assessment of the risk of blood borne virus transmission, including any risk factors for hepatitis B, hepatitis C or HIV in the donor patient, so that the need for post-exposure prophylaxis can be ascertained.

4. What is new in this version?

4.1 Inclusion of healthcare students on placement at the Trust and guidance on reporting of incidents involving undergraduate medical students.

Table added to appendix 1. to guide follow up blood testing in recipients.

Updated advice on the use of HBIG following significant exposure to hepatitis B in known vaccine non-responders in Appendix 1.7.

Guidance on baseline and follow up investigations to be carried out on recipients commenced on HIV PEP in Appendix 1.6.

HIV PEP prescription sheets removed as PEP is now prescribed on EPR.

Appendix 3. updated to provide more information on missed PEP doses.

Updated guidance of the protocol to be followed when undertaking and communicating donor blood borne virus testing/results in section 5.6.

Updated guidance on who to contact following a significant exposure in section 5.2.
5. **Policy**

### 5.1 Protocol for Management of Incidents

#### 5.1.1 First aid should be carried out immediately following any exposure to blood or a body fluid.

Wash the area liberally with soap and water but without scrubbing. Antiseptics and skin washes should not be used. In the case of a puncture wound or needlestick injury, encourage the wound to bleed freely but do not suck the wound. Dry the area and cover any percutaneous injury with a waterproof dressing. Exposed mucous membranes, including conjunctivae, should be irrigated copiously with water, before and after removing any contact lenses.

#### 5.1.2 If a significant exposure has taken place (percutaneous or mucocutaneous exposure to blood or a body fluid), the recipient if a volunteer, healthcare student or staff member should contact the Occupational Health Department at Pennine (8am-4pm Monday-Friday) on 0161 720 2727 and select Option 1 to be assessed, or attend the Salford Royal Emergency Department (out of hours) immediately. If the recipient is a patient the appropriate advice should be sought from the medical team managing the patient or if this is not available, the RMO.

#### 5.1.3 The ward manager, or deputy, should provide the Health and Wellbeing Department or Emergency Department with necessary information required to make the appropriate informed risk assessment, including risk factors which could indicate the donor is more likely to be positive for hepatitis B, hepatitis C or HIV.

NB. Consent should be sought to disclose the donor’s infection status after an incident exposure to a serious infectious disease. If the donor cannot be persuaded to consent to disclosure, or if it is not safe or practicable to ask for their consent, the information may be disclosed in the public interest (e.g. if the information is needed for decisions about the continued appropriateness of post-exposure prophylaxis) – seek senior advice from the ward consultant or a consultant microbiologist.

#### 5.1.4 Circumstances that could allow the transmission of blood-borne viruses from a health care worker to a patient include:

- Visible lacerations occurring to a health care worker’s hand in circumstances where the patient’s open tissue or mucous membranes could be contaminated with the health care worker’s blood.

- Visible bleeding of a health care worker from any other site (e.g. nosebleed) leading to significant bleed-back into a patient’s open tissue or mucous membranes.

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• An instrument or needle contaminated with the blood of the health care worker is inadvertently introduced into a patient’s tissue.

• Where any health care worker is involved in, or observes, any of the above incidents, that health care worker should take the actions listed in this procedure for management of incidents.

5.1.5 The Risk Assessment form to be followed and filled in by the Emergency Department, the Health and Wellbeing Department or other clinician is (Appendix 1) This involves a risk assessment of the incident based on information available and facilitates initial decision making around the provision of PEP for HIV and HBV. For significant injuries/exposures a baseline sample of clotted venous blood in a serum gel tube (brown top) should be obtained from the recipient and sent to the Microbiology laboratory requesting storage. The sample will then be stored for 2 years for future testing, if required. An Adverse Incident Report (AIR) form must be completed.

If the recipient is a staff member or undergraduate medical student and attends the Emergency Department, a copy of the appropriate documentation needs to be either:

• emailed to occhealth@srft.nhs.uk
• or given to the recipient to take to Health and Wellbeing Department
• or sent to the Clinical Lead within the Health and Wellbeing Department via the internal post.
• If the recipient is an undergraduate medical student, the Department of Undergraduate Medical Education should be informed as soon as possible by email to the Undergraduate Manager (keshi.minett@srft.nhs.uk)

The recipient needs to be informed to attend the Health and Wellbeing Department as soon as possible so that any necessary follow-up can be arranged.

5.1.6 During normal working hours (Monday-Friday 8am-4pm), recipients of a potential blood borne virus exposure should report to the occupational health department, and out of hours to the emergency department for assessment. Where a significant exposure has occurred the recipient should have no role in donor blood borne virus testing, other than providing occupational health or emergency department staff with the name and hospital number of the donor (if known).

Blood borne virus testing in donor patients, where necessary following risk assessment, including counselling, consent and collection should be undertaken by a healthcare profession responsible for the ongoing care of the donor patient (as outlined in (Appendix 2). An occupational health or emergency department practitioner, respectively, will arrange for donor testing if necessary, directly with a member of the clinical team looking after the donor patient. In significant exposures a sample of clotted venous blood in a
serum gel tube (brown top) from the donor will be required for Hepatitis B surface antigen, Hepatitis C antibody and HIV antibody/antigen testing. Occupational health (or rarely, if testing done urgently out of hours emergency department) staff will be responsible for communicating the results of donor bloods to the recipient when available.

