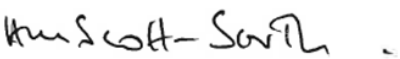
POLICY DOCUMENT

Burton Hospitals
NHS Foundation Trust

INOCULATION / SHARPS INJURY POLICY

Approved by:	**Trust Executive Committee**
On:	**8 August 2017**
Review Date:	**February 2020**
Corporate/Directorate	**Corporate**
Clinical/Non Clinical	**Clinical**
Department Responsible for Review:	**Infection Prevention and Control Team**
Distribution:	**All staff via Infection Prevention and Control pages of Trust Intranet**
• Essential Reading for:	**All Directorate Managers** **All Clinical Directors** **All Matrons** **All Senior Managers and Department Heads** **All clinical Staff**
• Information for:	**All Staff**
Policy Number	**76**
Version Number:	**8**
Signature:	
	Chief Executive
Date	**9 August 2017**

Burton Hospitals NHS Foundation Trust

POLICY INDEX SHEET

Title:	**Inoculation / Sharps Injury Policy**
Original Issue Date:	**February 2014**
Date of Last Review:	**February 2017**
Reason for amendment:	**Major revision and re-write**
Responsibility:	**Infection Prevention and Control Team**
Stored:	**Infection Prevention and Control Intranet Site**
Linked Trust Policies:	**Infection Prevention and Control Policies, Standards and Quick Reference Guides as published on the Intranet. Occupational Health and Wellbeing Policy (2015)**
E&D Impact assessed	**EIA 122**
Consulted	**Clinical Directors, Chief Nurse, Medical Director, Health Protection England, Matrons, Associate Directors, Directorate Infection Prevention and Control Leads, PPI, HR, Occupational Health, Clinical Audit, Infection Prevention and Control Team, Facilities including HSSU and Domestic Services**

REVIEW AND AMENDMENT LOG

Version	Type of change	Date	Description of Change
1	Conversion from Guideline to Policy	18/04/2013	Reformatting and change of approval route now that it is a Policy.
2	Updating	10/07/2013	Change to monitoring matrix
3	Updating	06/08/2015	Updating to include evidence from EPIC 3 (2014)
4	Revision/Update	01/01/17	Major revision/re-write
5	Updating	31/05/17	Changes to text and algorithms resulting from change of service from the Department of GU Medicine

INOCULATION/SHARPS INJURY POLICY

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BURTON HOSPITALS NHS FOUNDATION TRUST

INOCULATION / SHARPS INJURY POLICY

1 Introduction

1.1 A wide range of infections including blood borne viruses (BBV) may be transmitted to staff members, patients, visitors and contractors via an inoculation incident. This is an incident involving a sharp contaminated with blood or body fluid piercing the skin or by blood or body fluid contact to broken skin (percutaneous exposure) or, by blood or body fluid contact to mucous membranes (mucocutaneous exposure). The nature of healthcare provides the opportunity for these inoculation incidents / injuries to occur.

1.2 Occupational exposure to blood and body fluids potentially infected with blood can in the main be avoided by:

- Appropriate handling of sharps
- Not removing safety devices from needles
- Not re-sheathing needles
- Appropriate use of the vacutainer system for obtaining blood samples
- Wearing gloves and other Personal Protective Equipment (PPE) as appropriate

1.3 The most significant blood borne viruses are the hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV). The risk of acquiring HIV infection following occupational exposure to HIV infected blood is low**.** Epidemiological studies have indicated that the average risk of HIV transmission after percutaneous exposure to HIV infected blood in healthcare settings is about 3 per 1000 injuries (This risk is known to be lower when the source patient with HIV has an undetectable HIV viral load). After a muco-cutaneous exposure (to eyes, mouth or nose), the average risk of HIV transmission is estimated at less than 1 in a 1000. It is considered that there is no risk of HIV transmission where intact skin is exposed to HIV infected blood (DH Sept 2008). The risk of acquiring HBV infection from HBV infected blood is 1 in 3, and the risk of acquiring HCV infection from HCV infected blood is 1 in 30.

1.4 Incidents where exposure may have occurred must be managed appropriately in order to reduce the risk of infection. We can never be certain which micro- organism may be present in any blood or body fluid. It is therefore important that staff exercise extreme caution at all times when handling used or contaminated sharps (UK Health Departments 1998).

1.5 The Health and Social Care Act 2008 – Code of Practice requires the Trust to have a policy in place for the safe handling and disposal of sharps. Systems must be in place to ensure staff are aware of this policy and that it is implemented.

2 Purpose

The purpose of this policy is to describe the process for managing and reducing the risk associated with Inoculation Incidents among Trust employed healthcare workers and in-patients. This includes:

- Reference to guidance on safe sharps practice
- Reporting arrangements in relation to Inoculation Incidents
- The procedures to follow should a person sustain an Inoculation Injury or other injury which could result in exposure to or transmission of a blood borne virus
- The immediate management of an Inoculation Incident (including Post Exposure Prophylaxis)
- The support available to those who are involved or affected

- Training that will be provided in accordance with the Trust Training Needs Analysis
- The process for monitoring compliance
- A process whereby deficiencies are identified, recommendations and action plans are developed, and changes implemented accordingly

3 Key Responsibilities / Duties

3.1 Director of Infection Prevention and Control

Implementation of policy in the Trust and reporting to Trust board

3.2 Infection Prevention Board

3.2.1 Will receive a three monthly report on Inoculation Injuries from the Occupational Health Department.

3.3 The Governance Department

3.3.1 Will collate Inoculation Incident statistics and report to the Health and Safety Committee / Infection Prevention Board

3.3.2 Will ensure that all DATIX reports relating to Inoculation Injuries are copied to the Occupational Health Department to enable appropriate staff to be followed up in the event that they have not had direct contact with the staff member involved.

3.4 The Infection Prevention and Control Team

3.4.1 Will advise the Trust on which products and resources to be made available for staff use to prevent inoculation incidents.

3.4.2 Will provide up to date guidance for practice.

3.4.3 Will support Inoculation Incident Training at both Trust Induction and mandatory Infection Prevention and Control Training.

3.5 Consultant Microbiologist / Genitourinary Medicine (GUM) Consultant

3.5.1 Will give expert advice on the management of incidents on an individual basis

3.5.2 Consultant Microbiologist will, where necessary, authorise the supply of hepatitis B virus Immunoglobulin from the supply maintained in the Pharmacy / Genito-Urinary Medicine/ Microbiology Department.

