

## Management of Incidents which have the potential to transmit Blood Borne Viruses

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### Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

# **Management of Incidents which have the potential to transmit Blood Borne Viruses**

## **Version History:**

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V1.0	Dec.2007	Dr Andrew Hilliard	Original
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V3.0	Dec 2009	Wendy Sharp	Superseded
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V12.0	August 2023	Head of Workplace Health, Safety and Wellbeing	Removal of action line telephone number which is no longer in use

## **Consultation**

The following were consulted during the development of this document:  
Guideline were drawn up by the Authors following a review of published literature. The following were consulted during the development of this document. (see references).  
Discussions took place with colleagues in Microbiology, ED, iCaSH Norfolk, Health & Safety and Infection Control.

## **Monitoring and Review of Procedural Document**

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

## **Relationship of this document to other procedural documents**

This document is a Clinical guideline applicable to the Norfolk & Norwich University Hospitals NHS Foundation Trust

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# ***Management of Incidents which have the potential to transmit Blood Borne Viruses***

Quick reference Guides (Links to 1-7)

[Quick Reference Guide 1 – Flow chart - Management of Staff Blood and Body Fluid Exposure](#)

[Quick reference Guide 2 – Flow Chart - Source Testing in Blood & Body Fluid Exposure Incidents](#)

[Quick Reference Guide 3 – Blood and Body Fluid Exposure & Sharps injuries / Guidance for Accident and Emergency Departments](#)

[Quick Reference Guide 4 – A&E Checklist for assessing Blood and Body Fluid Exposure](#)

[Quick Reference Guide 5 – HIV PEP Prescribing assessment](#)

[Quick Reference Guide 6 – Potentially Infectious Material / Patients at High Risk of Blood Borne Virus'](#)

[Quick Reference Guide 7 - Post Exposure Prophylaxis Risk Assessment Proforma for use in Emergency Departments / OH Department](#)

Quick Reference 8

## **Important Contact Numbers**

Workplace Health & Wellbeing:	01603 287035 or ext: 3035
Accident & Emergency Department:	01603 287324/5 or ext: 3324/5
Health & Safety Dept:	01603 287423 or ext: 3423
Trust Virology Department:	Contact duty Virologist via Trust Switchboard
ICaSH Norfolk (integrated contraception and sexual health):	0300 300 3030

# **Management of Incidents which have the potential to transmit Blood Borne Viruses**

## **1. Introduction**

### **1.1 Rationale**

This guidance is aimed at all Health Care Workers (HCW), subcontracted HCWs, Health Care students (including work experience) on Trust premises. This guideline is to be used in the event of a potential occupational exposure to Blood Borne Viruses (BBV) or other potential infectious material (OPIM), particularly those contaminated with blood.

This guideline reflects the UK Guideline for the use of post-exposure prophylaxis for HIV (BASHH Guidelines) and also the guidance produced by the British Medical Association with regards to testing adults who lack the capacity to consent in the event of a needlestick injury.

### **1.2 Objective**

The objective of the guideline is to:

- Provide guidance to staff members on the actions to be taken in the event of a needlestick injury / blood exposure incident
- Provide guidance to Emergency Departments on the actions to take in such incidents
- Provide guidance on when HIV or Hepatitis B post exposure prophylaxis treatment is recommended
- Provide overview information on the risk associated with such incidents

### **1.3 Scope**

This document applies to all HCW, subcontracted HCWs, Health Care students (including work experience) on Trust premises.

This document can also be used by Emergency department to provide guidance on the provision of emergency treatment for patients attending who have had exposure to potentially infectious material

### **1.4 Glossary**

The following terms and abbreviations have been used within this document:

<b>Term</b>	<b>Definition</b>
<b>BASHH</b>	British Association for Sexual Health and HIV
<b>HWC</b>	Health Care Workers
<b>OPIM</b>	Other Potential Infectious Material
<b>PEP</b>	Post Exposure Prophylaxis
<b>UKHSA</b>	Current UK Health Security Agency
<b>Blood Borne Viruses (BBV)</b>	BBVs are viruses which can be present in blood or other body fluids and which have high potential for transmission to another person by direct contact with their blood or susceptible fluids. For practical purposes these are Hepatitis B (HBV), Hepatitis C (HCV), and Human

