Worcestershire Acute Hospitals NHS Trust

INOCULATION INCIDENT PROTOCOL

(including Needlestick Injuries and Human Bites)

This guidance does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and / or carer. Healthcare professionals must be prepared to justify any deviation from this guidance.

Introduction

This protocol is designed to give guidance to manage inoculation injuries to any member of staff, patient or visitor on all sites of the Worcestershire Acute Hospitals Trust following charted risk assessment procedures.

This Protocol Is For Use by All Staff Groups

Lead Clinician(s)

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Approved by Trust Infection Prevention & Control Committee:	19th December 2018
Review Date:	19th December 2020

This is the most current version of the document and should be used until a revised version is available

Key amendments made to this document:

Date	Amendment	By
July 2010	D2.6.2 regarding consent for HIV testing D2.4.8 changes to testing regime D2.7.2 and D2.7.5 changes to PEP regime Other small alterations to text to align with WAHT-CG-003 Removal of reference to paper incident reporting and substitution of Datix in paras D2.2.7, D2.3.5 and D2.4.10	Dr Anne Dyas
July 2010	Approved by Trust Medicines Safety Committee	
April 2012	Full review	All contributors
18 June 2012	Approval by Trustwide Infection Prevention and Control Committee	
Jan 2013	Minor amendments to comply with NHSLA Approval by Trustwide Infection Prevention and Control Committee 21/01/2013	A Dyas
May 2014	Reviewed, procedure after PEP administration amended	A Dyas
October 2014	Changes to PEP regimen	Tina Evans
November 2016	Documents extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
November 2017	Document extended whilst under review	TLG

January 2018	Change wording of 'expiry date' on front page to the sentence added in at the request of the Coroner	
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
October 2018	Document extended until end of November	Heather Gentry
December 2018	Clinical content current, approved for two years	TIPCC

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1. Introduction

This protocol applies following an inoculation / skin piercing incident to Worcestershire Acute Hospitals NHS Trust staff and contractors, but is also **applicable to any incident involving the risk of transmission of blood borne viruses**. The aim of the protocol is to ensure that risks of occupational / non-occupational exposure and transmission of blood borne virus infection are minimised. For this purpose action to be taken by the member of staff, the Occupational Health Departments, the ED / MIU Departments, the Pathology Department and clinical staff are described. It should be read in conjunction with the Policy for the Prevention of Inoculation Incidents WAHT-CG-003.

Definition of an inoculation incident:

"a needlestick, cut or puncture or traumatic injury to the skin with any used sharp instrument, or contamination of mucous membranes, conjunctiva or uncovered broken skin with blood or blood stained body fluid. Other body fluids which may or may not be blood stained should also be regarded as potentially infectious", eg

- CSF
- peritoneal fluid
- pleural fluid
- pericardial fluid
- synovial fluid
- amniotic fluid
- unfixed tissues and organs
- semen / vaginal secretions
- saliva (dentistry)

Organisms involved:

Several infections may be transmitted via inoculation injury, the most important being HIV, Hepatitis B and Hepatitis C. The relative risk of acquiring these infections varies with each agent and the type and degree of inoculation accident that occurs. It is also very likely that there are other infections as yet not discovered or fully characterised which may be spread via the blood borne route.

It is the individual member of staff's responsibility to prevent such incidents where possible by following infection prevention and control measures and using the personal protective equipment provided.

It is the ward / departmental manager's responsibility to ensure that there is adequate provision of appropriate personal protective equipment and access to the relevant protocols, policies and procedures to reduce the risk of exposure occurring.

The prevention of inoculation accidents is always preferable to dealing with an incident once it has occurred. Ways of avoiding injury include:

- application of good basic hygiene practice with regular hand washing / gelling
- taking measures to avoid contamination of clothing, linen, and skin with blood or body fluids
- protecting existing wounds or skin lesions with a waterproof dressing and protecting the mucous membranes of the eyes, mouth and nose from blood splashes

- preventing puncture wounds, cuts and abrasions in the presence of blood
- avoid using sharps wherever possible
- if you use sharps, to avoid injury :
    - always carry them in a tray
    - do not pass from hand to hand
    - do not guide needles with fingers
    - do not re-sheath needles
    - use sharp safe needle devices or needleless blood collection systems wherever possible
    - dispose of all sharps safely into approved containers

