BLOOD BORNE VIRUS POLICY – care of suspected or confirmed patient with a BBV

POLICY

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Approving Body	Infection Prevention and Control Committee		
Date Approved	13/07/2021		
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	YES	**NO**	**N/A**
	X		
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Sponsor (Position)	Director of Infection Prevention and Control		
Author (Position & Name)	Sally Palmer, Nurse Consultant IPC		
Lead Division/ Directorate	Diagnostics and Outpatients		
Lead Specialty/ Service/ Department	Infection Prevention and Control Team		
Position of Person able to provide Further Guidance/Information	Infection Prevention and Control Team		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Not Applicable	Not Applicable
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CONTENTS

1.0 INTRODUCTION

Transmission of blood borne virus (BBV) occurs when blood or body fluids from an infected person enters the body of a susceptible person (one who is not immune) for example:

- Via sexual intercourse
- Via sharing injecting equipment
- Via skin penetration by blood contaminated sharps objects such as used needles, instruments
- Via blood transfusion
- Through childbirth, the mother may infect her child before or during birth or through breast feeding

In healthcare, precautions must be taken to protect staff and patients from this risk, while ensuring that infected patients receive standard treatment and care they need. For this reason the Trust has adopted the policy of taking 'standard precautions' (previously known as universal precautions); with blood and body fluids. The **key** to preventing transmission of BBVs is the strict observance of standard infection prevention and control measures which treat all blood, body fluids and body tissues from all patients as potentially infectious at all times.

The BBVs which present most cross infection hazard for healthcare staff are those associated with a carrier state with persistent replication of the virus in the human host and persistent viraemia. These include HIV and several hepatitis viruses; for other rarer potentially blood-borne viruses, specialist microbiological and/or virological advice should be sought from the Consultant Microbiologist.

This policy describes the accountability framework for implementation of the protocols that are recommended within Sherwood Forest Hospitals NHS Foundation Trust (Trust) for the prevention of transmission of BBV and for ensuring the safe care and management of all patients suspected or confirmed with a BBV.

2.0 POLICY STATEMENT

The purpose of this policy is to ensure staff members employed by Trust are aware of the correct precautions to be taken when a) contact with blood/body fluid is anticipated and b) when handling and disposing of sharps; these are known as Standard Precautions. The policy has a preventive focus and will enable staff within the Trust to understand when and why they should apply Standard Precautions effectively. The policy also provides information with regards to the Trust's legal responsibilities to reduce the risk of transmission of BBV.

This clinical policy applies to:

Staff group(s):

- All clinical staff
- All non-clinical staff when they enter a clinical environment
- All clinical and non-clinical staff who may be exposed to 'used sharps' during their disposal

Clinical areas(s):

- All clinical areas

Patient group(s):

- All patient groups

3.0 DEFINITIONS/ ABBREVIATIONS

3.1 Definitions

Infection	When the organism invades and multiplies to cause a systemic host response
Blood borne virus	Occurs when blood or body fluids from an infected person enters the body of a susceptible person
Susceptible person	One who is not immune
Source patient	The person from whom the blood or body fluid originates
Hepatitis	Inflammation of the liver (often due to viral infection)
Percutaneous exposure	Needle or other sharp object contaminated with blood or body fluids causing injury, a bite causing visible bleeding, or other visible skin puncture
Contamination via mucous membrane	Blood or body fluid splashes to the eyes, nose or mouth
Contamination via broken skin	Blood or body fluids entering cuts, abrasions, or patches of eczema

3.2 Abbreviations

Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employers of the Trust including those managed by a third party on behalf of the trust
DIPC	Director of Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IPCT	Infection Prevention and Control Team
HCAI	Healthcare Associated Infection(s)
BBV	Blood borne virus
HBV	Hepatitis B virus

HCV	Hepatitis C virus
HDV	Hepatitis D virus
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
PCP	Pneumocystis Carinii Pneumonia
PCR	Polymerase chain reaction
PEP	Post Exposure Prophylaxis
PHE	Public Health England
RNA	Ribonucleic acid
RIDDOR	Reporting of Injuries, Disease and Dangerous Occurrences Regulations
COSHH	Control of Substances Hazardous to Health Regulations
UK	United Kingdom

4.0 ROLES AND RESPONSIBILITIES

Everyone has a clinical and ethical responsibility to carry out effective infection prevention procedures and to act in a way which minimises the risk to the patient, staff and visitors. If you have any reason to believe that you have been exposed to a serious communicable disease you must seek and follow advice without delay from Occupational Health.