3.5.1 The GUM Physician will advise on prescribing initial and continuing PEP for HIV when clinically indicated.

3.6 The Occupational Health Department

3.6.1 Will liaise with the Health and Safety Advisor as appropriate in accordance with RIDDOR 1995. The Trust Health and Safety Advisor will take responsibility for RIDDOR reporting

3.6.2 Will provide an immunisation programme for hepatitis B

3.6.3 Will submit a 6 monthly report on Inoculation Incidents to the Health & Safety and the Infection Prevention Board

3.6.4 Will offer on-going support and appropriate follow-up to employees following Inoculation Incidents

3.7 The Emergency Department

3.7.2 Will liaise with the Consultant Microbiologist and the local Genitourinary Medicine Department for advice on management and follow up

3.7.3 Will offer initial counselling and support to employees relating to Inoculation Incidents.

3.7.4 Will prescribe and dispense initial PEP for HIV when clinically indicated

3.8 Associate Directors / Health and Safety/ Quality and Risk Leads

3.8.2 Will ensure that all staff comply with the Policy and Procedures for the Management of Inoculation Incidents.

3.8.3 Will receive Inoculation Incident reports, disseminate findings and take any action appropriate in a timely manner.

3.9 Managers / Matrons / Clinical Leads

3.9.2 Will ensure the Policy and Procedures for the Management of Inoculation Incidents is implemented and complied with in their areas of responsibility

3.9.3 Will ensure staff are informed of the Inoculation Incident Policy and Procedure and Safe Sharps Practice as part of Staff Induction

3.9.4 Will ensure that appropriate equipment including Inoculation Incident Procedure Posters (Appendix 1 to 5) are available and placed correctly in their clinical areas of responsibility

3.9.5 Will confirm that all Inoculation Incidents are reported via DATIX to the Governance Department.

3.10 Individual Employees

3.10.2 Are responsible for ensuring their own practice complies with this Policy and for encouraging others to do so

3.10.3 Are responsible for attending the Occupational Health Department to undergo and complete immunisation programmes as identified by Trust Risk Assessment.

3.10.4 Should be aware of their immunisation history and Hepatitis immunity status (responder or non-responder)

4 Prevention and Management of Inoculation Incidents

4.1 Prevention

Prevent sharps injuries by following the Trust Safe Management of Sharps Policy.
Ensure any cuts or breaks in the skin are covered with waterproof dressings.
Wear PPE as risk assessed for any contact or risk of splashes with blood or body fluids (follow Trust Personal Protective Equipment policy)

4.2 Definition of an Inoculation Incident

- **"**Needlestick" or other contaminated sharps injury
- Exposure of open skin cuts or abrasions to blood/body fluids
- Splashing of blood or body fluids into the eye, nose or mouth.
- Human bites and scratches, contaminated with blood or body fluid, and where the skin is broken

The following actions (4.3-4.5) must be followed whether or not the source is known to pose a risk of blood borne virus infection

4.3 First Aid

- Do not suck the wound
- Encourage free bleeding of puncture wounds
- Immediately wash the site of exposure (e.g. wound or non-intact skin) liberally with soap and water without scrubbing
- Dry area and apply waterproof dressing
- Exposed mucous membranes (eyes, nose, mouth), should be irrigated with water. For eyes this should be before and after removal of any contact lenses.

4.4 Reporting and Initial Actions following Inoculation Incidents

4.4.1 All incidents must be reported immediately to the senior person on duty in the area where the incident occurred. This person is responsible for making the initial risk assessment of the incident (see Appendix 1 and 2) and to ensure the actions are taken. Further advice on risk assessment may be obtained by the senior person on duty from the Emergency Department Occupational Health or the Infection Prevention and Control Team

4.4.2 For **high risk incidents** (i.e. HIV or hepatitis B / C exposure likely) refer the injured member of staff to the Emergency Department without delay. Post Exposure Prophylaxis (PEP) May be required in these cases and ideally should be commenced within an hour of the incident. The algorithm at appendix 4 should be followed. The individual does require follow-up by the Department of GU Medicine and an appointment needs to be made and sufficient PEP issued to cover the period until the appointment.

4.4.3 **Low risk incidents** involving **high risk fluids** should be reported to Occupational Health, if out of hours a message should be left on the answer machine and the call will be returned the next working day.

4.4.4 **Incidents involving low risk body fluids** may not need to be reported to GU Medicine, and bloods do not need to be taken. First aid and DATIX reporting is required. If there is any doubt regarding the presence of blood, treat as high risk fluid and follow risk assessments chart (Appendix 1 and 2) accordingly.

4.4.5 Inoculation Incidents involving neonates/newborns less than 6 months old. In these cases the mother's blood should also be taken – please contact the Department GU Medicine / ED for further advice.

4.4.6 If further advice is needed the Emergency Department Consultant should contact the GUM Consultant or the Consultant Microbiologist via switchboard.

4.5 Blood Specimen Collection and Testing

4.5.1 The senior person on duty is to arrange for the collection of 5-10 ml blood in a red topped bottle from the source individual after seeking verbal informed consent for testing for HIV antigen / antibody, hepatitis B Surface antigen and hepatitis C antibody. Use the Meditech V6 order set "*NeedlestickSource*" to order these tests. (see Appendices 7 and 8 for guidelines on seeking consent for blood borne virus testing from a source patient).

4.5.2 Collect blood in red-topped bottle from the recipient (healthcare worker) for **serum store and a baseline HIV, Hepatitis B and hepatitis C test** (if PEP is indicated) within 3 days of the exposure**.** The baseline HIV test is used to identify individuals who are already infected with HIV. PEP should however be initiated without waiting for the results of the baseline HIV test. The stored serum sample is not for testing at this time. Testing of this sample may be requested at a future date by Occupational Health with the healthcare worker's specific consent. These tests are requested using a "Combined Pathology Request" envelope and must be completed as illustrated in appendix 2. This will include the name of the source or stated as source unknown.

4.5.3 Send both the blood samples to Microbiology

4.5.4 If urgent testing is required out of hours contact the On Call microbiologist with background information and label as 'URGENT'

4.5.5 The results of source patient blood tests and arrangements for follow-up blood tests on the recipient (the healthcare worker) will be co-ordinated by Occupational Health

4.6 Inoculation incidents affecting Trust staff in the Community

Community staff should follow this policy as closely a possible, however, it is accepted that due to accessibility of staff, it may be the person who has sustained the inoculation incident who needs to also undertake the preliminary risk assessment, consent and take bloods from the source patient. Contact the clinical lead for the team, Department of GU Medicine or the Emergency department if further advice is required.

4.7 Documentation

4.7.1 Complete the post exposure tracking form detailing the incident, name of source patient (if known) and confirm that the appropriate actions have been taken.

4.7.2 The following information should be recorded in the exposed worker's confidential medical record :

- date and time of the exposure
- details of the procedure being performed and the use of protective equipment at the time of the exposure
- the type, severity, and amount of fluid to which the worker was exposed
- details about the source patient
- whether consent was obtained for HIV testing of the source patient
- medical documentation that provides details about post-exposure management
- If the exposed worker declines PEP, this decision should be documented in the worker's medical record.

4.8 Procedure for issuing Post Exposure Prophylaxis (PEP) for HIV

4.8.1 The decision to prescribe HIV PEP will be made by the Genito-Urinary Medicine (GUM) Physician. Out of hours PEP for HIV will be prescribed by the Emergency Department.