      Single use items, eg needles, scalpel blades, stitch cutters, intravenous cannulae, lumbar puncture needles: discard into an approved sharps container (do not overfill) **– do not rely on others to do this for you.**

      Reusable items, eg trocars, bone marrow needles: place into tray provided in pack and return to TSSU / HSDU in a biohazard bag. Surgical drapes should be checked to ensure no sharps are present prior to being folded for return to TSSU / HSDU.
    - do not send needles attached to syringes to the laboratory
- clean up spillages of blood and other body fluids promptly (see General Decontamination ProtocolINF-009

It is your duty to protect yourself and others from inoculation injuries.
Care should always be taken to minimise the risk of needlestick type injuries. All staff should ensure that used needles are placed in approved sharps containers. No attempts should be made to re-sheath needles before discarding them and where needles are required to be removed from a syringe, an appropriate device should be used, eg on sharps bin. Sharps boxes must not be overfilled and should be replaced when ¾ full.

All those involved in the management of inoculation injuries, skin or mucous membrane exposure with blood, or body fluids contaminated with blood, should follow the procedure outlined in the following protocol.

2. Action to be taken by member of staff when an inoculation incident occurs

2.1 Encourage the wound to bleed

2.2 Do **not** suck the wound

2.3 Wash thoroughly with soap and water (do **not** use alcohol alone)

2.4 Cover with a sterile waterproof dressing if appropriate

2.5 Note name and diagnosis of source patient involved, if known

2.6 Report incident to manager or senior member of staff present, in order that a risk assessment of the source patient can be undertaken.

2.7 Ensure completion of an electronic incident report using the online system, Datix.

2.8 Immediately following the incident **contact the Department of Occupational Health** on:

2.8.1 Outside Direct Dial: (01905) 760693
2.8.2 Internal Extensions: 34752

Out of hours only, ie evenings, weekends and public holidays the member of staff should attend their nearest ED Department or MIU.

NB: It is the responsibility of every member of staff to know their Hepatitis B immune status, so that in the event of an inoculation injury they will be able to give this information to the ED or MIU staff treating them.

2.9 There is a leaflet available for staff, 'Blood contamination incident' (Appendix 10) which you may find helpful

3. Action to be taken by Manager / Senior Member of Staff

NB: If you are the manager of a healthcare worker from either professions allied to medicine (eg physiotherapy, radiography and occupational therapy), or support services (eg porters, catering and TSSU) who has had an inoculation incident, you must contact the senior nurse on duty in the ward / area where the incident occurred and verify they have undertaken a risk assessment of the source patient.

3.1 Ensure that member of staff has received appropriate first aid treatment, including referral to the Occupational Health or ED / MIU Department.

3.2 Ensure an initial assessment is undertaken of risk of Hepatitis B, Hepatitis C or HIV infection in the source person (Appendices 2 and 8). But see introductory paragraph above. The risk assessment must be documented in the patient notes. It should be explained to the patient that investigation for all these viruses is routine after an inoculation incident.

3.3 The patient's clinical team must be contacted as a priority to take a blood sample from the source patient, with consent, for serological testing for Hepatitis B, C and HIV. Consent must be obtained, and the request form must specifically mention HIV, and bear a legible signature.

3.4 Notify the ED doctor, Emergency Nurse Practitioner or Occupational Health Adviser treating the injured member of staff of the risk assessment outcome immediately.

3.5 Ensure an Incident Report is completed on Datix. This will initiate an investigation, to be carried out be the manager of the member of staff.

3.6. Ensure that all action taken is recorded in the source patient's medical notes and on the form in this protocol, 'Record of Action Taken' (Appendix 1). A/e departments have their own record form (Appendix 2). This form should then be sent to Occupational Health, within one working day. The following details should be noted (see introduction above):

- a brief description of the incident,
- identity of the injured member of staff
- source patient risk assessment undertaken and record either no risk identified or clinical team notified for further assessment.

Example entry for source patient's medical records:
Today's date and time

"Staff Nurse Joanne Bloggs sustained an inoculation injury to her left hand when administering Mrs Smith's insulin injection. Patient risk assessment undertaken, Dr Jones bleeped at 18.00 hrs to bleed patient for Hepatitis B Hepatitis C and HIV status test."

