GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board	**Reference Number: UHB 019** **Version Number: 3** **Date of Next Review: September 2022** **Previous Trust/LHB Reference Number: UHB 075**

INFECTION CONTROL PROCEDURE FOR NEEDLESTICK AND SIMILAR SHARPS INJURIES

INTRODUCTION

Because of the risks of blood borne diseases caused by hepatitis B Virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV), and other agents, all health care workers (HCWs) must take precautions to protect themselves from contact with blood and other high-risk fluids and especially to avoid needlestick and other similar injuries.

AIM

To provide a structure and appropriate advice to staff for the management needlestick and other similar injuries

Objectives

- To outline who is responsible for managing the exposed member of staff and the procedure to be followed for their management.
- To outline who is responsible for making a risk assessment of the source patient for blood borne viruses and approaching the source patient for permission to test for BBVs.

Scope

This procedure applies to all staff in all locations including those with honorary contracts and students on placement at Cardiff and Vale UHB.

Cardiff And Vale UHB accepts its responsibility under the Health and Safety at Work Act etc. 1974 and the Control of Substances Hazardous to Health Regulations 2002, to take all reasonable precautions to prevent exposure to hepatitis in patients, staff and other persons working at or using its premises.

Equality Impact Assessment	An Equality Impact Assessment has been completed. The Equality Impact Assessment completed for the policy found there to be no impact.
Documents to read alongside this Procedure	Infection Prevention and Control Transmission Based Precautions Infectious Incidents and Outbreaks Hand Decontamination Infection Prevention and Control Standard Precautions Procedure Period of Increased Incidence (PII diarrhoea pack)
Approved by	IP+C Group
Accountable Executive or Clinical Board	Director of Nursing

Director	
Author(s)	Director IP&C, IP&C Nurse, SpR Microbiology/Infectious Diseases

Disclaimer

If the review date of this document has passed please ensure that the version you ar using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
2	*02.10.15*	*23.10.15*	The procedure was updated to comply with the Safety (Sharps Instruments in Healthcare) Regulations 2013, requiring implementation of the 'EU Council Directive 2010/32/EU on the prevention of sharps injuries in the hospital and healthcare sector'
3	04.09.19	03.12.2019	Updated at IPCG meeting

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1. INTRODUCTION

1.1 Because of the risks of bloodborne diseases caused by hepatitis B Virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV), and other agents, all health care workers (HCWs) must take precautions to protect themselves from contact with blood and other high-risk fluids and especially to avoid needlestick and other similar injuries.

1.2 Hepatitis B Virus

1.2.1 For HBV there is effective vaccination, post exposure prophylaxis (PEP) with vaccine +/- immunoglobulin (HBIG) for those not vaccinated, and post exposure HBIG for HCW's who fail to respond to the vaccine.

1.2.2 Vaccinated HCW's who have developed immunity are at extremely low risk of infection. Unvaccinated persons have a risk from a single needlestick injury or cut exposure of 6-30% (depending on viral load) to HBV infected blood.

1.3 Hepatitis C Virus

1.3.1 There is no vaccine or PEP available for HCV but effective treatment is available for those exposed.

1.3.2 The risk of infection after a needlestick or cut exposure to HCV infected blood is approximately 1.8%. The risk following blood splashes is unknown.

1.4 HIV

1.4.1 For HIV there is no vaccine available but there is PEP but this requires immediate action.

1.4.2 The risk of HIV infection after needlestick or cut exposure to HIV infected blood is low at approximately 0.3%. The risk after exposure of the eye, nose or mouth is less than 0.1%. There is no risk of HIV transmission where intact skin is exposed to HIV infected blood.

1.5 Testing Source Patients

1.5.1 Testing source patients for HBV, HCV and HIV is the most effective way of providing reassurance to those injured, because the majority of patients will not be infected. A universal approach to asking source patient to agree to have BBV tests avoids the need to make difficult judgements and avoids any appearance of discrimination against people perceived as being in 'risk groups'. In practice, there has been some reluctance to seek patients' consent to be tested, yet patients have usually been found willing to co-operate if approached in a sensitive manner.

1.6 Staff Responsibilities

1.6.1 Staff should take all reasonable precautions to avoid sharps injuries. This includes avoiding the use of medical sharps so far as is practical, using safer sharps where possible and correctly following protocols for sharps disposal.

1.6.2 In the event of a needlestick or similar injury all staff should know:-

- What action to take.
- Who has responsibility to ensure proper assessment.
- Where to go for treatment of the injury and follow-up.
- How to report the incident so that future injuries are reduced or avoided.