4.8.2 Between 0900hrs to 1930 hrs Monday and Thursdays only and Tuesdays, Wednesdays and Fridays 0900hrs to 1600 hrs excluding Bank Holidays. HIV PEP will be prescribed by the GUM Physician and issued by Pharmacy at Queens Hospital. Out of hours, at week-ends and on Bank Holidays HIV PEP will be prescribed and issued by the Emergency Department. Prior to HIV PEP being prescribed the recipient (the healthcare worker) will be asked about other medication, pregnancy, and the side effects of PEP will be discussed.

4.8.3 **HIV PEP should be supplied and the medication commenced as soon as possible and ideally within one hour of exposure.** HIV PEP should not be commenced more than 72 hours after the inoculation incident. When Genito-urinary Medicine is closed for bank holidays and where the aggregate is more than 3 day then a six day supply of PEP should be issued in ED

4.8.4 HIV Post Exposure Prophylaxis reduces the risk of seroconversion by more than 80% when taken following exposure to the HIV virus. HIV PEP is most effective if started **within one hour** of exposure but can be started within 72 hours of exposure. HIV PEP needs to be taken for 28 days to be most effective

4.8.4.1 If the recipient (the healthcare worker) declines to take PEP after this has been advised by the GUM Physician, Occupational Health will be informed. Occupational Health will arrange appropriate follow up. The individual refusing treatment is to sign to that effect. Should the individual wish to change their mind regarding treatment this is perfectly acceptable up to 72 hours from the time of the incident.

4.9 Procedure for issuing Post exposure prophylaxis for Hepatitis B

4.9.1 The decision whether hepatitis B prophylaxis should be considered will be made by either the Occupational Health (0830hrs to 1700hrs, Monday-Thursday Friday 0830hrs to 1630hrs excluding bank holidays), If hepatitis B immunoglobulin is required (please refer to appendix 9 or green book / immunisation against infectious disease), the on call Consultant Microbiologist must be contacted for approval. The immunoglobulin will be issued by pharmacy.

4.9.2 Hepatitis B immunoglobulin and hepatitis B vaccination may reduce the risk of seroconversion following a high risk exposure to hepatitis B in a non immune individual. If a significant inoculation exposure to a source known to be hepatitis B surface Antigen positive has occurred, and the healthcare worker is a known non-responder to hepatitis B vaccination (hepatitis B antibody levels <10iu/ml), or if the recipient is unvaccinated against hepatitis B, contact the on-call Consultant Microbiologist without delay for advice. Human anti-hepatitis B immunoglobulin may be issued. The protective level of hepatitis B antibody is >10iu/ml.

4.9.3 If the recipient is hepatitis B core antibody positive they have previously acquired immunity to hepatitis B and do not require hepatitis B immunoglobulin or hepatitis B booster vaccine.

4.9.4 An accelerated course of Hepatitis B vaccine is also effective as Hepatitis B Post Exposure Prophylaxis.

4.9.5 Information on the immunity status of the healthcare worker is available by contacting the Occupational Health Department.

4.10 Hepatitis C

4.10.1 Currently there is no post exposure prophylaxis available for hepatitis C.

4.10.2 For inoculation incidents sustained from a known or high risk hepatitis C positive source, Occupational Health will provide follow up with appropriate blood tests.

4.11 Exposure to Unknown Source / Discarded Needle

Where it is not possible to identify the source individual (e.g. needlestick injury from a discarded needle), a risk assessment should be conducted to determine whether the exposure was a significant risk. The risk assessment will consider the circumstances of the exposure and the epidemiological likelihood this item is contaminated with HIV or another blood borne virus. The use of Post Exposure Prophylaxis is unlikely to be justified in the majority of such exposures (DH 2008)

4.12 Training

4.12.1 Infection Prevention and Control training (including Inoculation Incident procedure) is a compulsory requirement for all staff and is part of the Trust's Induction Programme

4.12.2 Inoculation incident procedure is also to be included in annual infection prevention and control updates to all clinical staff.

5 Monitoring Compliance and Effectiveness

Monitoring Requirement :	To monitor the incidence and type of inoculation incident and emergent risks/themes and to provide feedback to clinical staff to the Infection Prevention Board and Health and Safety Group, escalating relevant issues to the Trust Board.
Monitoring Method:	Inoculation Incident Statistics
Report Prepared by:	Occupational Health in conjunction with Governance Team will collate the Inoculation Incident Statistics
Monitoring Report presented to:	1 .A summary of Divisional Audit results will be reviewed by the Infection Control Committee 2 .Occupational Health will provide a report to the Health & Safety Committee and the Infection Prevention Board detailing compliance with the policy. Relevant issues will be escalated in the Infection Prevention Board report to Quality Committee.
Frequency of Report	1. Annual Summary of Audit Results 2. 6 monthly

6 References

Department of Health. (2008), HIV post – exposure prophylaxis: Guidance from The UK Chief Medical Officers' Expert Advisory Group on AIDS

UK National Guidelines for HIV Testing 2008 (Sept 2008) British HIV Association British Association of Sexual Health and HIV British Infection Society

The Health and Social Care Act (2008): Code of practice for the NHS on the prevention and control of healthcare associated infections.

Department of Health. Immunisation against Infectious Diseases (2006)

Infection Control Nurse Association (2003) reducing sharps injury prevention and risk management Bathgate: ICNA