Your signature, print your name and job title

3.7 If the source patient is unknown:

3.7.1 Ensure a risk assessment of the likelihood of a high risk source for Hepatitis B, C or HIV is undertaken (see introduction above).

3.7.2 Treat as potential for Hepatitis B and Hepatitis C transmission, ensure appropriate follow-up of member of staff (refer to 4.). It may occasionally be necessary to investigate for HIV also, in these circumstances.

4. Action to be taken by the Occupational Health Department

4.1 Obtain detailed history of incident, using the risk assessment guide and a proforma record. ("Record of Action Taken" – Appendix 1).

4.2 Record clearly in the Occupational Health notes the factors that lead to the risk assessment conclusion.

4.3 Arrange follow-up as below for Hepatitis B, Hepatitis C or HIV infection.

4.4 Counsel employee regarding level of risk, taking into account employee's immunisation status.

4.5 Blood should be taken from the exposed member of staff / other person and sent to the Microbiology Department, labelled ***"(Staff) inoculation incident – for storage",*** **ensuring the name of the source of injury (this may be a patient, member of staff, or other person) is clearly stated on the pathology request form under clinical details. Please also state if source is not known.**

4.6 It should be noted that staff or other persons have the right to refuse this test; if they choose to do so, and if appropriate their occupational health / clinical notes should record that they have been counselled, and have declined to have blood taken.

4.7 Check member of staff's / exposed person's Hepatitis B immunisation record. If necessary give Hepatitis B vaccine booster **(a single booster dose should be offered to all fully immunised individuals, 5 years after completion of the primary course)**, commence accelerated vaccine course and / or give immunoglobulin as appropriate. **If source is known or found to be Hepatitis B sAg positive** management will depend on immunisation status of

exposed person (see Table below, from Immunisation against Infectious Disease 2006))

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

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

samples from member of staff / exposed person: EDTA blood sample for PCR at 6 and 12 weeks and clotted blood sample at 12 and 24 weeks for anti-HCV antibody testing.

4.9 **If source is unknown** treat as a potential for Hepatitis C, Hepatitis B and HIV transmission at time of injury, risk will depend on the circumstances of the injury. The risk where injury occurs as a result of needles discarded in the community containing old dried blood is significantly lower than incidents involving fresh blood. Arrange future samples from member of staff / exposed person, as appropriate: EDTA sample for Hepatitis C PCR and clotted sample for HIV combined antigen/antibody testing at 6 weeks and clotted blood sample for anti-HCV and anti HIV antibody testing at 12 and 24 weeks. The risk of Hepatitis B transmission should also be considered (see 4.7 above).

4.10 **If source patient known or strongly suspected to be HIV positive**, post exposure prophylaxis (PEP) should be considered (see below). Follow-up serology will be co-ordinated via Sexual Health Services. The source patient should be referred to the Genito-urinary medicine clinic. Contact details must be obtained from the patient and referral will be made on the next working day by one of the consultant microbiologists.

4.11 Ask if an Incident Report has been completed using the electronic risk reporting system, Datix.

4.12 If appropriate, take the opportunity to address issues of safe practice and avoidance of such incidents and the use of personal protective equipment.

5. Action to be taken in ed departments (redditch & worcester) and the minor injuries unit (kidderminster)

ALL INOCULATION INJURY / BODY FLUID CONTAMINATION INCIDENTS WILL REQUIRE IMMEDIATE ASSESSMENT and should be fast tracked for assessment, as treatment may need to be instigated within a very short period of time.

5.1 Obtain detailed history of incident and record. Suitable documentation is included at Appendix 1 and Appendix 2a (ED proforma).

5.2 Record clearly in the notes the factors that lead to the risk assessment conclusion.

5.3 Arrange follow-up as below for Hepatitis B, Hepatitis C or HIV infection. **For members of staff, this can be organised through OHD. For members of the public, GP referral is appropriate.**

5.4 If in ED, send record of event to OHD by FAX (Appendix 2b and 2c)

5.5 Counsel exposed member of staff / other person regarding level of risk, taking into account immunisation status.

5.6 Blood should be taken from the exposed member of staff / other person and sent to the Microbiology Department, labelled ***"(Staff) inoculation injury – for storage",*** **ensuring the name of the source of injury (this may be a patient, member of staff, or other person) is clearly stated on the pathology request form under clinical details. Please also state if source is not known.** It should be noted that staff or other persons have the right to refuse this test; if they choose to do so, and if appropriate their occupational health / clinical notes should record that they have been counselled, and have declined to have blood taken.