5.1.7 Further follow-up of staff and any investigations will be arranged as required by Health and Wellbeing.

If a patient is a recipient, the consultant in charge of their care will arrange appropriate follow-up. Referral may be made to Sexual Health Services (212 5720), Infectious Diseases at Pennine Acute NHS Trust (795 4567) or the GP.

5.1.8 Further information and advice:

Health and Wellbeing Department (206 5768)
Consultant Microbiologist (206 5030/5027)
Consultant Sexual Health Physician (212 5717 or 212 5727)
Medicines Information (206 5223)

For advice out of hours contact the on-call Medical Microbiologist via switchboard.

Specialist prescribing information can be obtained from Sexual Health at SRFT (working hours) or the on-call registrar in Infectious Diseases at North Manchester General Hospital (e.g. pregnancy, paediatrics).

6. Roles and responsibilities

6.1 The Chief Officer

Has overall responsibility on behalf of the Trust for managing all aspects of Health and Safety. In practice in the instance of managing the potential occupational exposure to blood borne viruses this responsibility is delegated.

6.2 The Directors of Medicine and Nursing

Will ensure that the following mechanisms are in place in order to ensure the potential occupational exposure to blood borne viruses is managed appropriately.

- inform staff, patients, visitors and any other relevant personnel of the policy.
- To ensure that this policy is adhered to by staff and that resources are available to ensure effective implementation. This includes making sure that all managers and staff are made aware of their specific responsibilities as stated in this policy.
- To ensure adequate measures are in place, through the provision of the Health and Wellbeing service, to immunise staff against the risk of blood borne viruses.

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To ensure, through the Health and Wellbeing service, that procedures are in place to carry out health checks in respect of exposure to substances hazardous to health, as defined under the Control of Substances Hazardous to Health Regulations 2002 as amended, including pathogenic organisms.

6.3 Trust Directors and Senior Managers

Will ensure that:
- Appropriate resources are allocated to adequately control risks associated with sharps and needlestick injuries that are identified in the risk assessment process, including the provision of suitable information, instruction, training and supervision of staff.
- The procedures and protocols identified within this policy are adhered to and that arrangements are monitored following incidents relating to potential exposure to blood borne viruses.
- Appropriate guidance is available for those who are involved in or affected by such incidents.
- Staff attends infection control training, including refresher and update training.

6.4 Department and Ward Managers

Will ensure that:
- The management of potential exposure to blood borne viruses is incorporated into the risk assessment process.
- Suitable equipment is available for the safe disposal of sharps, body fluids and blood, and is readily available and in appropriate use.
- All personnel within their area of control are informed of the correct and safe procedures for the management of potential occupational exposure to blood borne viruses at induction, during refresher training or when a significant change of practice occurs which results in a change of policy.
- All personnel are aware of the appropriate action to take should an incident involving the potential occupational exposure to blood borne viruses occurs.
- They co-operate with the Occupational Health team, the health and safety team and the infection control team to ensure this policy is implemented and followed appropriately.
- The information from the yearly audit and performance report is appraised and corrective action taken as necessary.

6.5 Head of Risk Management

Will ensure that:
- management systems are in place for the reporting of inoculation incidents.
- Incident management systems are in place for the reporting of inoculation incidents.
- Information from the audit and the performance reports is appraised and the recommendations made to managers, via Inoculation Working Group.
- High risk inoculation incidents are reported under RIDDOR.
- Health and Wellbeing and Infection Control are routinely advised of adverse incident reports regarding sharps or splash injuries.
6.6 Health and Wellbeing Department

Will ensure that:
- Personnel potentially exposed to blood borne viruses are managed in accordance with this policy.
- Where appropriate information regarding evidence based practice or best practice with regard to the management of potential occupational exposure to blood borne viruses is communicated to the relevant committees and working groups.
- Communication occurs between the Health and Wellbeing department and the Health and Safety team when they become aware of injuries which raise particular concerns including those covered by RIDDOR.
- Appropriate incident statistics are reported to the Infection Control Committee, Health and Safety Committee and Inoculation Working Group at each meeting.
- A yearly audit of practice takes place and results disseminated to managers, Inoculation Group and Health & Safety Committee.

6.7 The Infection Control Team

Will ensure that:
- Information in order to assist in the prevention and management of exposure to blood borne viruses is made available as appropriate to all personnel of the Trust.
- Assistance in policy development regarding the management and prevention of potential occupational exposure to blood borne viruses is provided.

6.8 Emergency Department Staff

Will ensure that:
- All staff, visitors, volunteers or patients presenting following the potential exposure to blood borne viruses are managed in accordance with this policy.
- Ensure that the appropriate documentation is completed and transferred to the Health and Wellbeing Department either electronically, via the recipient, or as a hard copy via internal post.