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	Immunodeficiency Virus (HIV).
<b>Occupational Exposure</b>	<p>There are three types of exposure in health care settings associated with significant risk from blood or higher risk body fluids these are:</p> <ul style="list-style-type: none"> <li>• Percutaneous injury (e.g. a needlestick or cut with a sharp instrument contaminated with the source's blood or bodily fluids)</li> <li>• Mucous membrane (e.g. splash to eye or into the mouth) or non-intact skin exposure (e.g. exposed skin that is abraded or afflicted with dermatitis) abrasions, cuts, eczema). It is important to note that intact skin is a safe protective barrier against BBV transmission.</li> <li>• A bite if the skin is broken as a result of trauma</li> </ul>
<b>Bleed Back Incident</b>	<p>An incident in which the blood of a health care worker comes into contact with the blood or open tissues of a patient. The following are examples of when this could occur:</p> <ul style="list-style-type: none"> <li>• Bleed back from a visible laceration to a Health Care Worker's hand during an Exposure Prone Procedure (e.g. during surgery).</li> <li>• Visible bleeding from a Health Care Worker from any site leading to significant bleed back into a patient's open tissues or mucous membranes.</li> <li>• In the unlikely event that an invasive device or product contaminated by use on one patient is accidentally reused on another patient.</li> </ul>
<b>Post Exposure Prophylaxis (PEP)</b>	PEP is the treatment which may be advised and supplied to the recipient following a risk assessment from a known or high-risk HIV or Hepatitis B exposure incident. The treatment for Hepatitis B is only recommended when the recipient does not have adequate immune protection
<b>Recipient</b>	The individual who has been exposed to the possibility of acquiring a blood borne infection as a result of an incident with the potential to transmit a BBV.
<b>Source</b>	The individual who was the source of the blood or body fluid, who made contact with the recipient. The source will usually be a patient but may be a HCW as in a bleed back incident.

## **2. Responsibilities**

### **2.1 Responsibility of the Trust**

To ensure the health & safety of staff is protected and if accidental exposure does occur then rapid access to appropriate treatment and support is provided

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## **2.2 Line Manager Responsibility**

- To ensure all staff are informed of the risk of acquiring a BBV through occupational exposure. This will form part of the local induction process.
- To ensure an exposed member of staff has followed the appropriate guidance and contacted Workplace Health & Wellbeing or Site nurse / Emergency Department depending on the time of incident (**See quick reference 1**).
- To ensure that the incident has been reported on Datix (incident reporting system).
- To investigate all blood and body fluid exposure injuries and to ensure safe working practices are adhered to at all times. To consider if a specific exposure incident was due to poor practice or negligence, which may require guidance, training or even in certain cases disciplinary procedures. To disseminate learning to the team following incident investigation.
- Ensure that source testing process has been implemented where appropriate.

## **2.3 Clinician in Charge of Patient Responsibility**

- To advise if testing should take place if the source patient does not have capacity to consent by completing Appendix 4 and documenting the structured decision-making process that was undertaken.
- To advise the source patient of the test results if the patient remains an inpatient at the time of receipt. If the results are positive, then should arrange a referral to the appropriate specialist.
- If the patient has been discharged, the Clinician in charge of the patient at the time of the incident will be responsible for advising the GP of the source test results and request that the patient is advised and arrange any specialist referral if the results are positive.
- To advise a Patients GP if further follow up blood tests are required if the patient is the recipient following a bleed back incident.

## **2.4 Site Nurse Responsibility**

- To support the staff member who has had the incident out of hours and advise if ED attendance is required.
- This can be established by completing the checklist Quick reference Guide 4. If PEP is recommended, then the recipient should attend ED for urgent assessment.
- If the Site Nurse has any concerns about the outcome of the assessment or actions to be taken, then the recipient should attend ED.