5.7 Check member of staff's / exposed person's Hepatitis B immunisation record. If necessary give Hepatitis B vaccine booster, commence accelerated vaccine course and / or give immunoglobulin as appropriate. **If source is known or found to be Hepatitis B sAg positive** management will depend on immunisation status of exposed person (see Table in **D2.4**).

5.8 If appropriate, take the opportunity to address issues of safe practice and avoidance of such incidents and the use of personal protective equipment.

5.9 Advise the member of staff / exposed person to notify their Occupational Health Department (OHD) of their injury themselves on the next working day or to leave their details on the OHD answer phone. This enables the OHD to ensure that the appropriate course of action has been taken promptly.

5.10 Give staff/patient information leaflet (Appendix 10)

5.11 **If a significant risk of possible HIV infection is identified** via the risk assessment of the source, the circumstances (where source unknown) and type of exposure (Appendix 1 and 3), the on-call designated person (see box "Designated Persons" below) **MUST** be contacted

IMMEDIATELY for advice on the appropriate course of treatment / action to be taken. For the MIU also see point 12 below.

Community inoculation injuries with discarded sharps are low risk for HIV transmission.

DESIGNATED PERSON:-

On call Consultant Medical Microbiologist

contacted via Switchboard

5.12 When post exposure prophylaxis (PEP) against HIV is recommended, it should be administered within 1 to 2 hours of exposure if possible, although it should also be considered up to 2 weeks after the exposure (Appendices 4 & 6).

NB: A pregnancy test should be performed for all females if pregnancy is possible and PEP is to be considered.

5.13 Support, information and follow-up will be made available to the member of staff/ exposed person through the Genito-urinary medicine service; the HIV / Sexual Health Nurse Specialist should be notified if PEP issued – (Appendices 3 & 5). Referral will be made on the next working day by one of the consultant microbiologists.

5.14 Appendix 1(a) should be completed to record any telephone instructions given by the Microbiology / GU Medicine / Infectious Diseases Consultant who has requested PEP be administered. This will enable nursing staff to be able to dispense and administer PEP treatment in the absence of medical staff, eg Minor Injuries Unit, Kidderminster.

Information required will include:

- Injured person's details including any current medication or herbal supplements and serious illness resulting in renal and / or liver impairment
- Ward or department
- Source person ID if known
- Date and time of telephone contact with **and**
- the name of Consultant Microbiologist / GU Medicine / Infectious Diseases requesting PEP
- Record full and accurate details of the conversation held, including information given to the Microbiology / GU Medicine / Infectious Diseases Consultant and their recommended course of action.
- Record full and accurate details of PEP prescription including each drug's name and dosage.

The Microbiology / GU Medicine / Infectious Diseases Consultant will confirm their prescription by sending a fax or hard copy of the completed and signed standard letter (Appendix 7) **within 48 hours**, to ED / Minor Injuries Unit, Kidderminster / Occupational Health Department.

6. Action To Be Taken By Clinical Staff (Doctor) Involved In The Care Of The Source Patient Where A Blood Borne Virus Risk Has Been Identified

6.1 **Undertake further assessment of the source patient to confirm if there are** specific risk factors for potential infection with a blood borne virus (refer to Appendices 2 and 8).

6.2 Obtain a **minimum** 10 ml sample of clotted blood following verbal consent from the source patient for routine testing for evidence of Hepatitis B, Hepatitis C and HIV infection. These **MUST** be requested on the form to allow the laboratory staff to process the specimen, and the form **MUST** be signed by the requesting doctor. Document action taken in the source patient's notes. The source patient's consent for a blood sample should be obtained at all times. If the patient is unconscious when the injury occurs consent should be sought once the patient has regained full consciousness.

6.3 If the patient refuses testing, is unable to give or withholds consent because of mental illness or disability, advice should be sought from a medical consultant in Microbiology, Infectious diseases, GU medicine or Occupational medicine.

6.4 If appropriate the injured person can take prophylactic treatment until consent has been obtained and the result is known or a detailed assessment of the severity of the health risk can be undertaken with input from appropriate specialists.