6.9 All Employees

Will:
- Co-operate with the Trust to enable it to meet its obligations in respect of managing potential occupational exposure to blood borne viruses.
- Make full and proper use of the control measures identified, including the use of personal protective equipment.
- Attend, where appropriate, appointments with Health and Wellbeing and give any information about the incident and their health that may be reasonably required in order to complete fully the appropriate risk assessment.
- Act in such a way, by using safe working practices as to reduce the risk of transmission of blood borne viruses to patients and colleagues.
- Attend the required training in order to familiarise themselves with the guidance regarding the safe management of sharps, the correct disposal of waste and how to manage an incident involving the potential occupational exposure to blood borne viruses.
- Report any incidents or unsafe practice on the Trust’s adverse incident system.

### 7. Monitoring document effectiveness

#### 7.1 The Infection Control Team will review this policy every two years or more frequently if new evidence or guidance emerges.

<table>
<thead>
<tr>
<th>What</th>
<th>How</th>
<th>Frequency (per year)</th>
<th>Reporting to</th>
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<tbody>
<tr>
<td>Duties</td>
<td>Production of incidence figures</td>
<td>Once</td>
<td>Health and Safety Committee</td>
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<tr>
<td>How inoculation incidents are reported</td>
<td>Adverse Incident Reports (AIRs) monitored against documentation held by Health and Wellbeing</td>
<td>Once</td>
<td>Health and Safety Committee</td>
</tr>
<tr>
<td>Process for the management of an inoculation incident (including prophylaxis)</td>
<td>Adverse Incident Reports (AIRs) monitored against documentation held by Health and Wellbeing</td>
<td>Once</td>
<td>Health and Safety Committee</td>
</tr>
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<td>How the organisation trains staff, in line with the training needs analysis</td>
<td>Mandatory training report</td>
<td>Twice per year</td>
<td>Health and Safety Committee</td>
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### 8. Abbreviations and definitions

- **Sharps** Items which could puncture the skin and thus permit the entry of bacteria and viruses into the body e.g. used needles, scalpel blades.
- **Sharps injury** An injury caused by a sharp.
- **Personal protective equipment (PPE)** This is equipment worn by an individual to reduce the risk of coming into contact with hazardous substances e.g. eye protection, gloves, apron.
- **Occupational exposure** An exposure which occurs within the working environment which results in
the exposure of broken skin or mucous membrane to blood or a body fluid.

Recipient
The individual who is exposed to blood or body fluid.

Donor
The individual who is the source of the blood or body fluid.

Mucocutaneous exposure
Blood or body fluid is in contact with a mucous membrane (e.g. eye, mouth) or visibly damaged skin (e.g. a wound or an area of dermatitis is exposed).

Percutaneous exposure
Puncture of the skin with an object contaminated by blood or a body fluid e.g. needlestick injury.

Significant exposure
Percutaneous or mucocutaneous exposure to blood or body fluid.

Post-exposure prophylaxis
Treatment given following the possible exposure to a blood borne virus to reduce the risk of infection.

9. References and Supporting Documents


10. Associated Documents:

   - Post-exposure prophylaxis (PEP) following out of hospital exposure to body fluids [ECDU1(09)](http://ECDU1(09))
   - Post-exposure prophylaxis following potential sexual exposure to HIV and Hepatitis B (PEPSE) [ECDU2(09)](http://ECDU2(09))
   - Health and Safety Policy [TG21(05)](http://TG21(05))
   - Standard Infection Control Precautions Policy [Infect2(09)](http://Infect2(09))
   - Consent for Examination or Treatment [RM16(06)](http://RM16(06))
## 10. Document Control Information

It is the author’s responsibility to ensure that all sections below are completed in relation to this version of the document prior to submission for upload.

Remove instructions once completed.

<table>
<thead>
<tr>
<th>Nominated Lead author:</th>
<th>Dr Eamonn Trainor</th>
<th>Consultant Microbiologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead author contact details:</td>
<td>0161 206 4073</td>
<td><a href="mailto:Eamonn.trainor@srft.nhs.uk">Eamonn.trainor@srft.nhs.uk</a></td>
</tr>
<tr>
<td>Lead Author’s Manager:</td>
<td>Dr Paul Chadwick</td>
<td>Consultant Microbiologist</td>
</tr>
<tr>
<td>Applies to:</td>
<td>Salford CO X Oldham CO North Manchester CO Bury &amp; Rochdale CO Northern Care Alliance Group (NCA)</td>
<td></td>
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<tr>
<td>Document developed in consultation with :</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Keywords/ phrases:</td>
<td>Needlestick, needle, sharps, PEP, post exposure prophylaxis, HIV, hepatitis B, hepatitis C, blood borne virus, occupational health</td>
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<tr>
<td>Communication plan:</td>
<td>All staff will receive information and instruction on induction to the trust as part of the Corporate Health and Safety induction. The policy will be available on the Trust's Intranet site Individual staff and their managers will be expected to refer to the policy as required Health and Wellbeing and Infection Control will refer enquiries to the policy as required.</td>
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<tr>
<td>Document review arrangements:</td>
<td>This document will be reviewed by the author, or a nominated person, at least once every three years or earlier should a change in legislation, best practice or other change in circumstance dictate.</td>
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<tr>
<td>Approval:</td>
<td>Dr Peter Turkington, Chair, Hospital Infection Control Committee</td>
<td></td>
</tr>
<tr>
<td>19/06/2018</td>
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<tr>
<td>How approved:</td>
<td>Chair's actions X Formal Committee decision</td>
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11. **Equality Impact Assessment (EqIA) screening tool**

Legislation requires that our documents consider the potential to affect groups differently, and eliminate or minimise this where possible. This process helps to reduce health inequalities by identifying where steps can be taken to ensure the same access, experience and outcomes are achieved across all groups of people. This may require you to do things differently for some groups to reduce any potential differences.