4.1 Chief Executive

The Chief Executive is ultimately responsible for ensuring that there are effective arrangements for infection prevention and control.

4.2 Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) has Trust wide responsibility for the development of strategies and policies for the management of infection prevention and control.

4.3 Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) will provide specialist advice regarding safe use and disposal of sharps, and ensure this policy is reviewed and amended at the review date, or prior to this following new development in sharps management research.

4.4 Consultants and Clinical Directors

Consultants and Clinical Directors are responsible for ensuring that infection prevention and control policies, procedures and guidance are applied consistently across the clinical team and that they act as a good role model for infection prevention and control. They will actively support all infection prevention and control measures and will have an active role in measuring outcomes and developing action plans for improvement. They will ensure medical teams are allocated appropriately.

4.5 Heads of Nursing and Matrons

Heads of Nursing and Matrons are responsible for ensuring that infection prevention and control policies, procedures and guidance are applied consistently across the clinical team and that they act as a good role model for infection prevention and control. They are also responsible for ensuring that resources are available for all healthcare professionals to undertake effective standard and isolation precautions. They will have an active role in measuring outcomes and developing action plans for improvement.

4.6 Departmental Leads/Ward Sisters/Charge Nurses

Departmental/Ward Sisters/Charge Nurses are responsible are responsible for ensuring that infection prevention and control policies, procedures and guidance are applied consistently across the clinical team and that they act as a good role model for infection prevention and control. They are also responsible for ensuring that all members of staff under their management control are appropriately trained, have access to appropriate personal protective equipment and adherence to safe practices. They must also keep clear and contemporaneous records.

4.7 Clinical staff

Clinical staff are responsible for complying with the requirements of the Trust Infection Prevention and Control policies and guidelines, attend appropriate training and use appropriate personal protective equipment. Clinical staff are required to maintain clear and contemporaneous records.

4.8 Non-clinical staff

Non-clinical staff are responsible for complying with the requirements of the Trust Infection Prevention and Control policies and guidelines, attend appropriate training and use appropriate personal protective equipment.

4.9 Occupational Health

The Occupational Health department is required to be aware of this policy. Occupational Health is responsible for ensuring that there is appropriate written advice about blood borne viruses for staff. The Occupational Health Department is proactive in providing appropriate occupational immunisation to protect staff from disease and they also provide post incident advice. Occupational Health will assist the Trust in the monitoring of sharps injuries.

4.10 The Trust Infection Prevention and Control Team

- prepare policies jointly with Occupational Health which describe Standard Precautions and safe handling of sharps, to prevent the spread of healthcare associated infections (HCAI) and blood exposure incidents in staff, and to describe the procedures to follow if preventive measures fail
- promote the correct precautions to prevent the spread of HCAI and blood exposure incidents
- provide learning materials, including e-learning, which reinforce the practices and precautions discussed in this policy
- respond to queries and advise in specific circumstances

- influence decisions to provide medical devices that incorporate sharps protection
- provide feedback on practices observed in clinical areas, particularly if these are not consistent with the practices and precautions discussed in this policy
- review and audit compliance against elements within this policy

4.11 Infection Prevention and Control Link Representatives

Infection prevention and control link representatives are responsible for disseminating all relevant infection prevention and control information to staff within their own work environment, supporting the IPCT within their own ward/ department.

5.0 APPROVAL

Following appropriate consultation this policy (v3.0) has been approved by the Trust's Infection Prevention and Control Committee.

6.0 DOCUMENT REQUIREMENTS (NARRATIVE)

Blood-borne viruses (BBVs) are viruses that some people carry in their blood and which may cause severe disease in certain people but few or no symptoms in others (HSE 2012). The virus can spread to another person, whether the carrier of the virus is ill or not. The main BBVs of concern are:

- Hepatitis B virus, hepatitis C virus and hepatitis D virus which all cause hepatitis
- Human Immunodeficiency Virus which causes Acquired Immune Deficiency Syndrome (AIDS)

These viruses can also be found in body fluids other than blood, for example, semen, vaginal secretions and breast milk. Other body fluids or materials such as urine, faeces, saliva, sputum, sweat, tears and vomit carry a minimal risk of BBV infection, unless they are contaminated with blood. Care should still be taken as the presence of blood is not always obvious.