6.5 The specimen should then be sent to the Microbiology Laboratory for testing and storage. Ensure the name of the injured member of staff / individual is clearly stated on the specimen form under the clinical details section.

6.6 If the source patient is unable or refuses to give verbal consent to testing for blood borne virus infection (for whatever reason), the doctor treating the patient should notify their ED colleague treating the member of staff. The guidance offered in *Serious Communicable Diseases* issued by the General Medical Council should then be considered. The on-call Microbiology / GU Medicine / Infectious Diseases Consultant will be able to assist in making a decision as to how important it is to obtain a blood sample in this instance.

6.7 **NB: If the healthcare worker sustaining the injury is one of the clinical staff (doctor) involved in the care of the source patient, it is preferable the above action is taken by a colleague.**

7. Action to be taken by the Laboratory

7.1 Any specimen received for investigation following needlestick accident should be given the code NSI

7.2 All specimens requesting storage following NSI should be retained for at least 6 months.

8. Audit Mechanism

A monitoring group, comprising Occupational Health, Health and Safety and Infection Prevention and Control staff will meet monthly to review incidents, and will report on a quarterly basis to the Trust-wide Infection Prevention and Control Committee. The Infection

Prevention and Control Team will monitor copies of Incident Forms for evidence of trends in practice and provide appropriate training or advice including improving the uptake of safe sharps devices across the Trust. An audit of practice is conducted, using a bespoke audit tool, at least every three years, by the lead CMM for infection prevention, or to whom it is delegated. The results are reported to the Trustwide Infection Prevention and Control Committee when available.

9. Training

Training in the management of inoculation incidents is included at induction and ongoing training for all appropriate levels of staff.

10. References

- Department of Health (1998). Guidance for clinical healthcare workers: Protection Against Infection with Blood-borne Viruses. Recommendations of the expert advisory group on AIDS and the advisory group on Hepatitis paragraph 5: 30-37.
- General Medical Council (1998). Protecting patients, guiding doctors - Serious communicable diseases: Pages 4-5. General Medical Council, London. update
- Department of Health (1997). Guidance on post-exposure prophylaxis for healthcare workers occupationally exposed to HIV. PL/CO(97)1 Department of Health, London.
- Department of Health (1995). Guidance on the control of infection in hospitals. Prepared by the joint DH / PHLS Hospital Infection Working HSG(95)10.
- Royal College of Nursing (2001). Be sharp be safe. RCN, London.
- Department of Health (2004). HIV Post-Exposure prophylaxis: Guidance from the UK Chief Medical Officer's Expert Advisory Group on AIDS
- Department of Health (2008) HIV post-exposure prophylaxis Guidance from the UK
- Chief Medical Officers' Expert Advisory Group on AIDS
- Department of Health (2006) Immunisation against Infectious Disease – 2006 edition
- National Public Health Service for Wales (2006). All-Wales inoculation injury guidelines for primary care.
- British HIV Association Guidelines for the management of HIV infection in pregnant women 2012

11. Appendices

APPENDIX 1

Strictly confidential

Inoculation injury – record of action taken

EXPOSED PERSON:

NAME .... Date of Birth.....

ADDRESS ……..…..

……..

JOB TITLE (if appropriate) ……..……..……

SITE / WARD / DEPARTMENT (if appropriate) …….....

HEPATITIS B STATUS .....…….....

If known;

SOURCE PERSON:

NAME .... Date of Birth.....

RISK ASSESSMENT – please delete those not relevant

Type of injury:
1) Percutaneous injury (from needles, instruments, bone fragments, human bites, etc)
2) Exposure of broken skin (abrasions, cuts, eczema, etc)
3) Exposure of mucous membranes including the conjunctivae of the eye

Comments / description of how injury occurred

.....…….....

.....…….....

High risk body fluid involved (circle):
Blood
Amniotic fluid
Vaginal secretion, semen
Human breast milk
Cerebral spinal fluid
Peritoneal fluid
Pleural fluid
Pericardial fluid
Synovial fluid
Saliva in association with dentistry
Unfixed tissues and organs

Low risk fluids involved (circle):
Urine ***) These should be***
Vomit ***) considered as high risk***
Saliva ***) if they are visibly***
Faeces ***) contaminated with blood***

Continue to 2nd page

Appendix 1 continued

Record of Action Taken –

ED Department / MIU to complete relevant sections only or use dedicated A/E record form (Appendix 2)

EXPOSED PERSON:

NAME ..... Date of Birth …….....