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## **2.5 Employee Responsibility**

- To report any blood exposure incident to the person in charge of the area (so that source testing can be arranged) as well as reporting on the organisations incident reporting system, Datix.
- To report to Workplace Health & Wellbeing (or to the Site Nurse / ED if out of hours) to ensure appropriate urgent care is provided. If occurs in an out of hours situation, report to Workplace Health & wellbeing on the next working day.
- To attend follow up testing as advised by Workplace Health & Wellbeing.
- To inform Workplace Health & Wellbeing if they believe (particularly if involved in EPP) they may have been exposed to infection with HIV, Hepatitis B or Hepatitis C to consider whether they should be tested for these BBV infections. Failure to do so may breach the duty of care to patients. Therefore, HCWs are under continual obligation to report their own BBV infections risks

## **2.6 Workplace Health & Wellbeing Responsibility**

- To provide advice, support and treatment (during the hours of 0830 and 1700, Monday to Friday) and review all staff who have been involved in a blood or body fluid exposure incident in line with internal Workplace Health & Wellbeing procedures and best practice.
- To ensure the individual exposed has appropriate psychological support in the event of a significant incident or if the individual has significant anxieties in relation to the incident.
- To Liaise with the person in charge of the source patient to ensure that arrangements have been made for a blood sample to be tested for BBV.
- To liaise with the Clinician in charge of the source patient prior to Workplace Health & Wellbeing advising the recipient about further management.
- To advise the recipient of the source patient's results once the source patient has been informed by the Clinician in charge of their care. If the source results are positive, an urgent appointment will be made for the recipient to see an Occupational Health Physician at the earliest opportunity. All source patient results will be released to Workplace Health & Wellbeing as long as the source blood sample request has been clearly marked **"Source patient of occupational blood/body fluid exposure incident, written consent obtained"**.
- To provide information and training on the management of exposure incidents mandatory and induction training for the Trust. Where resources available, they can provide any other training when requested, on all aspects of the management of blood and body fluid exposure incidents.



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- To undertake ongoing audit of source testing and blood borne exposure incidents.
- To provide the Trust with advice about the management of blood and body fluid exposure incidents for staff.
- To report all high risk HIV, Hepatitis B or C blood and body fluid exposure incidents Health & Safety Executive (under RIDDOR Regulations)
- To liaise with Virology when PEP is considered required / Hep B Immunoglobulin

### **2.7 Accident & Emergency Department Responsibility**

- To provide emergency care for all HCWs in accordance with current UK Health Security Agency (UKHSA), British Association for Sexual Health and HIV (BASHH) guidance and best practice.
- To manage the member of staff in accordance with internal ED protocols and procedures (**see quick reference guides 3, 4, & 5**).
- To triage as requiring urgent medical attention since HIV Post Exposure Prophylaxis should ideally be given within one hour of exposure. However, it can be commenced up to 72 hours afterwards.
- To provide HIV and Hepatitis B prophylaxis when indicated. Hepatitis B Immunoglobulin is only available from UKHSA Immunoglobulin Service in London and therefore the Consultant Virologist on Call will need to be contacted to discuss the case and supply if indicated.
- To provide advice to managers when the Workplace Health & Wellbeing department is closed.
- If the cases of occupational injury, the ED should instruct the recipient to telephone their Occupational Health on the next working day for any further treatment or advice. If the member of staff is employed by Norfolk and Norwich University Foundation Trust they should contact Workplace Health & Wellbeing on (01603 287035 ext: 3035)
- To undertake the initial management of any blood and body fluid exposure incident sustained by a member of the public and to refer them to their GP or the Integrated Contraception and Sexual Health clinic (iCaSH clinic) if HIV PEP has been commenced (for sexual exposure).

### **2.8 Virology Responsibility**

- To provide advice to both Emergency Department and Workplace Health & Wellbeing staff with regards to provision of Hepatitis B Immunoglobulin and HIV Post exposure Prophylaxis
- To facilitate the provision of Hepatitis B Immunoglobulin if identified a requirement

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## **2.9 Integrated Contraception and Sexual Health (iCaSH) Responsibility**

- To provide any follow up management for members of the public in the event of a high risk blood and body fluid exposure incident from sexual exposure incidents.
- To provide consultant advice via telephone for the Occupational Health Physician when Post Exposure Prophylaxis (PEP) is indicated, but either due to health condition of source patient or recipient of incident cannot prescribe the standard PEP starter pack.
- To take a referral of an occupational health patient following a blood exposure incident when PEP is likely to be indicated, but WHWB do not have a doctor present to assess and prescribe. This would include a consultation and baseline bloods. WHWB would be responsible for necessary follow up consultations and employee support. To advise WHWB on the activity undertaken so that appropriate follow up can take place (as per agreed SLA)
- In the event where the source patient is identified as HIV positive, to advise WHWB on the most appropriate choice of HIV PEP, taking into account previous treatment of the source patient, and any other medical conditions or medications taken by the exposed worker.