1a) Have you undertaken any consultation/involvement with service users, staff or other groups in relation to this document? If yes, specify what.  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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1b) Have any amendments been made as a result? If yes, specify what.  

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2) Does this policy have the potential to affect any of the groups listed below differently?  

*Place an X in the appropriate box: Yes, No or Unsure*  

This may be linked to access, how the process/procedure is experienced, and/or intended outcomes. Prompts for consideration are provided, but are not an exhaustive list.

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<tr>
<td>Age (e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)</td>
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<td>Sex (e.g. is gender neutral language used in the way the policy or information leaflet is written?)</td>
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<td>Race (e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)</td>
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<td>X</td>
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<tr>
<td>Religion &amp; Belief (e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered.)</td>
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<td>Sexual orientation (e.g. is inclusive language used? Are there different access/prevalence rates?)</td>
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<tr>
<td>Pregnancy &amp; Maternity (e.g. are procedures suitable for pregnant and/or breastfeeding women?)</td>
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</tr>
<tr>
<td>Marital status/civil partnership (e.g. would there be any difference because the individual is/is not married/in a civil partnership?)</td>
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<td>Gender Reassignment (e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)</td>
<td></td>
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<td>X</td>
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<tr>
<td>Human Rights (e.g. does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)</td>
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<td>X</td>
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<tr>
<td>Carers (e.g. is sufficient notice built in so can take time off work to attend appointment?)</td>
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<tr>
<td>Socio/economic (e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)</td>
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<tr>
<td>Disability (e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.</td>
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Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? (e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)

3) Where you have identified that there are potential differences, what steps have you taken to mitigate these?
   (what action has been taken or will be taken, who is responsible for taking a future action, and when it will be completed by – may include adjustment to wording of policy or leaflet to mitigate)
   N/A

4) Where you have identified adjustments would need to be made for those with disabilities, what action has been taken?
   (what action has been taken or will be taken, who is responsible for taking a future action, and when it will be completed by – may include adjustment to wording of policy or leaflet)
   N/A

Will this policy require a full impact assessment? No
(a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - Please contact the Inclusion and Equality team for advice on equality@pat.nhs.uk)

Author: Type/sign: Eamonn Trainor          Date: June 2018

Sign off from Equality Champion:          Date:
12. Appendices

Appendix 1 Risk Assessment for Exposure to Blood or Body Fluid

RISK ASSESSMENT FORM FOR EXPOSURE TO BLOOD OR BODY FLUID

For healthcare workers: sections 1-5 of this form should be completed immediately following exposure to blood or blood stained body fluids and other high risk body fluids, by a member of the Health and Wellbeing Department or Emergency Department. The form is confidential and once completed it will be retained within the Health and Wellbeing records of the recipient.

For patients: the principles laid out in this form should be followed and entered into the Electronic Patient Record (EPR) by a member of the clinical team or the RMO.

A1.1 Details of Health Care Worker and Incident

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
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| Occupation | Ward/Dept | Telephone Home |
|           |           |                |

<table>
<thead>
<tr>
<th>Manager</th>
<th>Telephone Work</th>
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</table>

Incident details

Were gloves worn at the time of the incident? Yes/No

Significant exposure (see A1.3) Yes/No

Date of incident Time (24hrs) Location of incident

Date of last HBV booster (give one if not in last 12 months) Anti-HBs titre levels if known (immunity) Bloods taken for storage (significant exposure only)

Follow-up arranged (see appendix A1.9 for guidance on recipient follow up testing) Yes / No 6 weeks Date 12 weeks Date 24 weeks Date

HCV RNA 12 weeks HIV Ab HBsAg 24 weeks HCV Ab Date Result

HCV Ab Result

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### A1.2 Immediate Action

<table>
<thead>
<tr>
<th>First Aid measures</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage bleeding &amp; wash with copious amounts of running water</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>Cover with a dry dressing where appropriate</td>
<td>Date</td>
<td>Time</td>
</tr>
</tbody>
</table>

Inform manager

Complete Incident Form

**Date**

**Time**

### A1.3 Assessment of Exposure

Please tick ✓ as appropriate

<table>
<thead>
<tr>
<th>Significant exposure</th>
<th>Non-significant exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contaminated sharp (with blood etc)</td>
<td>Clean sharp</td>
</tr>
<tr>
<td>Contamination of broken skin</td>
<td>Sharp not used in direct patient contact eg drawing up medicines/fluids</td>
</tr>
<tr>
<td>Splash to conjunctiva/mouth</td>
<td></td>
</tr>
<tr>
<td>Human bite (where the skin is broken)</td>
<td></td>
</tr>
</tbody>
</table>

**If any of the above are ticked continue with completion of this form**

If any of the above are ticked, administer first aid.