1.6.3 The Injured Person must:-

- Immediately apply first aid
- Report to Supervisor / Clinical Manager
- Contact Occupational Health (OH) between 9am and 5pm.
    - UHW - Ext 43264
    - UHL - Ext 25140
- Out of hours contact:-
    - UHW – Emergency Unit (EU) - Ext 48792/48285
    - UHL – Medical Emergency Admissions Unit (MEAU) – Ext 25215/25216
- Collect Risk Assessment form 2 to take to Occupational Health/ EU/MEAU.
- Complete an incident form- this must be done via eDatix.

1.6.4 The Supervisor / Clinical Manager for the injured person must:-

- Ensure first aid has been carried out.
- Refer injured person to Occupational Health/Emergency Unit/Medical Emergency Admissions Unit
- Ensure Form 2 is completed and communicated either by sending in a sealed envelope with the injured worker or by secure fax using the safe haven procedure.
- Ensure that source patient risk assessment is carried out by liaising with the Clinical Manager covering the area of the source patient. The clinical manager should where possible:-
    - Liaise with the Consultant responsible for source patient.
    - In Primary Care liaise with the GP responsible for the source patient.
    - Ensure that an e-Datix incident form is completed.
    - Investigate the cause of the injury and put in place any appropriate preventative measures to reduce likelihood of any further injuries

1.6.5 The Supervisor / Clinical Manager is the Line Manager to whom the injured person is responsible at time of the injury. The Line Manager may not be in a position to carry out the risk assessment in which case it should be referred to the Clinical Manager of the area.

1.6.6 Risk assessment of the source patient is the responsibility of the Consultant or GP responsible for their care.

1.6.7 The injured party must not be involved in the risk assessment of the source patient and must not approach the source patient for permission to test for blood borne viruses.

2. PROTOCOL FOR NEEDLESTICK OR SIMILAR INJURIES

2.1 **First Aid**

2.1.1 First Aid should be performed immediately after the injury occurs.

2.1.2 Skin/Tissue

- Encourage local bleeding by gently squeezing, do not suck area.
- Wash the affected area with soap and running warm water. Do not scrub the area.
- Cover area with waterproof dressing.

2.1.3 Eyes or Mouth

- Rinse out / irrigate with copious amounts of water (use eye washout kits if available).
- If wearing contact lenses irrigate eyes before and after removing them.
- Do not swallow water used for rinsing mouth.

2.2 **Injury Assessment other than Human Bites**

2.2.1 For an injury to be considered significant, both the type of injury incurred and the body fluid involved must be high risk.