## **3. Processes to be followed**

### **3.1 Immediate management of blood or Body Fluid Exposure Incident**

Following an exposure to blood or other body fluids, the exposed site should be immediately cleansed as follows:

- The recipient of the incident should undertake the following action:
  - Wash it (soap & water and clean with alcohol hand gel)
  - Small wounds and punctures may also be cleansed with an antiseptic, for example an alcohol-based hand hygiene solution. Alcohol is virucidal to HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV). Other antiseptics, such as iodophors, chloroxylenol, and chlorhexidine also inactivate HIV.
  - Cover it
  - Report it – Via Datix as well as undertaking actions in Quick Reference Guide 1
  - **Squeezing the wound to express blood is not recommended.**
- In cases of mucosal exposure, the exposed mucous membranes should be flushed with a copious amount of water. Eyes should be irrigated with saline or water.

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### **3.2 Person in charge of the department or ward where the incident occurred or who is in charge of the source patient**

- To ensure all first aid measures have been undertaken and that the recipient has contacted Workplace Health & Wellbeing or Site Nurse / ED (depending on time of incident) as appropriate. (See Quick Reference 1). NB: Staff working at Cromer / external locations should in the first instance contact Workplace Health & Wellbeing or the ED department by telephone to assess the need to travel to Norwich for further treatment
- To obtain consent as soon as possible from the source patient for BBV blood testing (see section 3.3), as the purpose of this assessment is to ascertain whether the recipient requires URGENT referral for PEP for possible HIV and HBV exposure. Post Exposure Prophylaxis (PEP) should be started for maximal effectiveness preferably within ONE HOUR of the exposure / injury.
- In certain situations, the source patient may move departmental areas before consent for source testing can be obtained (e.g. if occurs incident occurs during a surgical theatre). If this occurs the person in charge of the area at the time of the incident must liaise with the person now in charge of the source patient to implement the source testing process.
- Where the patient has been discharged before consent for source testing can be obtained, and the incident has been deemed as high risk (i.e. there is a requirement for PEP), the person in charge of the area or the clinician who oversaw the patient's care is responsible for contacting the source to ask if they will agree to return to the department to allow source testing procedures to be implemented OR if they are unable to return to liaise with their GP to arrange for source testing to be undertaken via their GP surgery.
- If the incident occurs at night and the recipient is the person in charge of the department or ward where the source patient is being nursed then they must contact the Site Nurse who will take on the role of the person in charge of the source patient.

### **3.3 Source Consent and Blood Testing**

(See quick reference Guide 2)

- Consent MUST be gained from the source patient for blood tests to be undertaken using the appropriate Patient Consent Form – (Appendix 2 or 3), even if an appropriate sample (taken in a plain orange-topped tube) is already available in the laboratory. The following blood tests MUST be requested:
  - Hepatitis B Surface Antigen
  - Hepatitis C Antibodies – NB If the source patient has a risk factor for hepatitis C (i.e. a person who injects drugs) then a Hepatitis C RNA should be undertaken as well as Hepatitis C antibody does not distinguish between past and current infection
  - HIV-1 Antigen and HIV-1 and-2 Antibodies