**No further action required re BBV**

### A1.4 Material Involved

<table>
<thead>
<tr>
<th>Tick ✓</th>
<th>Tick ✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood / Plasma</td>
<td>Amniotic fluid</td>
</tr>
<tr>
<td>CSF</td>
<td>Saliva – visibly blood-stained or in association with dentistry</td>
</tr>
<tr>
<td>Pleural / Peritoneal fluid</td>
<td>Vaginal secretions</td>
</tr>
<tr>
<td>Other blood-stained fluid</td>
<td>Other</td>
</tr>
<tr>
<td>Specify:</td>
<td>Specify:</td>
</tr>
</tbody>
</table>

**NB: Urine, faeces and vomit, unless blood stained, carry no risk of blood borne virus transmission.**

### A1.5 Details of Donor

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital number</td>
<td>Consultant</td>
</tr>
<tr>
<td>Ward / Dept and contact number</td>
<td></td>
</tr>
<tr>
<td>Bloods obtained with consent for BBV screen (HBV surface antigen, HCV antibody, HIV 1,2 antibody/antigen)</td>
<td></td>
</tr>
</tbody>
</table>
A1.6 Assessment of Need for Post-Exposure HIV Prophylaxis (PEP)

Use the following charts (A1.6a for staff, A1.6b for patients) to assess whether there may have been significant exposure to HIV risk. If PEP for HIV is recommended or offered (chart A1.6c), prescribe a 7 day PEP starter pack using EPR to record that drugs have been dispensed.

If post-exposure prophylaxis is started, occupational health should review recipient as soon as possible and within seven days to monitor any side effects and obtain baseline blood samples for FBC, U&Es, and LFTs, as well as HIV testing and storage.

NB. PEP, if indicated must be commenced as soon as possible after HIV exposure, preferably within one hour and within 72 hours at the latest.

Each PEP drug pack contains 7 days of the 28 day course and can be found in either the Emergency Department or Pharmacy emergency cupboard. If continuation is required following the results of donor testing the remaining course will be supplied at follow-up. If Health and Wellbeing request that the remaining 21 day continuation course is prescribed by the Emergency department this should be prescribed using EPR to provide a further 3 PEP packs.

The drugs are Truvada (Emtricitabine and Tenofovir co-formulation) one tablet daily (24 hourly intervals) and Raltegravir one 400mg tablet twice a day at 12 hourly intervals. These can be taken with or without food.

Diarrhoea, nausea and vomiting may occur as side effects and loperamide may be taken if required. This is not included in the PEP pack but is available from community pharmacies without a prescription. The patient should be counselled to seek medical attention if they develop a rash whilst taking PEP.

The BNF or Liverpool University HIV drug interaction web site (www.hiv-druginteractions.org) must be checked prior to drug issue for any potentially significant interactions. If there are any doubts consult the on-call pharmacist.

Prior to prescribing to someone with a significant co-morbidity (e.g. liver or renal dysfunction) check the BNF or contact a clinical pharmacist.

Truvada and raltegravir may be prescribed during pregnancy and should be offered if PEP is indicated following a risk assessment. If necessary, advice on this and other specialist prescribing issues (e.g. paediatrics) can be obtained from Sexual Health at SRFT (working hours) or the on-call registrar in Infectious Diseases at North Manchester General Hospital.

Please record decisions about HIV PEP here:

- HIV PEP offered or recommended? Yes / No
- HIV PEP offered but declined? Yes / No

If HIV PEP is either not indicated or declined it is important to continue with
the assessments for hepatitis B & C on the following pages.

**A1.6a Assessment of Post-Exposure HIV Prophylaxis for Staff**

- **HCW exposed to blood or high risk body fluid within last 72 hours**
  - **Significant exposure?**
    - No
    - Yes
      - **Donor HIV +ve?**
        - No
          - PEP not indicated
        - Yes
          - Uncertain
            - PEP recommended
              - First dose should be given as soon as possible, *ideally within 1 hour of exposure*
              - Consider whether PEP should be offered based on risk assessment pending testing of the source particularly if exposed to blood from a donor with risk factors for HIV infection. Use A1.6c for risk assessment
        - *Donor risk factors for HIV*
          - Men who have sex with men
          - Person who injects drugs
          - Commercial sex worker
          - Donor from Sub-Saharan Africa, L. America, S&SE Asia, E Europe, Caribbean

- **Follow up via Health and Wellbeing Team**

* A bite injury, including breakage of the skin with passage of the recipient’s blood, is not normally considered a significant HIV exposure. HIV PEP is not indicated unless contamination of broken skin by the assailant’s/doner blood is suspected. However, any bite which causes bleeding or visible skin puncture is considered a significant exposure when assessing Hepatitis B exposure risk.