Table 1: Flow diagram for injury risk assessment

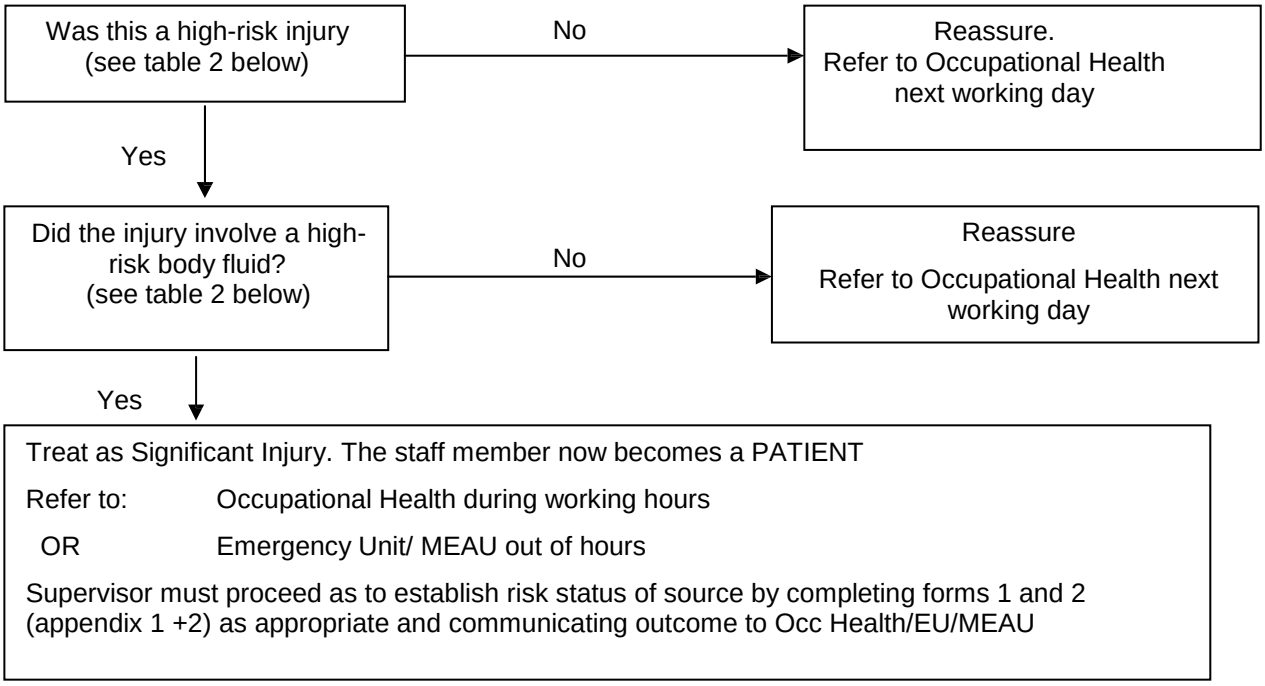


Table 2: Injury Type

High-Risk Injury	Low-Risk Injury
Percutaneous exposure e.g. needlestick or other sharps injury Exposure on broken skin Mucous membrane exposure (e.g. eye)	Splash on intact skin.

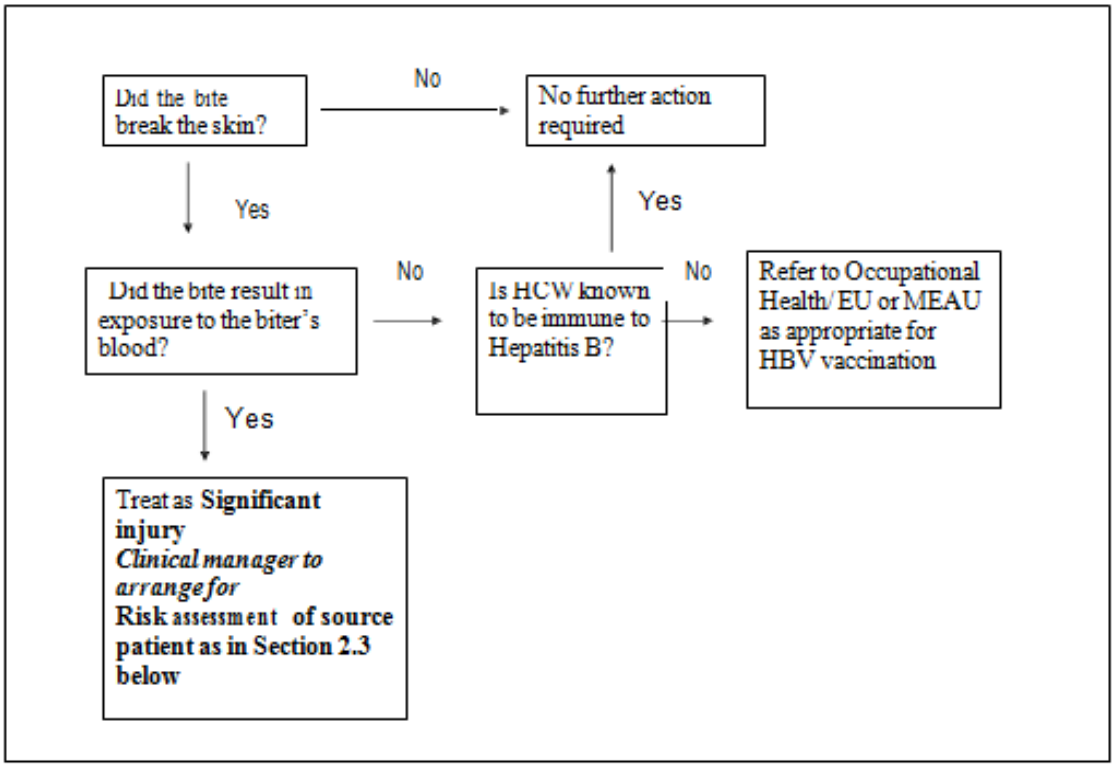
Table 3: Body Fluids

High-Risk Body Fluid		Low Risk Body Fluid (unless blood-stained)
Blood Low risk fluid if bloodstained Amniotic fluid Breast milk Pericardial fluid Peritoneal fluid	Pleural fluid CSF Saliva associated with dentistry Semen Synovial fluid Unfixed tissues or organs Vaginal Secretions	Urine Vomit Saliva Faeces