The transmission of blood-borne viruses, from patient-to-patient, or patient to healthcare staff, can have serious consequences not only for the person infected but also for the Trust because of Health and Safety legislation. Despite guidance and education, many healthcare staff continue to be exposed to blood-borne viruses from needle-stick, sharp injuries and mucosal exposures.

Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV) are all BBVs. These viruses can be transmitted when a needle or sharp object contaminated with infected blood or body fluid penetrates the skin or through the mucosa. These viruses can also be contracted through sexual contact with an infected person because of its presence in semen and saliva (DH 2000). There is no evidence that these infections can occur through social contact such as shaking hands, sharing telephones or other office equipment.

The outcome of these infections depends on the particular virus'; HIV can progress to AIDS; hepatitis B and C infections may clear up completely or lead to a chronic carrier status, which can progress to cirrhosis of the liver.

Please note: not all patients with BBVs may have had their infections diagnosed. Therefore it is important that all blood and body fluids, including tissues are regarded as potentially infectious. Healthcare workers must follow standard precautions routinely in all circumstances to avoid contact with blood and body fluids.

6.1 Legislation

In addition to the need to reduce the risk of infection there are legal duties to protect the patients, staff and visitors from harm:

- **Health and Safety at Work Act 1974:** the primary piece of legislation covering occupational health and safety in the United Kingdom (UK). It places a duty on employers to provide a safe place of work and protect the health and safety of both their employees and anyone who may be affected by their work activities. There is a legal obligation to ensure that all their employees are appropriately trained in the procedures necessary for working safely. All employees have a legal duty to take reasonable care of themselves and others, and to co-operate with their employer and follow policies and guidelines so that they and others are not exposed.

- **Management of Health and Safety at Work Regulations 1999:** employers have a legal duty to protect the health of their employees and anyone else who may be affected or who may be on the premises at any time. These regulations list the responsibilities of employers in all general aspects of health and safety management.

- **Control of Substances Hazardous to Health Regulations 2002 (COSHH):** this legislation covers pathogenic microorganisms as hazards, and is the main legislation relevant to controlling the workplace risks of exposure to BBVs. However employers also have health and safety responsibilities under other regulations that overlap with COSHH. A risk assessment and instruction on how to avoid contact, or lower the risk of infection as far as is reasonably practicable for employees and others affected, is required. In addition to the responsibilities under the management of health and safety at work regulations 1999, employers are legally required to keep health records in relation to work involving risk of exposure to blood borne viruses under COSHH regulation 11 (3).

- **Reporting of Injuries, Disease and Dangerous Occurrences Regulations 1995 (RIDDOR):** employers are legally required to report any infections and dangerous occurrences with biological agents at work under this Act.

- **HIV post exposure prophylaxis (PEP):** Public Health England (PHE) PEP guidance is to be applied to healthcare staff who are occupationally exposed to material which is known to be, or has the potential to be, a source of HIV infection.

Healthcare staff must not display negative attitudes or fears when caring for patients with a blood-borne infection; these patients must be cared for in the normal way.

6.2 Notification

Viral (infectious) hepatitis is a statutory notifiable infectious disease. The doctor in charge of the patient's care has a duty to notify the proper officer of the local authority as soon as possible (the consultant in communicable disease control (CCDC) at Public Health England (PHE)).

6.3 Confidentiality

For all patients and staff with a blood borne infection the normal rule of medical confidentiality applies. Personal health data relating to the individual must not be disclosed without their agreement to anyone for any purposes other than the healthcare of the individual. Adequate safeguards to protect against unauthorised disclosure must be adopted. Only in exceptional circumstances can confidentiality be breached e.g. infected healthcare staff continuing to undertake exposure prone procedures or seizure of medical records by court order. Consequently, patients should also be advised that confidentiality is not absolute and that doctors may be legally bound to disclose HIV status information.

Should a patient be exposed to blood from an infected healthcare member of staff, the incident must be managed without revealing which member of the clinical team is infected. When a **known** infected patient is admitted to a ward, the clinician looking after the patient should only inform those nursing and medical colleagues who need to know in order to provide the necessary counselling, support and clinical care. Other staff do not need to know a patient has a BBV.

6.4 Hepatitis viruses

Hepatitis is inflammation of the liver; several viruses have been identified as causative agents of hepatitis, the most important of which are hepatitis A, B, C, D and E. Hepatitis A and E are mainly spread via the faecal-oral route and do not induce a carrier state and do not present a significant risk of blood-borne infection.