**A1.6b Assessment of Post-Exposure HIV Prophylaxis for Patients**

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It is your responsibility to check on the intranet that this printed copy is the latest version.
A1.6c Risk Assessment for HIV PEP

Assess risk that donor is HIV positive

<table>
<thead>
<tr>
<th>Donor Risk</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known to be HIV positive (if on treatment ascertain drug therapy and viral load)</td>
<td>Recommend PEP</td>
<td>Recommend PEP</td>
<td>No PEP</td>
</tr>
<tr>
<td>Men who have sex with men (London or Manchester (inc.Salford) Sub-Saharan African origin People who inject drugs Commercial sex worker</td>
<td>Recommend PEP</td>
<td>Offer PEP</td>
<td>No PEP</td>
</tr>
<tr>
<td>Other men who have sex with men Heterosexual male/female (Caribbean, L. America, S&amp;SE Asia, E. Europe)</td>
<td>Recommend PEP</td>
<td>Offer PEP</td>
<td>No PEP</td>
</tr>
<tr>
<td>Other heterosexual male/female</td>
<td>No PEP</td>
<td>No PEP</td>
<td>No PEP</td>
</tr>
</tbody>
</table>

Assess exposure risk

<table>
<thead>
<tr>
<th>Exposure risk</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>High – Large blood transfer</td>
<td>Recommend PEP</td>
<td>Recommend PEP</td>
<td>No PEP</td>
</tr>
<tr>
<td>e.g. deep percutaneous laceration with a hollow needle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.g. extensive blood contamination of a mucous membrane</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium e.g. percutaneous injury with a solid needle e.g. exposure of broken skin, including contamination of a bite wound by the assailant’s blood</td>
<td>Recommend PEP</td>
<td>Offer PEP</td>
<td>No PEP</td>
</tr>
<tr>
<td>Low e.g. exposure to urine with no visible blood-staining e.g. bite injury without contamination of broken skin by the assailant’s blood</td>
<td>No PEP</td>
<td>No PEP</td>
<td>No PEP</td>
</tr>
</tbody>
</table>

* A bite injury, including breakage of the skin with passage of the recipient’s/donor blood, is not normally considered a significant HIV exposure. HIV PEP is not indicated unless contamination of broken skin by the assailant’s blood is suspected. However, any bite which causes bleeding or visible skin puncture is considered a significant exposure when assessing Hepatitis B exposure risk.
## A1.7 Risk Assessment for Hepatitis B Post-Exposure Prophylaxis (PEP)

<table>
<thead>
<tr>
<th>HBV status of person exposed</th>
<th>Significant exposure</th>
<th>Non-significant exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HBsAg positive donor</td>
<td>HBsAg negative donor</td>
</tr>
<tr>
<td><strong>≤ 1 dose of HBV vaccine pre-exposure</strong></td>
<td>Accelerated course* of HBV vaccine plus HBIG × 1</td>
<td>Accelerated course* of HBV vaccine</td>
</tr>
<tr>
<td><strong>≥ 2 doses of HBV vaccine pre-exposure (anti-HBs not known)</strong></td>
<td>One dose of HBV vaccine + 2nd dose one month later</td>
<td>One dose of HBV vaccine</td>
</tr>
<tr>
<td><strong>Known responder to HBV vaccine (anti-HBs &gt;10 mlU/mL)</strong></td>
<td>HBV booster</td>
<td>HBV booster</td>
</tr>
<tr>
<td><strong>Known non-responder to HBV vaccine (anti-HBs &lt;10 mlU/mL 2-4 months post immunisation)</strong></td>
<td>HBIG × 1 plus booster dose of HBV vaccine</td>
<td>HBIG × 1 plus booster dose of HBV vaccine</td>
</tr>
</tbody>
</table>

Notes: HBIG = Hepatitis B immunoglobulin, obtained via on-call consultant Virologist, Central Manchester Hospitals (0161 276 1234)

*An accelerated course of vaccine consists of doses spaced at zero, one and two months plus a booster dose at 12 months.

**Record here the HBV status of the recipient**

**Record here the HBsAg status of the donor: positive/negative/unknown**

**Record here the action taken for HBV PEP**

Please note a booster dose of vaccine should be given if the individual is known to respond and has not had a HBV vaccine in the last 12 months.

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A1.8 Risk Assessment for Hepatitis C

Risk factors for hepatitis C include:
- Injecting drug use - either past or present
- Blood transfusion before screening introduced in UK / abroad

The recipient should be advised that there is currently no vaccine or post-exposure prophylaxis for hepatitis C. However, there is some evidence that early treatment of acute hepatitis C infection may prevent chronic hepatitis C infection. Follow-up will be arranged by the Health and Wellbeing Team or clinician in charge, as appropriate.