2.2.2 Injury Assessment for Human Bites

- Apply first aid (See section 2.1).
- Refer to EU at UHW or MEAU at UHL.
- Give tetanus vaccination as appropriate. If immunisation schedule is incomplete or unknown, a dose of tetanus vaccine should be given at the time of treatment. Follow up with Occupational Health / GP should be arranged for further doses if required.
- Give antibacterial prophylaxis as appropriate for all bites if under 72 hours old.
- Refer to Occupational Health.
- Assess the risk of BBV transmission. The clinical evaluation should include the possibility that both the person bitten and the person inflicting the bite may have been exposed.

Table 4: Flow diagram for injury assessment for human bites



2.3 Establishing risk status of source

2.3.1 This remains the responsibility of the clinical team caring for the source patient even if the staff member has been referred to Occupational Health or the Emergency unit.

2.3.2 The clinical manager covering the area where the source of blood is located should:-

- Locate the source patient if possible.
- Arrange for a source patient risk assessment to be carried out IMMEDIATELY and for the source patient's informed consent to be sought for:
- HBV, HCV and HIV testing ideally within 30 minutes of the incident occurring.

2.3.3 The source patient risk assessment should be carried out by an experienced health care professional e.g. senior nurse or doctor from the clinical team caring for the patient, not by Occupational Health or Emergency Unit. The injured health care worker must not carry out the source patient risk assessment.

2.3.4 Inform Occupational Health or out of hours Emergency Unit/MEAU whether or not a source patient risk assessment has been arranged and provide them with contact details of the person carrying out the risk assessment.

2.3.5 Inform the Consultant / GP responsible for the source patient if not already involved.

2.4 Known Source Patient, guidance on approach to risk assessment and permission to test

2.4.1 In the case of a known source patient, a risk assessment should be carried out and consent for testing sought. The situation must be handled sensitively. The patient must not be approached by the injured healthcare worker.

2.4.2 A review of the case notes should take place to establish if there is known infection with any blood borne viruses. If this is not clear from case notes then it will be necessary to seek information from the patient themselves.

2.4.3 There is no single approach that will cover every interview, but it is recommended that the following points be observed:

- The discussion should take place in a location where proper privacy can be maintained.
- The patient should be informed that someone has been injured in an accident involving their blood/other body fluid. Injuries of this kind can cause considerable anxiety and worry to healthcare workers because infections such as hepatitis B, hepatitis C and HIV can be transmitted in

this way (see appendix 5).

- Patients should be asked if they would consent to answering some personal questions, which would help to address the concern. Emphasise that the questions are very personal and might very well not apply to them, but they are now asked routinely, for example, by the Blood Transfusion Service before accepting blood donations.
- If the patient agrees, ask them the questions detailed on Form 1 of the source patient assessment tool (see appendix 1).

2.4.4 If any of the answers to the questions on Form 1 is Yes then the patient should be considered as high risk for blood borne viral infections.

2.4.5 Permission to test for Hepatitis B, Hepatitis C and HIV

- Unless there are reasons for not testing, all source patients should be asked if they would be willing to allow a sample of their blood to be taken for testing for HIV, HBV and HCV, as a negative result gives reassurance to the injured person.
- Emphasise that testing is also in their interest as these diseases may be entirely asymptomatic, but have effective treatment if diagnosed and are best diagnosed at the earliest opportunity. It is important that undue pressure is not applied and that the decision lies entirely with the patient and this must be explained clearly to the patient. The outcome of the discussion should be recorded in the patient's notes.
- Inform source patient that he/she will be notified of the result. Inform source patient that the test result will be passed to the doctor / nurse managing the injured staff member to help with their management.
- Negative test results will be available within 24 hours. However, if a result is not negative then the laboratory will need to carry out confirmatory tests the next working day.
- In the past, patients have expressed concerns that consenting to an HIV test might adversely affect their insurance policies. Patients can be advised that a negative HIV test will not affect their insurance premiums although a positive result may have implications. The great advances in treatment of HIV mean that early diagnosis facilitates the best outcome.
- After testing, permission will be sought to communicate any positive result to the GP.
- If the request raises serious anxiety, or if the source patient requests anonymous testing (where a code is used on the request form and sample rather than the patient name), then refer for specialist management to Infectious Diseases Department or Genitourinary Medicine Department.