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- BBV testing must not be undertaken without the patient's informed consent as otherwise there may be a breach of the Human Tissue Act 2004 which may result in disciplinary proceedings from the Trust or the member of staff's professional organisation (e.g. GMC, NMC).
- The Hepatitis B,C and HIV blood tests should be requested on ICE, select microbiology/serology and the Blood and Body Fluid Exposure Incident option (hard copy if ICE not applicable state **URGENT** source test and "**source patient of occupational blood/body fluid exposure incident, written consent obtained**"). The patients name and date of birth should be used as identification. When requesting the HIV tests on ICE, when the requester has reached the 'reason for request screen' they should click 'other' and then type in 'Source patient of blood / body fluid injury'
- The Trust Microbiology department should receive the sample within 24 hours of the incident and must be informed by telephone on ext 4587 that this is an **URGENT** source test request. If the incident occurs at night then a message must be left on the answer machine to alert Microbiology of the urgency of the request for the morning. The test results should be requested for Workplace Health & Wellbeing and not recorded in the patient's notes.
- Once the blood sample has been taken, Workplace Health & Wellbeing must be contacted via [occhealthoncall@nnuh.nhs.uk](mailto:occhealthoncall@nnuh.nhs.uk) with the following information:-
  - Name, Date of Birth and contact number of Recipient
  - Name and Hospital Number of Source patient
  - Managers name and contact number

For an incident occurring between 17.00 and 08.30 Monday to Friday and at any time during a weekend or on a Bank Holiday, email the completed '**Source consent form**' to **Workplace Health & Wellbeing** via [occhealthoncall@nnuh.nhs.uk](mailto:occhealthoncall@nnuh.nhs.uk) (NB: **the original source consent form must be filed in patient's hospital notes.**

- If no source bloods have been taken then Workplace Health & Wellbeing will continue to manage the incident as if the incident occurred from an unknown source.

### **3.3.1. Source patient who does not have capacity to consent**

If the source patient does not have capacity to provide consent, then the physician in charge of the care of this patient should consider the factors listed within the BMA 2016 'Needlestick injuries and blood-borne viruses: decision about testing adults who lack the capacity to consent'.

### **The key points are as follows:**

- Where the patient is expected to regain capacity before a decision on testing is needed, testing should not take place until consent has been obtained.

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- If the patient lacks capacity and has a valid and applicable ADRT is held (advance decision refusing treatment) this must be respected and testing cannot take place.
- If the patient has an attorney or a deputy with the legal authority to make treatment decisions, that person can give consent to testing on behalf of the patient.
- If none of the above apply, then doctors are entitled to make a decision whether to test the patient without consent but must do so in accordance with the law in that jurisdiction.
- The doctor must make that decision by assessing whether testing is in the best interests of the patient and must follow a structured decision making process in making the decision. All relevant circumstances need to be considered by any doctor making that decision but where there is a potential clinical benefit to the patient, it is highly likely that ultimately the 'balance sheet' will indicate that testing should be undertaken.
- In England, Wales and Northern Ireland, where there is no potential clinical benefit, in the absence of evidence to the contrary it is legitimate for doctors to assume that the patient would want to 'do the right thing' and that this factor weighs in favour of testing.

If testing is undertaken on a patient that does not have capacity to consent, the doctor authorising the test should complete the form **Appendix 4**

### **3.4 Bleed Back Incident**

- In the rare event of a 'bleed back' incident, it is important that both the HCW and the exposed patient have access to appropriate clinical management following the incident. Following a 'bleed back' incident the HCW must attend Workplace Health & Wellbeing for counselling and blood testing for BBVs (under a code number) following appropriate consent to do so.
- If the HCW tests negative for BBVs the DoH have indicated that there is no need to inform the patient about the incident as this would avoid causing the patient unnecessary anxiety.
- If the HCW tests positive for any BBV, the patient should be notified of an 'intra operative episode' without revealing which member of the clinical team is infected. PEP should only be recommended to a patient following a positive test in the HCW for HIV or Hepatitis B (except in very exceptional circumstances e.g. high likelihood of BBV infection). If the HCW tests positive, the patient will be followed up with baseline blood test for (storage) and further testing, as appropriate. It is the responsibility of the Clinician in charge of the patient to advise their GP that further blood tests are required.
- HIV test results should, ideally be available within eight hours of the exposure incident to maximise the benefit of PEP for the patient if indicated. However, if the 'bleed back' incident occurs at the weekend or on a bank

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holiday and the microbiology lab is not able to supply the result within an eight hour period, if the source (HCW) has high risk factors for HIV infection then the recipient (patient) should be informed of the incident and commenced on PEP until the result has been received.