6.4.1 Hepatitis B:

HBV has a very low prevalence in the United Kingdom but is more frequently found in low-and middle-income countries where children often acquire the infection from their mother; it is an international public health challenge comparable to HIV, malaria and tuberculosis. Since 2017, hepatitis B vaccine has been part of the UK routine childhood immunisation programme.

The clinical course of HBV infection is variable and unpredictable, ranging from subclinical cases to fulminant hepatitis and death. HBV surface antigen may be found in blood and virtually all body fluids of patients with acute hepatitis B and carriers of the virus, but blood, semen and vaginal fluids are mainly implicated in the spread of HBV infection. Transmission usually occurs:

- by unprotected sexual intercourse

- by people who inject drugs sharing blood contaminated injecting equipment
- perinatally from an infected mother to her baby

Up to 90% of babies infected perinatally, and around 5% of those infected as adults, develop chronic carrier status.

Acute infection follows a variable incubation period from 6 weeks to 6 months. Symptoms that may present include: malaise, nausea, loss of appetite, abdominal discomfort, joint pains, dark urine, clay coloured stools and jaundice. The recovery period may take up to 6 months and some people experience post viral depression and fatigue.

Sub-clinical infection: Most people experience no symptoms or at worst a feeling of fatigue, malaise or unaccountable depression. However, they are still infectious and may be more likely to become chronic carriers. The infection may go undetected.

Chronic infection (carrier status) occurs when the virus surface antigen is still detectable in the blood after 6 months. Chronic carriers are potentially infectious to others. The risk of chronic carriage may increase when there is impaired immunity. There is also a likelihood of progression to permanent liver damage and other serious liver disorders e.g. cirrhosis or liver cancer.

Diagnosis is confirmed by detection of the antigens or their antibodies. The precise mix of antigen/antibody detected will vary according to the state of infection

Patients who are pregnant: Routine booking antenatal screening includes Hepatitis B screening. If found to be HBV surface antigen positive, patients will be counselled and offered hepatitis B vaccine and hepatitis B immunoglobulin for their babies as appropriate. There are no contra-indications to breastfeeding of babies born from hepatitis B carriers when immunisation is given at birth and proceeds with a complete course of immunisation (Refer to Maternity protocol).

6.4.2 Hepatitis C

Hepatitis C (HCV) is the main cause of hepatitis previously referred to as parenterally transmit non-A, non-B hepatitis (post-transfusion hepatitis). HCV is predominantly blood borne and routine screening of blood donors was introduced to prevent transmission. Up to 42% of injecting intravenous drug users are hepatitis C antibody positive. Both sexual and perinatal transmission can occur but in general these are less efficient modes of transmission. The incubation period ranges from 2 weeks to 6 months, and the acute phase of hepatitis C is often asymptomatic or mild. If it proceeds to chronic disease, progress is usually slow and the most common complaint is fatigue. It is estimated that 80% of infected persons develop chronic infection, of whom 70% develop chronic liver disease with a risk of progression to cirrhosis or cancer.

Diagnosis: Serological tests are available which mostly become positive within 6 months of exposure. PCR may need to be carried out to confirm diagnosis. Antibody positive indicates current or previous infection; HCV RNA positive indicates active replication.

Patients who are pregnant: The transmission of hepatitis C through breast milk has not been documented. There appears to be no evidence to suggest that breast feeding will increase the incidence of transmission to the baby except in the case of cracked nipples. The incidence of transmission during birth is relatively low at 4%.

6.4.3 Hepatitis D

Hepatitis D (HDV) was previously known as Delta agent and is a defective virus, which requires the present of HBV to allow it to replicate. Therefore, HDV only occurs in people who already have HBV or in people who acquire both viruses simultaneously. Acute Hepatitis caused by HDV is usually severe and patients with the double infection usually develop rapidly progressive disease. HDV infection can occur either as co-infection with HBV or as super infection of an HBV carrier.

Immunisation: since HDV depends on an HBV infected host for replication, prevention of HBV infection by immunisation will also prevent HDV infection.