2.4.6 Document the risk assessment outcome on Form 2, along with whether or not consent for blood testing has been obtained and samples sent (see appendix 2). Forward completed Form 2 to Occupational Health or Emergency unit.

- By giving the form the injured worker in a sealed envelope.

- Or by secure Fax using the safe haven procedure

- Occupational Health UHW Ext 44411
- Occupational Health UHL Ext 25432
- Emergency unit UHW Ext 48062
- MEAU UHL Ext 25215/25216

2.4.7 Great care should be taken to ensure that the fax is sent to the correct location using the safe haven procedure, and as personal identifiers will be transmitted that prior notice of transmission is given so that there is someone ready to receive the information securely.

2.4.8 Record that an assessment has been carried out in the source patient's case notes, but do not record the assessment outcome.

2.4.9 Record the name and contact details of the person carrying out the assessment in source patient's case notes.

2.4.10 Destroy Form 1.

2.4.11 Where the patient declines any engagement with the risk assessment process, and a risk assessment cannot be carried out from patient notes, proceed as per "unknown source" (6.7).

2.5 Sending samples once obtained

2.5.1 Specimens taken for storage and for blood borne virus testing should be sent to the Specialist Virology Centre, PHW Microbiology, University Hospital of Wales, Cardiff.

2.5.2 The preferred sample for both storage and source patient testing is a 9ml EDTA sample (2 purple cap vacuum tubes).

2.5.3 During working hours (i.e. Monday to Friday, between 9am – 5pm) the Specialist Virology Centre will test patients for BBV to establish that the exposed individual is not already HIV infected. Where possible, specimens should be sent during working hours. Contact details are listed in appendix 3. All positive HIV antibody tests will require confirmatory testing which will be carried out on the next working day.

2.5.4 If the sample is being sent out of hours (e.g during the weekend) the on call virology consultant should be contacted via switchboard to discuss processing of the sample and its effect on immediate management. They may request that the virology laboratory technician is informed separately (see appendix 3 for contact details) to inform them that a specimen is being sent and the agreed processing time.

2.5.5 Ensure that the specimen is labelled with the contact details of the person who should be telephoned with the results. Only positive or equivocal results will be telephoned. Negative results will be automatically authorised and available for review via the clinical portal.

2.5.6 Mark request form “copy to Occupational Health”.

2.6 Managing results of source patient test

2.6.1 It is the responsibility of the person carrying out the source patient risk assessment to ensure the results of the source patient blood tests are telephoned to the doctor or nurse managing the injured person.

2.6.2 If the person carrying out the risk assessment is not going to be on duty when the results become available then the name of nominated deputy should be given to the laboratory. The nominated deputy must then take responsibility for passing the results on to the doctor or nurse managing the injured person.

2.6.3 The person carrying out the source patient risk assessment must ensure that the source patient is informed of their test results within 24 hours of them becoming available.

2.6.4 In the event of the source patient test results being positive, specialist advice should be sought from an infectious diseases consultant or GUM clinic CRI, before the patient is informed (see appendix 3 for contact details).

2.7 Unknown source

2.7.1 If it is not possible to identify the source patient for a particular needle or sharp implement, a risk assessment should be carried out to determine the likelihood that the needle may have been used on a patient with a BBV infection. Are there patients known to be infected with a BBV in the clinical area concerned?

2.7.2 If no further information is available background prevalence rates can be used in the risk calculation (appendix 4)

2.8 Testing when source patient is unable to give consent

2.8.1 When the source patient is deceased, unconscious or unable to give informed consent for any other reason, testing should not be carried out without first seeking further advice from the on call ID (see appendix 3 for contact details). However, if the source patient has died, consent for testing can be given by a “nominated representative” (if appointed) or by a person with a “qualifying relationship” to the deceased”. The decision to start PEP should be made on the basis of the source patient risk assessment and should not be delayed by waiting for the blood test.

2.9 Risk assessment and testing when source is a child

2.9.1 For children and their parents / guardians all the above considerations including privacy must be maintained. To establish the risk status of the child, the questions in the source patient assessment tool should be asked, not only regarding the child, but also the mother. If the child is deemed to have

sufficient understanding, whatever his/her age, an appropriate explanation should be given, and consent sought from the child. If the child refuses, blood should not be taken or tested. If the child consents, consent should also be sought from the child's parents / guardian. As the route of transmission to children is usually vertical (from mother to child), testing the child may be a surrogate for testing the mother, so she should be aware of this prior to testing. The reason for refusal of consent may be the distress of venepuncture. If this is the case, in young children with no history of foreign travel, blood transfusion or needlestick injury, the mother's blood may be tested instead of the child's.