Follow up where donor is hepatitis C antibody positive or status unknown:
- Liver function tests
- HCV RNA at 6 and 12 weeks post-exposure
- HCV antibody at 6, 12, 24 weeks (up to 1 year in very high risk cases)

Follow up where donor is hepatitis C antibody negative:
- Recipient to be tested for HCV antibodies at 12 weeks and 24 weeks

A1.9 Follow-up blood tests, weeks after a significant injury/exposure (based on UK guidelines¹ for HIV and expert opinions for hepatitis B virus and hepatitis C virus)

<table>
<thead>
<tr>
<th>Blood borne virus risk in donor</th>
<th>6 weeks</th>
<th>12 weeks</th>
<th>24 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV*</td>
<td></td>
<td>HIV antibody (combined Ag/Ab assay)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td>Hepatitis B surface antigen</td>
<td>Hepatitis B surface antigen**</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Hepatitis C RNA</td>
<td>Hepatitis C antibody and RNA</td>
<td>Hepatitis C antibody</td>
</tr>
</tbody>
</table>

*If HIV post exposure prophylaxis has been started, follow up HIV testing should be guided by a Sexual Health Physician
**Not routinely recommended unless Hepatitis B immunoglobulin was given after injury/exposure

A1.10 Advice to be provided to the Recipient Post Exposure

The recipient should be advised: to use barrier methods of contraception; not...
to donate blood; to discontinue breast-feeding if applicable; to avoid pregnancy if applicable, during the follow-up period for HIV (12 weeks).

There are no work restrictions for staff during the follow-up period where the incident is considered low risk. Where the recipient is considered at high risk of developing HIV, Hepatitis C or Hepatitis B, each case will be assessed individually with the Health and Wellbeing consultant. It is possible that if the recipient is undertaking exposure prone procedures they will be asked to refrain from taking part in these until further information is available to undertake an assessment (usually at 6 weeks post incident). In the event of the recipient testing positive for hepatitis B, hepatitis C or HIV, he / she will be seen by a Consultant Health and Wellbeing Physician for advice regarding working practices and onward referral to a specialist Health Care consultant.

**THIS FORM** (pages 11 - 21 of this document) **MUST BE SENT TO:**

The Clinical Lead  
Health and Wellbeing Department  
Level 3  
Ladywell Building  
Salford Royal Hospital

Hard copy by post.................................................................Yes / No

Given to employee..............................................................Yes / No

Email occhealth@srft.nhs.uk ................................................Yes / No

**Signature of person making the assessment..........................**

Print name..............................................................................

Department...........................................................................

Date.......................................................................................
Appendix 2  Consent for Testing for Blood Borne Viruses

CONSENT FOR TESTING FOR BLOOD BORNE VIRUSES

The donor’s consent to testing must always be gained. If the rationale for testing is explained, it is unusual for consent to be refused. Where a patient may lack capacity to consent (including a patient who is unconscious or post-anaesthetic), refer to the Consent to Treatment Policy and the Mental Capacity Act 2005 Policy.

It should be within the competence of any doctor, nurse or midwife to obtain consent for testing, however this should not be done by the recipient. A senior member (Consultant or Upper Grade) of a different clinical team is best placed to do this accompanied, if appropriate, by a senior nurse.

The two essential elements of the pre-test discussion are:

- The benefits of testing
- Details of how the result will be given

Check that the patient is aware of the circumstances of the exposure. Explain that transmission of blood-borne infections via blood is rare in the UK, but that the recipient can take four weeks of treatment to help reduce the risk of HIV transmission. The treatment consists of several tablets daily and can cause side effects. It is not necessary if the donor patient does not have HIV.

Propose the donor is tested for blood-borne viruses. The donor may know they are HIV positive. Investigate disease stage, viral load / CD4 count and past / current use of antiretroviral treatment, if known.

Check that the donor understands:

- briefly, how blood-borne viruses are transmitted
- the meaning of results (e.g. some people may wrongly interpret a ‘positive’ result as good news)
- the testing procedure
- consent is needed to test and to disclose the result to the recipient

Lengthy pre-test HIV counselling is not a requirement for consent to testing, unless an individual requests or needs this – refer to a Health Adviser in Sexual Health.

Arrange follow-up; ensure that the donor knows when and where they can receive the results. A positive test result for a blood borne virus will be communicated to a senior member of the donor’s medical team by a member of the Microbiology Department. A senior member of the patient’s medical team will inform the donor of the result and arrange for further medical referral and counselling, as appropriate. Any donor who is newly diagnosed HIV positive as a result of this process will be given access to specialist post-test counselling and assurances about confidentiality.

Document the request to test for blood borne viruses in the EPR, together with
any relevant discussion. If the donor refuses a test the reasons why they have made that choice should be explored to ensure that these are not due to incorrect beliefs about the viruses (usually HIV) or the consequences of testing.

- Note that insurance companies should not ask whether an individual has ever had an HIV test (although a positive HIV test would have to be declared for a relevant insurance application as would be the case with any other medical condition).

- Concern about HIV testing and criminal prosecution for HIV transmission should not be a barrier to testing for this type of incident.

If the patient dies, testing should only be carried out where there is good reason to suspect that the patient may have been infected, and a health care worker has been exposed to the patient's blood or other body fluid. You must obtain the agreement of a 'nominated relative' or a person in a 'qualifying relationship' to the deceased before testing.
PATIENT INFORMATION SHEET - POST-EXPOSURE PROPHYLAXIS FOR HIV AFTER EXPOSURE TO BLOOD

The risk of catching HIV from your recent exposure has been carefully assessed and a short course of antiretroviral drugs has been recommended. This medication can reduce the risk of HIV transmission by over 80%.