6.5 Human immunodeficiency virus

Human immunodeficiency virus (HIV) is a retrovirus which interferes with the body's immune response to infection and malignancy. It has been isolated from blood, semen, vaginal secretions, saliva, tears, urine, breast milk, cerebrospinal fluid, synovial fluid and amniotic fluids. However, only blood, blood products, semen, vaginal secretions, donor organs and tissues and breast milk have been implicated in the transmission of infection. There is no evidence that HIV is spread by close social contact even when this is prolonged, as in a family setting. Although HIV transmission may occur in healthcare settings, most HIV transmission occurs:

- by unprotected penetrative sexual intercourse with an infected person (between men or between men and woman)
- by inoculation of infected blood - at present in the UK this results mainly from drug users sharing blood contaminated injecting equipment
- from an infected mother to her baby before or during birth or through breast feeding

A person infected with HIV may experience an initial acute illness followed by a period in which there are no clinical features, although antibodies to the virus can be detected in the blood. People with HIV infection may remain well for several years. As the immune system becomes increasingly impaired so the chances of opportunistic infections and tumours are increased.

AIDS is diagnosed when a person with HIV infection is found to be suffering from one or more of a number of specific diseases. These diseases include Pneumocystis Carinii Pneumonia (PCP), certain cancers e.g. Kaposi's sarcoma, and conditions thought to be due to the direct effect of HIV e.g. HIV encephalopathy.

HIV test: The HIV test is not a test for AIDS; it is a blood test to detect antibodies that are made once the body has been infected with HIV. Antibodies are normally detectable within 12 weeks of exposure however a negative test does not necessarily exclude exposure to HIV as antibodies can take up to 6 months to appear (window period). Therefore a person can be recently infected by HIV and have a negative result but still be capable of transmitting HIV to another person. A positive result means that antibodies to HIV were detected and therefore an infection has occurred at some point; this means that they are infectious and could pass the virus to other people via blood or body fluids (the virus cannot be passed on by normal everyday contact).

Patients who are pregnant: Routine booking antenatal screening includes HIV screening.

Pre and post-test discussions: These are essential both before the test to inform the individual of the nature and meaning of the test and the possible implications, and after the test to reassure and for aftercare as appropriate regardless of whether the test is positive or negative.

6.6 Specimens

Care must also be taken to ensure that the outside of the container and bag remain free from contamination with blood. Samples must be taken to the laboratory by hand; the pneumatic tube system **must not** be used.

6.7 Infection prevention and control guidelines

For admissions of an emergency patient with suspected or confirmed BBV inform the Infection Prevention and Control Team (IPCT) as soon as possible. Elective admission; inform the IPCT on or prior to the patient's admission. For out-patient department appointments, or visits to department, there is no requirement to inform the IPCT unless a specific procedure is going to be carried out that would increase the risk of transmission of a BBV.

Standard principles: all blood and body fluids are potentially infectious, precautions are necessary to prevent exposure to them. These routine procedures are referred to as 'Standard Precautions for Infection Prevention and Control'. Each member of staff is accountable for their actions and must follow safe practices. Key points to minimise infection include:

- All patients potentially present a risk of infection, therefore all blood and body fluids must be treated as infectious. When handling blood or body fluids staff must be careful to avoid spillages
- Effective hand washing using soap and water or alcohol-based hand-rub
- Exercise great care with all sharps to prevent puncture wounds, cuts or abrasions

- When using sharps, exercise particular care in handling and disposal, only use approved sharps containers, dispose of sharps at the point of use, never put needles or other sharps into hazardous or household waste stream and never re-sheath needles
- Protect existing wounds, skin rashes or lesions, conjunctivae (eye) and mucosal surfaces from all blood and body fluids
- Control surface contamination by blood and body fluids by containment and disinfection immediately following contamination
- Appropriate protective clothing (gloves/aprons and goggles/visors where needed) must be available for use at all times and must be worn whenever there is a risk of contamination with blood or body fluids. Remove of all PPE must be followed by hand washing
- All body fluids/tissues, including breast milk, should be handled the same precautions as for blood

Patients with simple chronic or acute hepatitis B, C or HIV infection do not require routine isolation.

6.8 Deceased patient

The body **must** be placed in a cadaver bag and a 'Danger of Infection' sticker attached to the outside of the bag. The appropriate information must be secured on the outside of the cadaver bag for mortuary staff protection.

6.9 Occupational risk

The risk of transmission of BBVs is much greater from patients to healthcare staff than from healthcare staff to patients. The risk to healthcare staff for each virus is proportional to the prevalence of that infection in the population served, the infectious status of the individual source patient, which may or may not be known, and the risk of a significant occupational exposure occurring during the procedures undertaken, as well as the transmissibility of the virus in question. In the healthcare setting transmission most commonly occurs after percutaneous exposure to a patient's blood by a sharp injury. Occupational transmission of BBVs arises from the exposure to blood or other body fluids or tissue contaminated with blood from infected patients. Semen and breast milk may pose a risk of infection but exposure to these body fluids is rare in most healthcare settings.