2.10 Management of the injured person

2.10.1 This is carried out by Occupational Health / Emergency Unit / MEAU staff.

2.10.2 Patients should be triaged and treated as a priority, within one hour if possible.

2.10.3 Ensure first aid has been carried out (see section 2.1)

2.10.4 Confirm that a significant injury has occurred (see section 2.2). If not a significant injury, the injured person can be reassured.

2.10.5 Check whether the source patient is known to have a BBV or at high risk of infection with a BBV

2.10.6 Check if source patient has given consent for testing and if so, when will the results be known. Arrange for results of source patient blood test to be phoned to a named doctor or nurse responsible for managing the injured person. If the source patient HIV antibody test is negative, and PEP has been started, then the injured person must be contacted as soon as possible and advised to discontinue PEP.

2.10.7 Assess the need for HIV PEP, remember that therapy should be started as soon as possible following injury, ideally within one hour.

2.10.8 Assess the need for hepatitis B vaccination +/- hepatitis B immunoglobulin. HCWs should know their vaccination status and whether they responded to HB vaccine (i.e. ever attained a level of >1OIU/L)

2.10.9 Consider the need for hepatitis C follow-up

2.10.10 Offer to take blood for storage (all significant injuries). Explain that testing will be carried out only with consent. Request form should state type of injury and 'blood for storage'.

2.10.11 If necessary, offer referral for specialist counselling / support. This can be provided by GUM or the Infectious Diseases department.

2.10.12 Ensure all appropriate follow-up is arranged:

- Appointment with ID physicians if HIV PEP started.

- Occupational Health (HCW) or GP (others) follow-up if further hepatitis B vaccination / testing or HCV screening is required.

- Referral to counselling services. Staff members may contact the Employee Wellbeing Service on 029 2074 4465.

- For all injuries in the workplace, advise the injured HCW to inform the Occupational Health Department at the earliest opportunity, regardless of outcome of the assessment.

2.10.13 Advise staff to report the incident by completing an e-Datix form.

2.11 Management of patients exposed to blood from a HCW

2.11.1 Circumstances that could allow the transmission of blood borne viruses from HCW to patient include:

- Visible laceration occurring to a HCW's hand where the patient's open tissue or mucous membranes could be contaminated with the HCW's blood.

- Visible bleeding form a HCW from any other site, e.g. nosebleed, leading to significant bleed-back into a patient's open tissues or mucous membranes.

- An instrument or needle contaminated with the blood of the HCW is inadvertently introduced into the patient's tissues.

2.11.2 The injured worker should:

- Stop the procedure as soon as possible, wash and dress the wound and stem the bleeding.

- Clean and disinfect any contaminated areas.

- Report the incident to the clinical supervisor or line manager.

- Inform the Occupational Health department (EU/MEAU out of hours)

- Complete an e-Datix form

- If from a known high risk source, inform the Health and Safety Dept

2.11.3 A risk assessment should then be carried out by someone other than the injured HCW, e.g. a senior doctor, to ascertain whether or not a significant exposure has occurred. If the incident is considered to be a significant

exposure, involving bleed-back into the patient, a source HCW risk assessment should be carried out IMMEDIATELY using Forms 1 and 2 and the injured HCW should routinely be asked to consent to testing for HIV, HBV and HCV.

2.11.4 If the HCW tests positive for any blood borne virus, the patient should be notified of an intra-operative exposure without revealing which member of the clinical team is infected. Only in exceptional circumstances would a patient be given PEP for HIV in the absence of a positive blood test in the HCW (eg high risk of having been infected with HIV and refusal to undergo a test). National Guidance indicates that it is unnecessary to tell the patient if the HCW's tests are all negative.

2.11.5 A written record of the incident and test results should be entered in the HCW's occupational health notes.

3. RESOURCES

3.1 The necessary resources for the management, training, risk assessments, monitoring and auditing for needlestick and similar sharps injuries are already in place and the implementation of this protocol will not entail additional expense.

4. TRAINING

4.1 Mandatory infection prevention and control training updated every three years.

4.2 Further departmental based training as identified by training needs analysis.

5. IMPLEMENTATION

5.1 The document will be available on the UHB intranet site and the Infection Prevention and Control clinical portal site. Individual directorates will be responsible for the implementation of the protocol document in clinical areas.