- Where PEP for HIV (or Hepatitis B) is required for an exposed patient the Clinician responsible for that patient will be advised by the Occupational Health doctor. The iCaSH Norfolk Consultant should be contacted to confirm the appropriate HIV treatment regimen.

#### **4. References**

BMA (2016) Needlestick Injuries and blood borne viruses: decisions about testing adults who lack the capacity to consent

<https://www.bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/ethics/needlestick-injuries-guidance-may2016.pdf?la=en>  
 Children's HIV Association (HIVA) (2005) [www.bhiva.org/chiva/](http://www.bhiva.org/chiva/)

UK guideline for the use of post-exposure prophylaxis for HIV following sexual exposure (2021)  
<https://www.bashhguidelines.org/media/1269/pep-2021.pdf>

EAGA guidance on HIV post-exposure prophylaxis  
 Change to recommended regime for post exposure prophylaxis (sept 2014)  
<https://www.gov.uk/government/publications/eaga-guidance-on-hiv-post-exposure-prophylaxis>

Health and Safety Executive. (1995) *A guide to the Reporting of Injuries, Diseases and Dangerous Occurrences*; HSE Books, Sudbury.

Jackel et al (2001), *Treatment of Acute Hepatitis C with Interferon Alfa-2b*, N. Eng. J Med Nov 15 (20); 345: pg;1452-1457.

#### **5. Audit of the process**

Compliance with the process will be monitored through the following:

<b>Key elements</b>	<b>Process for Monitoring</b>	<b>By Whom (Individual / group /committee)</b>	<b>Responsible Governance Committee /dept</b>	<b>Frequency of monitoring</b>
Proportion of PEP attendees having a baseline HIV test performed: aim 100% within 1 working day of presenting for PEP	Included in WHWB needlestick audit	WHWB Governance	Health & Safety Committee	Biennial

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Proportion of PEP attendees having a HIV test result available within 5 days: aim 97%	Included in WHWB needlestick audit	WHWB Governance	Health & Safety Committee	Biennial
Proportion of PEP prescriptions that fit within recommended indications (consider or recommended): aim 90%	Included in WHWB needlestick audit	WHWB Governance	Health & Safety Committee	Biennial
Proportion of PEP prescriptions administered within 24 hours of risk exposure: aim 70%	Included in WHWB needlestick audit	WHWB Governance	Health & Safety Committee	Biennial

The audit results are to be discussed at WHWB governance meetings to review the results and recommendations for further action who will ensure that the actions and recommendations are suitable and sufficient.

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## **6. Appendices**

[APPENDIX 1 - RECIPIENT CONSENT FORM FOR POST EXPOSURE PROPHYLAXIS AGAINST HIV INFECTION](#)

[APPENDIX 2 Source Patient Consent Form for Source Testing following a Blood Exposure Incident](#)

[APPENDIX 3 Parent/Guardian Consent Form for Source Testing following a Blood Exposure Incident](#)

[APPENDIX 4 – Source testing following a Blood Exposure Incident when the patient does not have capacity to consent for blood to be taken](#)



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## **APPENDIX 5 – Background information for Health Care Workers (HCW) on Blood Borne Viruses**

### **Human Immunodeficiency Virus (HIV)**

**Source:** Found in almost all body fluids. Only blood and blood products, semen, vaginal secretions, donor organs and tissues and breast milk have been implicated in transmission.

#### **UK Population**

**Transmission:** Men who have sex with men.  
Injecting drug users.  
Men and women who have lived as adults in countries where heterosexual transmission is common e.g., South, East or Central Africa (notably Sub Saharan Africa).  
Infants with HIV infected mothers or adults with HIV infected sexual partners.

#### **Occupational**

##### **Transmission: To HCW**

'Average' transmission risk for blood related sharps injury is 0.3%, for mucous membrane exposure is 0.1% (likely even lower for non-intact skin exposure). Risk also greater for patients with terminal HIV illness, but viral load assessment of source patient is not established as a means for assessing risk of transmission. In 2018, a systematic review was conducted to review the risk of HIV transmission through biting or spitting. No cases of HIV transmission relating to spitting were identified, supporting the conclusion that there is no risk of HIV transmission from spitting. Studies have indicated that risk of acquiring HIV from a bite by an HIV-positive person is negligible, but the risk is increased by presence of blood in the saliva plus a high viral load of the perpetrator plus deep wounds being inflicted.