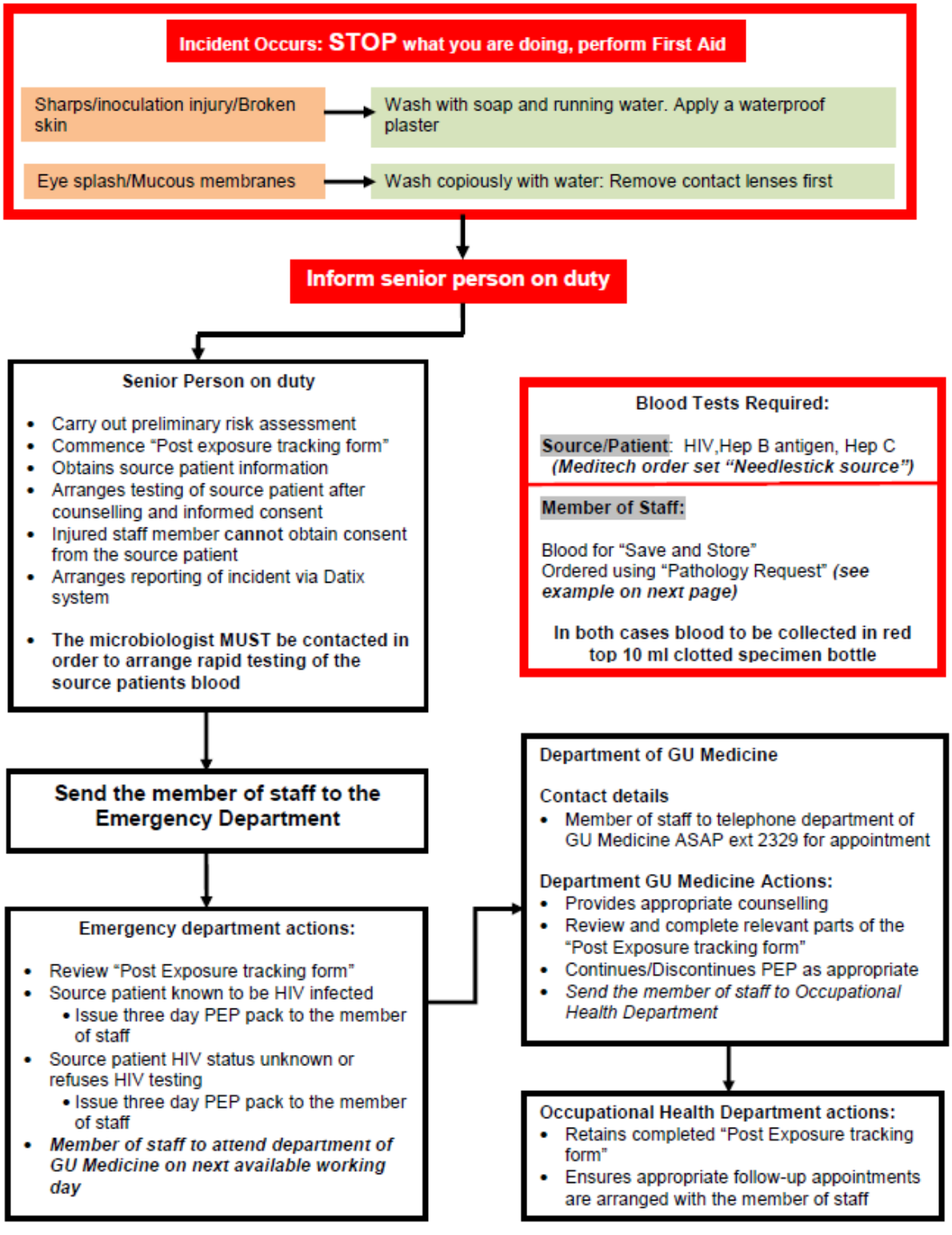
UK Health Departments (1998) Guidance for Clinical Healthcare Workers: protection against infection with blood borne viruses. Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis

NHSLA Risk Management Standards 2012-13 for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Non-NHS Providers of NHS Care

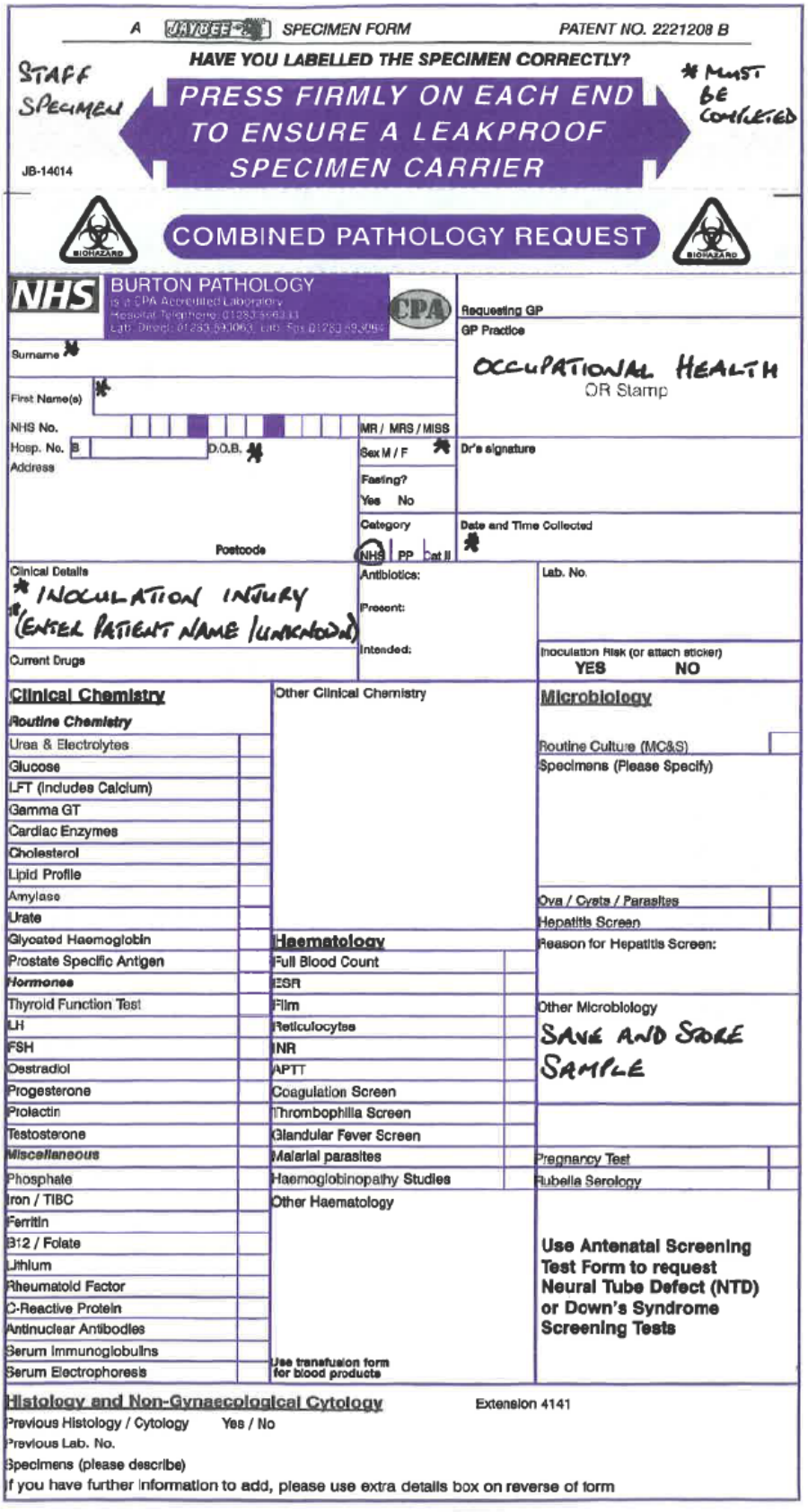
Directive 2010/32/EU - Prevention from Sharp Injuries in the Hospital and Healthcare Sector

Burton Hospitals
NHS Foundation Trust
Infection Prevention & Control Team

NEEDLESTICK / SHARPS INJURY TO STAFF: ACTION OVERVIEW



QHB Inoculation Injury – Version 4 dated 300317



A JAYBEE SPECIMEN FORM PATENT NO. 2221208 B

HAVE YOU LABELLED THE SPECIMEN CORRECTLY?

STAFF SPECIMEN

PRESS FIRMLY ON EACH END TO ENSURE A LEAKPROOF SPECIMEN CARRIER

* MUST BE COMPLETED

JB-14014

COMBINED PATHOLOGY REQUEST

NHS BURTON PATHOLOGY
is a CPA Accredited Laboratory
Hospital Telephone: 01283 566333
Lab. Direct: 01283 593063 Lab. Fax 01283 69 4095

CPA

Surname *

First Name(s) *

NHS No.