6. FURTHER INFORMATION

6.1 Revised guidelines for HIV Post Exposure Prophylaxis was released in 2008 by the UK Chief Medical Officers Expert Advisory Group on AIDS. This protocol takes into account the revised guidance and local circumstances within Cardiff and Vale UHB.

7. EQUALITY

7.1 This protocol has had an equality impact assessment and has shown there has been no adverse effect or discrimination made on any particular individual or group.

8. AUDIT

8.1 Audit of compliance with the protocol document will be carried out by the

Infection Prevention and Control department as part of their audit programme.

9. REVIEW

9.1 This protocol will be reviewed every three years or sooner if the national guidelines are updated.

10. REFERENCES

10.1 HIV Post Exposure Prophylaxis – Guidance from UK Chief Medical Officers Expert Advisory Group on AIDS. 2008

10.2 Exposure to Blood: What Healthcare Personnel need to know. http://www.cdc.gov/ncidod/dhgp/pdf/bbp/exp to blood.pdf

10.3 Health Protection Agency North West. Guidelines for the Management of Human Bites. June 2005

10.4 AIDS/HIV Infected Healthcare Workers: Guidance on the Management of Infected Healthcare Workers and Patient Notification. http://www.scotland.gov.uk/publications/2002/09/15338/10619

10.5 Hepatitis C Infected Healthcare Workers. http://www.scotland.gov.uk/publications/2002/11/15811/13927

14.6 Addendum to guidance issued in August 1993: Protecting Healthcare Workers and Patients from Hepatitis B. http://www.semd.scot.nhs.uk/mels/1996 93b.pdf

14.7 Policy for the prevention and control of blood borne viruses. NHS Plus 2010 (Draft)

Appendix 1

Source patient risk assessment Form 1

CONFIDENTIAL **For use following needlestick injury or similar**	
Is source patient known to have hepatitis B	**Yes/No**
Is source patient known to have hepatitis C	**Yes/No**
Is source patient known to have HIV	**Yes/No**
If the answer to any of these is YES, the patient is considered "High risk". If all answers are NO, then ask the following in an area where confidentiality can be assured. (based on questions asked routinely of blood donors)	
For men – Has he ever had sex with a man	**Yes/No**
For women, have she ever had sex with a man who has had sex with a man	**Yes/No**
Have he/she ever paid for or sold sex	**Yes/No/Not known**
Has he/she had a blood transfusion in a country outside Western Europe, Australia, New Zealand, Canada or the USA	**Yes/No**
Has he/she ever injected drugs	**Yes/No**
Has he/she ever had sex with someone who has injected drugs	**Yes/No**
If source patient answers "yes" to any of above should be considered "high risk"	
ON completion of risk assessment: • **Document outcome on Form 2** • **Forward part 2 to Emergency Unit or Occupational Health (by fax or in sealed envelope to be carried by injured worker** • **In patient casenotes** o **Record assessment has been done but NOT outcome** o **Record your name, grade and contact details**	

Source patient risk assessment should be carried out by an experienced health care professional.

Guidance for approaching source patient is given on pages xx to xx of Cardiff & Vale "Sharps" Policy

Appendix 2 **Source patient risk assessment Form 2**

You should contact the nurse or doctor managing the injured person PROMPTLY with an initial verbal report with results of risk assessment and when and to whom any lab test results will be notified. This form can be faxed to Emergency Unit or Occ Health using the safe haven procedure or injured worker could take it with them **in a sealed envelope**

To be completed by practitioner performing source patient risk assessment

Name of Injured Person_____Place where injury happened_____

Consultant/ GP responsible for source patient_____Date_____

Source patient reference……..

I have scrutinised the casenotes of the identified source patient	Yes/No
I have spoken to the medical team responsible for source patient	Yes/No
I have spoken to source patient and carried out risk assessment	Yes/No
Outcome of Risk assessment	
Has patient been diagnosed with a blood borne virus infection	Yes/No
Does patient have any possible syndrome suggesting acute HIV infection	Yes/No/Not known
Is patient HIGH RISK for BBV infection	Yes/No
Has Occupation Health or Emergency Unit been informed of risk status of source patient	Yes/No
Source patient blood test	
Has consent be sought and granted for blood to be taken and tested	Yes/No
Has blood been taken	Yes/No
When will result be available	
Has injured staff member been informed of source risk assessment and /or lab result	Yes/No

Practitioner's **name_____Post_____** **Page/contact no_____**	

To be completed by doctor or nurse managing injured person

Hepatitis B vaccine given	Yes/No	/ /200
HBIG given	Yes/No	/ /200
PEP for HIV started	Yes/No	/ /200
Has follow up been arranged	Yes/No	/ /200
Name_____Post_____ **Page/contact no_____**		