The tablets you have been prescribed are:

| TRUVADA  | take 1 tablet ONCE per day |
| Raltegravir | take 1 400mg tablet TWICE per day, 12 hours apart |

As treatment should start as soon as possible after exposure, your first dose may be at an inconvenient time to continue taking tablets at the same time each day. If your first dose is after midnight and before 4am, you should take your next dose the same morning and then at the same time each day (with the second Raltegravir dose taken 12 hours later). If you are given your first dose at any other time, you should continue to take your tablets at the same time each day (with the second Raltegravir dose taken 12 hours later).

Missed doses
Truvada – if a dose is less than 12 hours late, take the dose as soon as you remember and continue to take the next dose at your usual time. If it is more than 12 hours late, the missed dose should not be taken and the next dose should be taken at the normal time.
Raltegravir – If you miss a dose, take it as soon as you remember unless it is already time for your next dose in which case you should skip the missed dose and go back to your regular schedule. Do not take a double dose.

IMPORTANT INFORMATION
- All the medications can have common side effects (see table below and the information leaflet provided with your tablets).
- Inform your doctor or pharmacist if you are taking any other medicines or herbal remedies as these may interact with your medication.
- Truvada (Emtricitabine and Tenofovir co-formulation) should not be taken by people known to have kidney disease.
- An anti-diarrhoeal medicine, loperamide may be helpful if diarrhoea develops, and is available from pharmacies.
- Do not take antacids 2 hours before or after taking Raltegravir.
- Truvada should preferably be taken with food but Raltegravir can be taken with or without food.
- It is recommended you avoid becoming pregnant until you have completed the course of medication and had an HIV test to confirm you are not infected.
- You should not breast feed while taking these medicines.

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Unwanted effects of your treatment may include:

**TRUVADA**  Nausea, vomiting, headaches, muscle pain, lack of energy, skin rash, insomnia and anaemia.

**RALTEGRAVIR**  Skin rash, insomnia, headache, dizziness, nausea and fatigue.
Appendix 4  Sharps Safety

Sharps Safety

The use of sharps should be avoided where possible. When their use is essential, particular care is required in handling and disposal. If possible, use safer sharps devices.

Safe Handling

Sharps must always be handled carefully, in accordance with the following principles;

a) Do not re-sheath used needles.
b) In exceptional circumstances, if resheathing CANNOT be avoided, use a specific needle resheathing/removing device.
c) Always get help when using sharps with a confused or agitated patient.
d) Never pass sharps from person to person by hand – use a receptacle or 'clear field' to place them in.
e) Never walk around with sharps in your hand.
f) Never leave sharps lying around – dispose of them yourself.
g) Dispose of sharps at the point of use – take a sharps bin with you.
h) Dispose of syringes and needles as a single unit – do not remove the needle first.
i) When transporting a blood gas syringe, remove the needle using a removal device and attach a blind hub prior to transport.
j) Use needleless intravenous devices and safer needle systems whenever possible, where available.
k) See special instructions issued by Diabetes Lead for a procedure for dealing with pens.

Safety Devices

a) Many sharps injuries can be avoided by adherence to the principles of safe practice. However it is recognised that some injuries are complete accidents. It is possible to reduce the risk of these happening by the use of safety devices.
b) These are devices that incorporate a built-in safety feature in their design, which is intended to reduce the risk of sharps injury.
c) An integrated safety feature is part of the basic design of the device that cannot be removed. A passive safety feature is one that does not require the user to activate it, and remains effective before, during and after use.
d) It is the responsibility of managers to ensure that staff use safety devices whenever possible.
e) Managers should consider the supply of safety devices in preference to
standard devices wherever possible. In areas where there are assessed to be higher infection risks, safety needles should be used for venepuncture and other procedures.

**Use of Sharps Boxes**

a) Sharps must only be disposed of in designated sharps bins that meet the requirements of the British Standard: BS 7320 (1990).

b) Always assemble sharps bins correctly.

c) Put the lid on properly; ensure “clicks” into place.

d) Label completed.

e) (Place in suitable, safe location.

f) Ensure sharps bins are of an appropriate size for the clinical activity – do not select excessively large sharps bins, or those that are too small for the size needle/syringes you use.

g) Sharps bins should be available at the point of use of the sharp – they should be taken to the bedside, placed on drug and cardiac arrest trolleys.

h) Wall and trolley brackets should be used, as appropriate.

i) Sharps bins must be located at approximately waist height, and never placed on the floor, on top of high surfaces, or where children or confused adults can tamper with them.

j) Never push the contents of the sharps bin down to make more room.

k) Between uses use the temporary closure device on the bin to prevent accidental spillage of sharps if the bin is knocked over.

l) Always carry a sharps bin by the handle, or using the carry tray provided for smaller bins – never place it against your body.

m) Never overfill a sharps bin – replace it when filled to the line marked.

n) Ensure sharps bins are closed and locked before disposal, and complete the label on the bin.

o) Used sharps bins must be stored in a locked, segregated cupboard or clinical waste bin provided for the purpose.