MR / MRS / MISS

Hosp. No. B D.O.B. *

Sex M / F *

Address

Fasting? Yes No

Postcode

Category NHS PP Cat II *

Requesting GP

GP Practice

OCCUPATIONAL HEALTH
OR Stamp

Dr's signature

Date and Time Collected *

Clinical Details
* INOCULATION INJURY
(ENTER PATIENT NAME / UNKNOWN)

Current Drugs

Antibiotics:
Present:
Intended:

Lab. No.

Inoculation Risk (or attach sticker)
YES NO

Clinical Chemistry

Routine Chemistry

- Urea & Electrolytes
- Glucose
- LFT (includes Calcium)
- Gamma GT
- Cardiac Enzymes
- Cholesterol
- Lipid Profile
- Amylase
- Urate
- Glycated Haemoglobin
- Prostate Specific Antigen

Hormones

- Thyroid Function Test
- LH
- FSH
- Oestradiol
- Progesterone
- Prolactin
- Testosterone

Miscellaneous

- Phosphate
- Iron / TIBC
- Ferritin
- B12 / Folate
- Lithium
- Rheumatoid Factor
- C-Reactive Protein
- Antinuclear Antibodies
- Serum Immunoglobulins
- Serum Electrophoresis

Other Clinical Chemistry

Haematology

- Full Blood Count
- ESR
- Film
- Reticulocytes
- INR
- APTT
- Coagulation Screen
- Thrombophilia Screen
- Glandular Fever Screen
- Malarial parasites
- Haemoglobinopathy Studies

Other Haematology

Use transfusion form for blood products

Microbiology

- Routine Culture (MC&S)
- Specimens (Please Specify)
- Ova / Cysts / Parasites
- Hepatitis Screen
- Reason for Hepatitis Screen:
- Other Microbiology: SAVE AND STORE SAMPLE
- Pregnancy Test
- Rubella Serology

Use Antenatal Screening Test Form to request Neural Tube Defect (NTD) or Down's Syndrome Screening Tests

Histology and Non-Gynaecological Cytology Extension 4141

Previous Histology / Cytology Yes / No

Previous Lab. No.

Specimens (please describe)

If you have further information to add, please use extra details box on reverse of form

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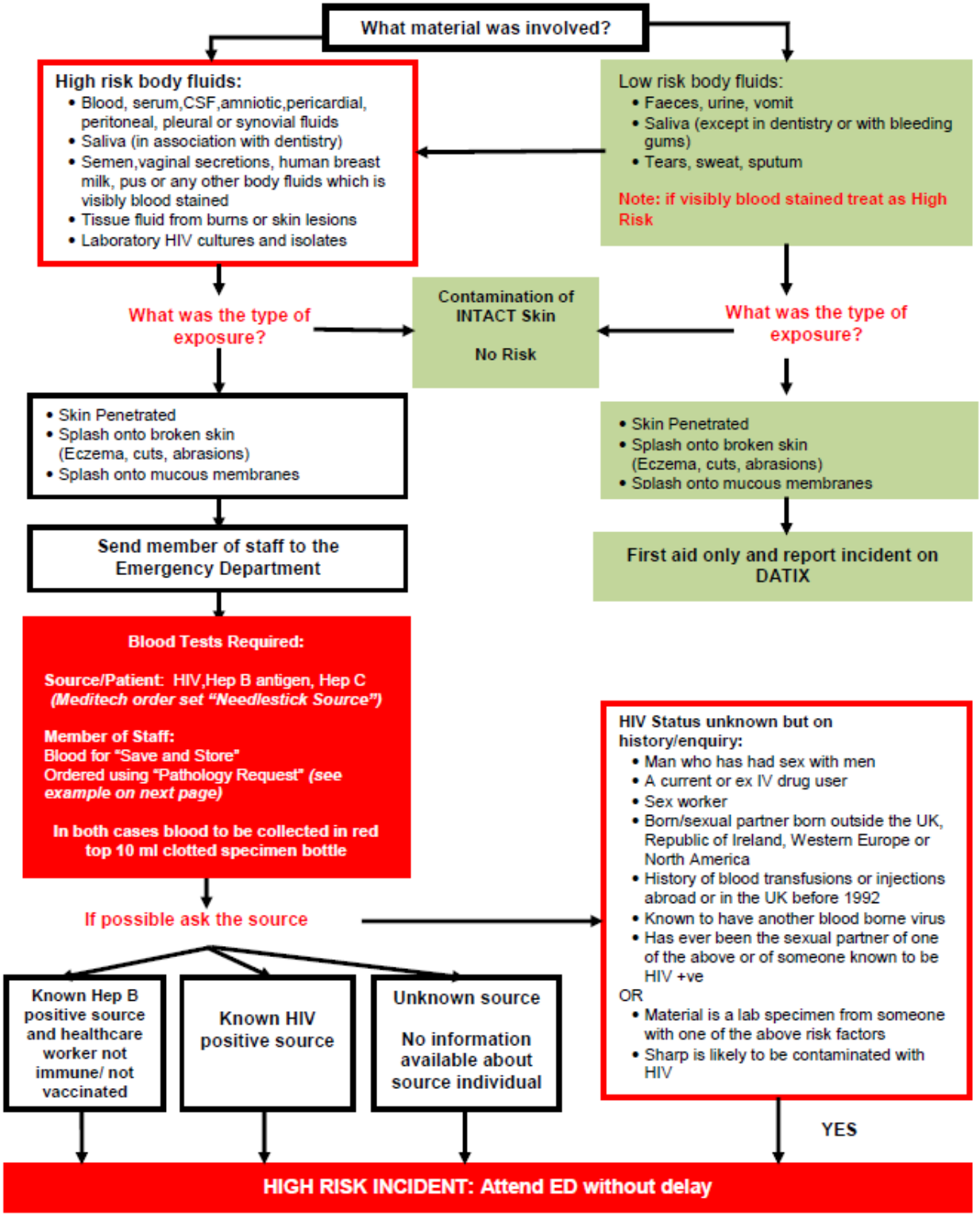
NHS Foundation Trust
Infection Prevention & Control Team