Appendix 3 - Contact Telephone Numbers

1.0 Occupational Health Departments

University Hospital of Wales
Tel : 02920 74 3264 or ext 43264
Fax: 02920 74 4411 or ext 44411

University Hospital of Llandough
Tel: 02920 72 5140 or ext 25140
Fax: 02920 72 5432 or ext 25432

2.0 Paediatrics

For specialist advice, contact on-call Paediatric ID consultant via UHW switchboard on 02920 747747.
Referrals to consultant paediatrician (Dr Jennifer Evans) for follow-up testing.

3.0 Specialist Virology Centre for Wales, NPHS Microbiology Cardiff

Monday to Friday, 9am to 5pm: Tel: 02920 74 2178.
Out of hours: Contact on call Microbiologist via UHW Switchboard:
Tel: 02920 747747

4.0 Genitourinary medicine, Cardiff Royal Infirmary

Switchboard: 100
Health Advisors: 02920 498900
GUM Secretaries: 02920 335169
Fax number: 02920 487096

Opening hours:

Monday 08:15 – 12:30 and 13:15 – 16.30
Tuesday 08:15 – 12:30 and 13:15 – 16:30
Wednesday Closed
Thursday 08:15 – 12:30 and 13:15 – 16:30
Friday 08:15 – 12:30 only - closed pm

Appendix 4 - Risk that Source is HIV Positive

Community Group	**HIV Seroprevalence**	**Risk**
1. Known HIV Positive people	100%	High
2. Homosexual Men		
London/Manchester/Brighton	Up to 15%	High
Elsewhere in UK including Wales	Up to 5%	Medium
3. Heterosexuals		
Sub Saharan Africa	Up to 39%	High
Caribbean	Up to 6%	Medium
Latin America	< 2.7%	Medium
South & SE Asia	< 2.7%	Medium
N Africa & Middle East	< 2.6%	Medium
UK	< 1%	Low
W Europe	< 1%	Low
E Europe and Central Asia	< 1%	Low
N America	< 0.6%	Low
Australia and New Zealand	0.1%	Low
4. Intravenous Drug Users		
S Europe	>50%	High
London	4.7%	Medium
E Europe	Variable	Medium/High
Elsewhere in UK (Wales)	0.23%	Low

Appendix 5 Suggested form of Words for approaching Source Patient

"Unfortunately one of the members of staff has had an accidental injury where your blood *(or specify relevant 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 blood *(or specify relevant body fluid*) is involved in such an accident. We need your agreement to do this and would appreciate your help.

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.

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 and the affected staff member will also be informed.

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. 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 and regardless of the results from your recent blood tests your Trust consultant will contact you. If the results are positive a meeting will be arranged to explain them to you."

Taken from: Draft "Policy for the Prevention and Control of Blood Borne Viruses" 2010 NHS Plus

APPENDIX 6 – Definitions and Acronyms

BBV	Blood Borne Viruses referred to in this policy include Hepatitis B, Hepatitis C and Human Immunodeficiency Virus
Donor	Person who is the origin of blood or body fluid. The preferred term is 'source.'
ED	Emergency Unit (also known as A&E)
EPP	Exposure Prone Procedure
HBIG	Hepatitis B immunoglobulin
HBsAb	Hepatitis B surface antibody
HBsAg	Hepatitis B surface antigen
HBV	Hepatitis B Virus
HCV	Hepatitis C virus
HCW	Health Care Worker
HIV	Human Immunodeficiency virus
Inoculation incident	consists of exposure to blood or other body fluids involving: • Broken skin – such as abrasions, fresh cuts, eczema • Percutaneous exposure - when contaminated material penetrates the skin e.g. needlestick injury, bites • Mucocutaneous exposure- exposure of blood or other body fluids to the lining of eyes, nose or mouth
PEP	Post Exposure Prophylaxis against HIV which is given following exposure in cases considered high risk for possible HIV exposure
Recipient	Person who was exposed to the body fluid
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
Sharps	Are objects with sharp edges such as suture needles, hollow needles, scalpels, blades lancets, surgical instruments, broken ampoules, bone, teeth or equipment used in dentistry e.g. burr which carry the risk of transmission of BBVs.
Source	Person who is the origin of blood or body fluid. Also known as 'donor.'
Victim	Person who was exposed to the body fluid. The preferred term is 'recipient.'