Advice to be followed in the event of a reverse needle-stick injury occurrence is available on the Occupational Health intranet site. This could be a patient or visitor at risk from exposure to body fluids from a member of staff or other source.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Use of personal protective equipment	IPCT	Audit	Quarterly	IPCC
Compliance with access to spill kits	Facilities Management	Joint Monitoring Audits	Annually	IPCC

8.0 TRAINING AND IMPLEMENTATION

Training and education in the process of pathogen control, disinfection and hygiene (including hand hygiene, exposure to blood borne viruses, and health and safety, and infection risk reduction (including waste disposal) will be part of staff induction/mandatory programmes and attendance will be recorded in staff training records.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix A
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

Advisory Committee on Dangerous Pathogens. 2008. *Protection against blood borne infections in the workplace: HIV and Hepatitis.* HMSO. London. https://www.hse.gov.uk/biosafety/blood-borne-viruses/health-care.htm Accessed Feb 2021

Health and Safety Executive. *Blood – borne viruses in the workplace – guidance for employers and employees* http://www.hse.gov.uk/pubns/indg342.pdf Accessed February 2021

DH. 2015. *The Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. At https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance* Accessed Feb 2021

DH. 2017. *Immunisation against infectious disease. The Green Book. Chapt 18. HBV https://www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18* Accessed February 2021

Loveday et al 2014. *Epic 3 National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England.* Journal of Hospital Infection

NHS Executive: 2000. *Hepatitis B infected healthcare workers: Health Service Circular HSC 2000/020*

NHS Executive: 2000. *Hepatitis B infected healthcare workers: Guidance on implementation of Health Service Circular HSC 2000/020*

DH. 2007. *Hepatitis B infected healthcare workers and antiviral therapy.* London

DH. 1998. *Guidance for clinical healthcare workers: protection against infection with blood borne viruses.* Accessed via https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/382184/clinical_health_care_workers_infection_blood-borne_viruses.pdf Accessed February 2021

PHE 2008 (updated 2020) *Immunoglobulin. When to use.* https://www.gov.uk/government/publications/immunoglobulin-when-to-use Accessed February

Health and Safety. *Blood-borne viruses in the workplace. Guidance for employers and employees.* Leaflet INDG342 Accessed via https://www.hse.gov.uk/pubns/indg342.pdf February 2021

Health and Safety at Work Act 1974.

Management of Health and Safety at Work Regulations 1999.

Control of Substances Hazardous to Health regulations 2002.

Reporting of Injuries, Disease and Dangerous Occurrences regulations 1995.

PHE EAGA guidance on HIV post-exposure prophylaxis at https://www.gov.uk/government/publications/eaga-guidance-on-hiv-post-exposure-prophylaxis Accessed February 2021

DH 2008 *HIV post exposure prophylaxis guidance*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/203139/HIV_post-exposure_prophylaxis.pdf Accessed February 2021

Recommendation for HIV post-exposure prophylaxis (PEP) following occupational exposure to a source with undetectable HIV viral load https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/275060/EAGA_advice_on_PEP_after_exposure_to_UD_source_Dec13.pdf

Change to recommended regimen for post-exposure prophylaxis (PEP) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/351633/Change_to_recommended_regimen_for_PEP_starter_pack_final.pdf Accessed February 2021

Related SFHFT Documents:

- Other relevant infection, prevention and control policies/ procedures as applicable

11.0 KEYWORDS

Hepatitis; HIV, needle-stick

12.0 APPENDICES

Appendix A – Equality Impact Assessment Form (EQIA)

APPENDIX A – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: BBV Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 06/02/2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	None	None
Gender:	None	None	None
Age:	None	None	None
Religion:	None	None	None
Disability:	None	None	None
Sexuality:	None	None	None
Pregnancy and Maternity:	None	None	None
Gender Reassignment:	None	None	None
Marriage and Civil Partnership:	None	None	None
Socio-Economic Factors (i.e. living in a poorer	None	None	None

neighbourhood / social deprivation):			

What consultation with protected characteristic groups including patient groups have you carried out? •
What data or information did you use in support of this EqIA? •
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? • NO

<u>Level of impact</u>
From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Sally Palmer
Signature:
Date:06/02/2021