PRELIMINARY RISK ASSESSMENT FOLLOWING INOCULATION INJURY



QHB Inoculation Injury – Version 4 dated 300317

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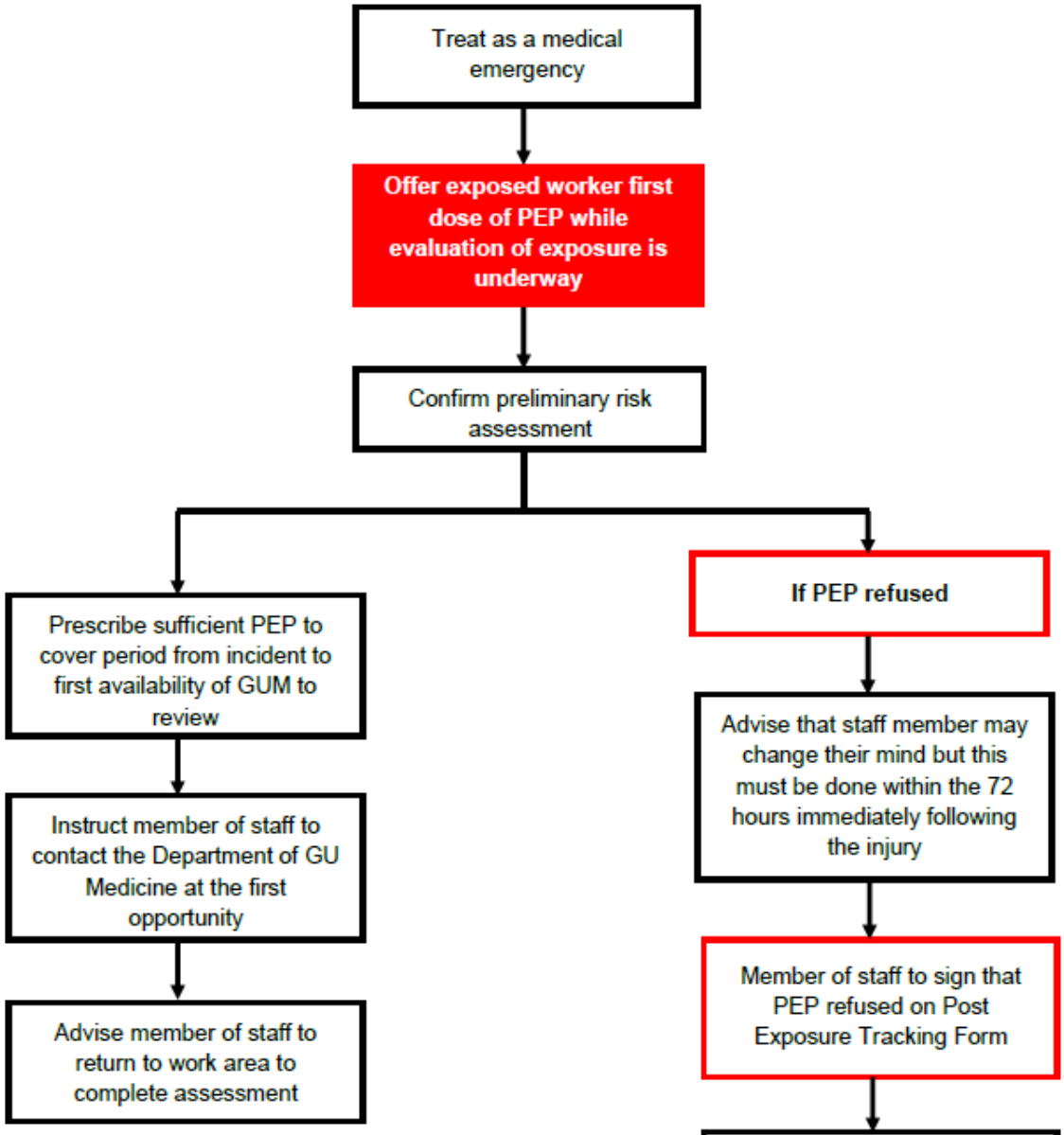
Infection Prevention & Control Team

ACTION TO BE TAKEN BY THE EMERGENCY DEPARTMENT FOLLOWING HIGH RISK INOCULATION INJURY (Out of hours* See note 1)



Note 1: GUM hours are as follows

- Monday and Thursday only 0900-1800hrs
- Tuesday, Wednesday and Friday 0900-1600hrs excluding Bank Holidays

QHB Inoculation Injury – Version 3 dated 19/01/17

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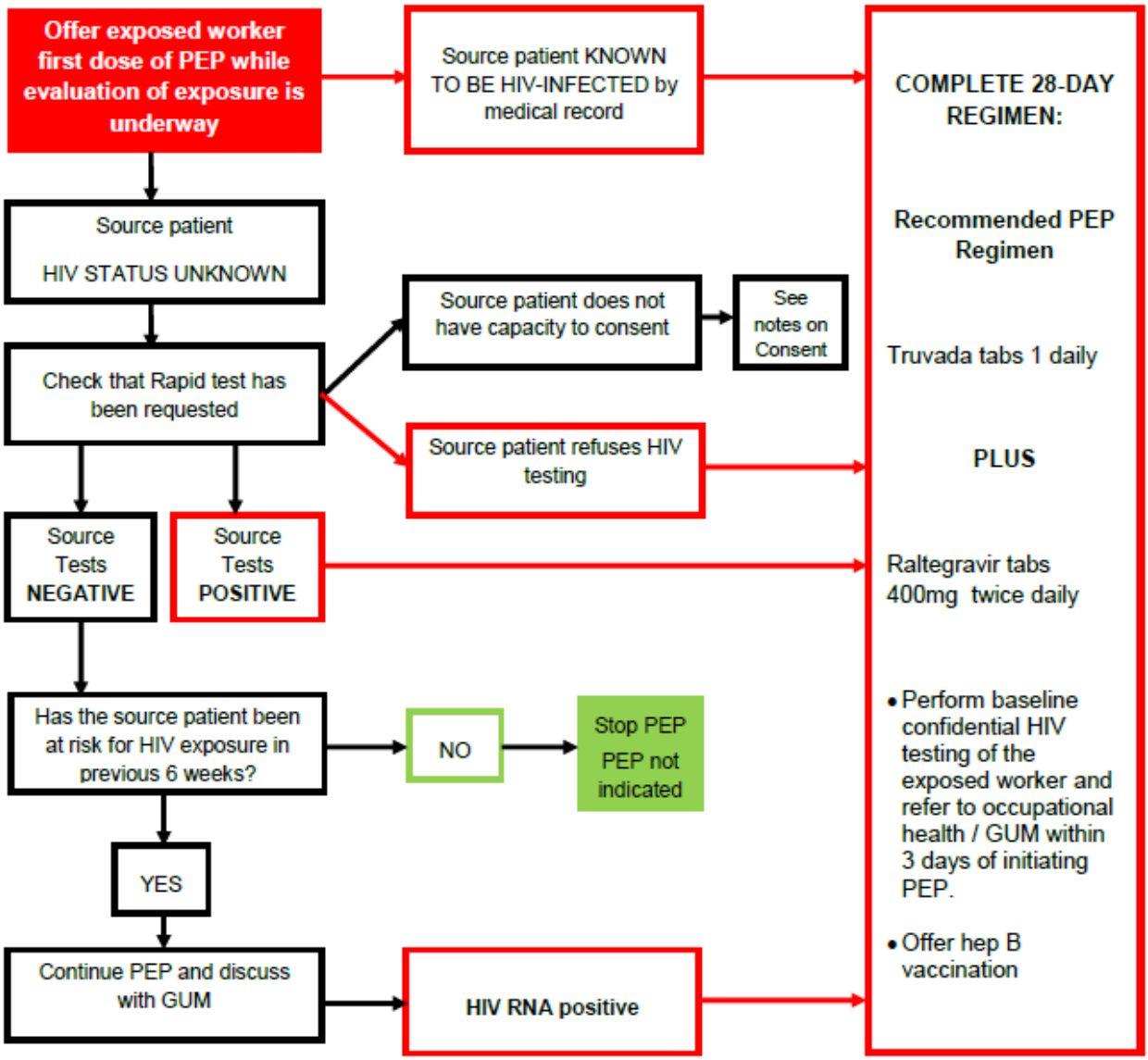
PEP EVALUATION FOLLOWING HIGH RISK INOCULATION INJURY