**From HCW** Transmission has occurred from Health Care Workers undertaking exposure prone procedures, but only very rarely.

**Immunisation:** Unavailable.

**Post-exposure prophylaxis:** If source is known to be infected or considered to be at risk but not yet tested a 4 week course of anti-HIV drugs is indicated. High likelihood of side effects. Used only on advice of occupational physician / Consultant Virologist / iCaSH service.

### **Hepatitis B Virus (HBV)**

**Source:** Found in virtually all body fluids. Blood, semen and vaginal fluid mainly implicated in transmission.  
May survive in dried blood at room temperature for at least 1 week.

## ***Management of Incidents which have the potential to transmit Blood Borne Viruses***

**UK Population transmission:** Unprotected sexual intercourse  
Inoculation of infected blood - shared injecting equipment amongst drug users.  
From infected mother to baby perinatally.

### **Occupational Transmission:**

**To HCW** Sharps injury, splash onto mucous membrane (eyes or mouth), splash onto broken skin.  
Risk of clinical hepatitis for sharps injury up to 30% for e-antigen positive source, 6% for e-antigen negative source, *although the risk of developing serological evidence of infection may be substantially higher in both groups*. In a given incident risk depends on viral load of source patient (not routinely assessed) and the extent of contact with the infected fluid.

**From HCW** Transmission has occurred from HCW undertaking exposure prone procedures and those working in renal dialysis units. Workplace Health & Wellbeing will test the HCW (as the Source Patient) for levels of infectivity.

**Immunisation:** Available and effective.

**Post-exposure prophylaxis:** For non-immune recipients If source known to be infected specific HB immune globulin (HBIG). For all occupational incidents, whether known infected source or not, unprotected individuals should be given accelerated course of vaccination. Protection from HBIG or post exposure vaccination alone up to 75%, increasing up to 95% if combined.

### **Hepatitis C Virus (HCV)**

**Source:** Blood mainly implicated in transmission.

Data on environmental viability limited.

### **UK Population**

**Transmission:** Inoculation of infected blood - shared injecting equipment amongst drug users. Main risk group.  
Unprotected sexual intercourse (low risk).  
From infected mother-to-baby perinatally (low risk).  
Is identified in individuals without obvious high risk factors.

**Occupational Transmission:** Sharps injury, splash onto mucous membrane (eyes or mouth), splash onto broken skin

### ***To HCW***

## ***Management of Incidents which have the potential to transmit Blood Borne Viruses***

'Average' incidence of anti-HCV seroconversion for sharps injury 1.8%. Actual risk depends on viral load of source patient. Risk seems very low if source has undetectable virus on PCR test. Transmission rare from mucous membrane exposure to blood and no transmission in HCW documented from intact or non-intact skin exposures to blood.

High risk of infection in intravenous drug users.

***From HCW*** Transmission has occurred from HCW undertaking exposure prone procedures

**Immunisation:** Not available.

**Post-exposure prophylaxis:** No evidence to support an effective PEP regime. Early treatment of established infection may result in higher 'cure' rate.

## **Management of Incidents which have the potential to transmit Blood Borne Viruses**

### 7. Equality Impact Assessment (EIA)

<b>Type of function or policy</b>	Existing
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<b>Division</b>	Corporate	<b>Department</b>	Workplace Health & Wellbeing
<b>Name of person completing form</b>	Hilary Winch	<b>Date</b>	21/10/2022

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	Nil	None	Trust	No
Pregnancy & Maternity	Nil	None	Trust	No
Disability	Nil	None	Trust	No
Religion and beliefs	Nil	None	Trust	No
Sex	Nil	None	Trust	No
Gender reassignment	Nil	None	Trust	No
Sexual Orientation	Nil	None	Trust	No
Age	Nil	None	Trust	No
Marriage & Civil Partnership	Nil	None	Trust	No
<b>EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?</b>				

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

**IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED**

**The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.**