QHB Inoculation Injury – Draft 2 dated 18/01/17

Burton Hospitals
NHS Foundation Trust
Infection Prevention & Control Team

INOCULATION / SHARPS / SPLASH INJURY: POST EXPOSURE TRACKING

1. Action to be taken by senior person on duty: Complete details below

Personal Details of injured staff member		**Trust Site:**	
Name:		**Job Title:**	
DOB:		**Work Area:**	
Place Injury Occurred:		**Date and time of injury:**	
Details of procedure being performed		**Details of protective equipment being used at time of the injury**	
Personal Details of source patient			
Name:		**Known HIV infected:**	
DOB:		**Known Hep B or C infected**	
Hospital Number			

ASSESSMENT OF RISK FOLLOWING INOCULATION INJURY (use algorithm to determine further action)	
High risk incident or the choice of the injured member of staff	
• In working hours: Refer **immediately** to Department of GU Medicine	
• Out of hours: Refer **immediately** to the Emergency department	
Member of staff accepts PEP treatment (Signature)	
Member of staff declines PEP treatment (Signature)	
Incident where first aid and DATIX reporting only required	

Signature of person completing assessment	
Print name	
Date	

Notes: *1 This form is to be handed to the injured member of staff to take to ED or GU medicine if referred or self-referred.*

2 Following treatment in ED the form must be handed back to the member of staff to take to The Department of GU Medicine who should either send to or give to the member of staff to take to Occupational Health

3 If not referred, injured Member of staff is to ensure completed form is taken to Occupational Health

QHB Inoculation Injury – Version 4 dated 010217

Patient Consent/Information

1 Seeking consent to test a source patient for blood borne viruses following an inoculation incident.

2 Unless in exceptional circumstances such as other trained staff not available in an appropriate timescale, this consent should be obtained from a healthcare worker other than that who sustained the inoculation injury. The outcome of the discussion should be recorded in your (the patient's) individual medical records.

3 Suggested approach

3.1 'Unfortunately one of the members of staff has had an accidental injury in which your body fluid has been involved. I am here to ask if you would let me take a blood sample for testing for the viral infections which can be transmitted to staff in this way. This is something that we ask for routinely whenever a patient's body fluid is involved in such an accident. We need your agreement to do this test and would appreciate your help".

3.2 The purpose of the testing is to reassure staff where the results are negative. This may allow them to stop taking precautionary medication which often causes unpleasant side effects. In the unlikely event that a test is positive you will receive specialist advice and management including treatment if required. The staff member may also be offered additional treatment.

3.3 The tests are for Hepatitis B, Hepatitis C and HIV. The test results should be available within a few days (but may take several weeks if extra investigations are required for clarification) and will normally be given to you by a member of the medical staff. The results are confidential, but they will appear in your health record. The affected staff member will also be informed.

3.4 Do you have any concerns? A common concern is whether having these tests done will affect any existing life insurance policies or future life insurance applications. The Association of British Insurers has issued guidance stating; "Existing life insurance policies will not be affected in any way by taking an HIV test, even if the result is positive." For new life insurance applications, companies should only enquire about positive test results, not whether a test has been performed. A positive test result may affect the outcome of a life insurance policy application.

3.5 Do I have your permission to take a blood sample for hepatitis B, C and HIV testing? I should remind you that you can refuse to have some or all of these tests performed and that if you do choose not to be tested it will not affect your future care.

3.6 If you are happy to proceed, please let us know so that we can arrange for the blood tests to be done as soon as possible.'

Useful sources of further information and advice

The Department of Genitourinary Medicine, London Road Community Hospital, Derby
The Terence Higgins Trust (a registered charity) 0115 8820121 www.tht.org.uk
NHS 111 (free-to-call single non-emergency number medical helpline run by NHS)

Seeking consent to test a source patient for blood borne viruses following an inoculation incident; the mental capacity of the source patient to consent

1 The individual who obtains consent from the source patient should be satisfied that the person has given explicit verbal informed consent to either testing of their stored blood or the taking of a blood sample for this purpose. Consent from the source patient should be obtained from a healthcare worker other than that who sustained the injury. Consent for blood borne virus testing should take into consideration the following factors;

- The individual's ability to make informed choices
- The individual's competency to consent
- Consent must be voluntary
- The individual should understand the purpose of testing
- The individual should be made aware how and when they will be informed of the test results

No signed consent form is necessary. Verbal consent in sufficient

Consent for blood borne virus testing in circumstances where the source patient may lack the capacity to consent.

1 The Human Tissue Act (2004) which governs the obtaining of source patient consent following an Inoculation Incident involving a healthcare worker supersedes previous General Medical Council (GMC) guidance in this area. The source patient's consent to testing must always be gained. Where the source patient lacks the capacity to consent, HIV testing may not be undertaken for the sole benefit of the injured healthcare worker following an inoculation incident. If the patient does not wish to know the result, the option of testing without any documentation should be considered.

Legislation in England, Wales and Scotland provides a framework for decision-making on behalf of adults aged 16 and over who lack capacity to make decisions on their own behalf. The Mental Capacity Act 2005 applies to England and Wales.

2 A person lacks capacity if, at the time the decision needs to be made, he or she is unable to make a decision because of a mental disorder, or is unable to communicate their decision. Key points to consider when assessing capacity:

- The assessment of capacity relates to the specific issue in question, in this case consent to HIV testing
- Start from the presumption that the patient has capacity to make this decision
- Consider whether the patient understands what decision they are being asked to make and can weigh up the information relevant to the decision; do they understand the consequences of making a choice?
- Take all possible steps to help patients make a decision for themselves (e.g. provide information in a more accessible form – drawings, tapes etc.). If you judge that a patient lacks capacity to consent to a HIV test you should consider whether this is temporary or permanent. If temporary, you should defer testing until the patient regains capacity, unless testing is immediately necessary to save the source patient's life or to prevent a serious deterioration of their condition. If the lack of capacity is, or is likely to be, permanent you should seek a decision from
- any person with relevant powers of attorney or follow the requirements of any valid advance statements. If the patient has not appointed an attorney nor left a valid advance statement, HIV testing may be undertaken where this is in the best interests of the source patient (England and Wales) or is necessary and of benefit to the source patient
- For a deceased source patient the Consultant in charge of the patient may seek consent from the source patient's relatives. The Coroner has additional powers to request HIV testing

Testing infants, children and young people

In England and Wales children are defined as those under 18 years old (Children Act 1989). Under English law young people aged 16 years or over are assumed to have the capacity to consent to medical treatment and should be treated in the same way as adults. Young people under 16 years without a parent or guardian should be assessed for competency to consent. If a child lacks the capacity to consent, then the consent of one parent or carer with parental responsibility is sufficient.

Commonly asked questions when counselling for blood borne virus testing

1 Of what benefit is the test to me?
It is helpful to know as soon as possible if you are carrying one of these viruses because treatments are available to try to reduce the risk of them causing serious disease. Also we can tell you about ways to reduce the risks of you passing on the infections to others.

2 Will I have difficulty with insurance in the future if I have been tested for HIV?
No. Insurers do not ask applicants if they have been tested for HIV, only if they are HIV positive. The Association of British Insurers decided this in 1994. All existing policies, mortgages etc are also unaffected. The Terence Higgins Trust, a registered charity, is a useful source of advice for individuals who are HIV positive (Terence Higgins Trust Nottingham Branch, 0115 8820121)

3 How might I have acquired any of these viruses?
Some people have them at birth, acquired from their mother. Otherwise, they can be transmitted during sex from an infected partner, or when drug users share needles, or perhaps even from a dirty needle when someone is having a tattoo or body piercing done.

4 What will happen if I test positive?
Your doctor will arrange for you to see a specialist with expertise in treating people with HIV, Hepatitis B virus and Hepatitis C virus.

5 What are the consequences of being tested?
For most people the advantages outweigh the disadvantages, but it has to be your choice. If the tests are all negative, then that's reassuring, and there are no drawbacks of having been tested.

If one is positive, then this may come as a shock, but the specialist care is likely to be of benefit to you. You will then have the opportunity to be able to start treatment to improve your own health, and be in a position where you can take action to prevent yourself from infecting others close to you with what may be a life threatening illness.

6 Do I need to decide whether to have the test straight away?
The sooner we know the result of your test, the sooner we can plan treatment, if necessary, both for yourself and for the healthcare worker who has been exposed to your blood or body fluids. In the interim, the healthcare worker may be advised to start on a strong course of medication as a preventative measure – receiving negative results quickly will allow this treatment to be stopped. We will try to answer any questions you might have in connection with the test.

7 What if I refuse the test?
No further action will be taken. It might be helpful to tell us why you don't wish to have the test, so we can try and address any concerns that you may have.

1 HIV Post-Exposure Prophylaxis

1.1 Please read this information together with the Patient Information Leaflets enclosed with your medication.

1.2 These medicines are used in patients diagnosed with HIV infection, including pregnant women. This is what they are licensed for. However, for you, they are being used outside this license. You are taking them to prevent possible infection with HIV after a high risk exposure to HIV.

1.3 To be most effective these medicines need to be started within one hour of the high risk exposure although they can be started up to 72 hours after the exposure. 3 days of PEP is not sufficient to give you the full 80% reduction in risk so it is important to follow the GUM Physician's advice on completing the course. The full course is 28 days in total. The GUM Physician will co-ordinate you receiving further supplies of medication if needed.

1.4 Before you take your medicines tell your prescriber if you have had a reaction to any of the ingredients in the past, are pregnant, are breast feeding or suffer with liver or kidney disease. If you are on any other medications, prescribed or non-prescribed let your prescriber know. An alternative medicine may be given if you are known to have kidney failure.

2 Side effects

2.1 The medication can cause a number of side-effects including nausea (feeling sick), diarrhoea, headache and tiredness. These side-effects usually settle if you keep taking the medicines as directed. Serious side effects are rare. It is recommended you take the medication just after food.

3 Secondary Prevention

3.1 It is important during the 12 week follow-up period that:

- You do not have unprotected sex (use condoms)
- You avoid donating blood, plasma, organs , tissue or semen
- You avoid pregnancy and breastfeeding

3.2 This applies until you have been cleared of the risk of contracting a blood borne virus following this exposure Occupational Health will arrange the necessary follow up blood tests. These medicines also reduce the effectiveness of hormonal contraception and this should not be relied upon while you are taking the medication.

4 Use in Pregnancy

Tell your prescriber if you could be pregnant. The possible risk of this medication taken in pregnancy needs to be carefully balanced against the risk of you contracting HIV infection following this exposure. You may wish to speak to the Genitourinary Medicine doctor on call for further advice on taking this medication in pregnancy. This doctor has experience of prescribing this medication in pregnancy (contact via the hospital switchboard). You are advised to avoid becoming pregnant or to father a child while taking these medicines. Loperamide, which is used to treat some of the adverse effects which may arise, is not recommended for use in pregnancy. Your doctor can discuss suitable alternatives if necessary.

Store the drugs in the containers provided at room temperature. Keep medicines out of reach of children.

If you have any further questions about these medicines contact Pharmacy or the Department of GU Medicine. Your confidentially will be guaranteed.

Pre-Printed Prescription to be used for HIV Post Exposure Prophylaxis

Name:	
Date of Birth	
Consultant (or other doctor) authorising HIV PEP prescription	
Bleep number and contact details of prescriber	
Hospital number (if available)	
Prescriber's signature, (and also prescriber's name written clearly in block capitals)	
Date	

Medication prescribed. This initial supply is for three days
Note: the Truvada and Raltegravir are supplied in a "PEP pack.. The prescriber should cross these out if they are not required.

Truvada (245 mg tenofovir + 200mg emtricitabine) × 3 tablets
Take one tablet daily after food

and

Raltegravir 400mg film coated tablets x 6 tablets
Take one tablet (400mg) every 12 hours after food

Hepatitis B

Table 18.5 HBV prophylaxis for reported exposure incidents

	Significant exposure			Non-significant exposure	
HBV status of person exposed	HBsAg positive source	Unknown source	HBsAg negative source	Continued risk	No further risk
≤ 1 dose HB vaccine pre-exposure	Accelerated course of HB vaccine* HBIG x 1	Accelerated course of HB vaccine*	Initiate course of HB vaccine	Initiate course of HB vaccine	No HBV prophylaxis. Reassure
≥ 2 doses HB vaccine pre-exposure (anti-HBs not known)	One dose of HB vaccine followed by second dose one month later	One dose of HB vaccine	Finish course of HB vaccine	Finish course of HB vaccine	No HBV prophylaxis. Reassure
Known responder to HB vaccine (anti-HBs > 10mIU/ml)	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	No HBV prophylaxis. Reassure
Known non-responder to HB vaccine (anti-HBs < 10mIU/ml 2–4 months post-immunisation)	HBIG x 1 Consider booster dose of HB vaccine A second dose of HBIG should be given at one month	HBIG x 1 Consider booster dose of HB vaccine A second dose of HBIG should be given at one month	No HBIG Consider booster dose of HB vaccine	No HBIG Consider booster dose of HB vaccine	No prophylaxis. Reassure

*An accelerated course of vaccine consists of doses spaced at zero, one and two months.
A booster dose may be given at 12 months to those at continuing risk of exposure to HBV.
Source: PHLS Hepatitis Subcommittee (1992).

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