1. Consent obtained for HBV / HCV / HIV testing – source person Yes / No
2. Source person (patient) risk assessment for HIV undertaken using assessment tool Yes / No
3. Source person identified as at risk for blood borne virus infection Yes / No
4. Source person blood taken (10 ml clotted sample) Yes / No
5. If source patient unknown, risk assessment of situation undertaken for HBV, HCV, HIV Yes / No/ NA
6. Exposed person blood taken for storage (10 ml clotted sample) Yes / No
7. Exposed person consent obtained for HIV test if applicable Yes /No/ NA
8. Referral to appropriate Physician arranged (by Occupational Health for staff) in event of source patient HCV or HIV positive Yes / No/ NA
9. Referral for follow-up counselling (if appropriate) Yes / No/ NA
10. Post exposure prophylaxis (PEP) prescribed Yes / No

Signature of person making assessment .....……...

Print name .....……

Job Title ……

Date .....……..... Time of injury ……..…….....……

Time of completion of form (for audit purposes) ...……

Summary of action taken ……..…….

…….

PLEASE ENSURE A COPY OF THIS FORM IS RETAINED WITH THE ED / MIU RECORDS (AND FOR MEMBERS OF STAFF ONLY, THE ORIGINAL COMPLETED FORM IS RETURNED TO THE OCCUPATIONAL HEALTH DEPARTMENT WITHOUT DELAY) FOR RELEVANT FOLLOW-UP TO BE ARRANGED

Appendix 1a

Strictly confidential

Record of the telephone instruction to administer Post exposure prophylaxis following inoculation injury

EXPOSED PERSON:

NAME ..... Date of Birth.....

ADDRESS ……

……

…… TEL NO: …….

JOB TITLE (if appropriate) ……..…….

SITE / WARD / DEPARTMENT (if appropriate) …….....

If known;

SOURCE PERSON:

NAME ..... Date of Birth.....

NAME OF MICROBIOLOGY /GU MEDICINE /INFECTIOUS DISEASES CONSULTANT
…….

DATE & TIME OF CONTACT WITH MICROBIOLOGY /GU MEDICINE /INFECTIOUS DISEASES CONSULTANT:-

Date …….. Time ……

DETAILS OF CONVERSATION HELD ……
……
……

PEP PACK ISSUED? Yes / No

PEP pack contains: 5 Truvada (tenofovir 245mg/ emtricitabine 200mg) labelled “take one tablet ONCE a day” **and** 10 x Raltegravir 400mg tablets labelled “take ONE tablet TWICE a day”

NAME OF PERSON COMPLETING FORM ……..…….

Date …….. Time…….

NAME OF PERSON ADMINISTERING PRESCRIPTION…….

Date …….. Time…….

PLEASE ENSURE THE COMPLETED FORM IS RETAINED WITH THE ED / MIU RECORDS (AND IF A MEMBER OF STAFF A COPY SUBMITTED TO THE OCCUPATIONAL HEALTH DEPARTMENT WITHOUT DELAY). THIS WILL ENABLE RELEVANT FOLLOW-UP TO BE ARRANGED.

Appendix 2

INOCULATION INJURY PROFORMA - A&E

Worcestershire NHS
Acute Hospitals NHS Trust

Affix Patient Label here or record

NAME: . . . . . .

NHS NO: | | | | | | | | | | |

HOSP NO: | | | | | | | | | | |

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

SITE: **ALX** ☐ **KIDD MIU** ☐ **WRH** ☐

First Aid / Initial Treatment

Sharps / bite injury - encourage bleeding and wash with soap and running water, do not scrub

Body fluid in eyes or mouth - irrigate with lots of cold water

First Aid measures undertaken? YES ☐ NO ☐

WAHT employee? YES ☐ NO ☐

VICTIM/RECIPIENT

Date of injury:	Time of injury (24hr)		Location (e.g. ward)				
Type of incident: (tick)	Needlestick ☐	Bite ☐	Unprotected sex ☐	other ☐			
Depth of injury:	Superficial ☐	Subcutaneous ☐	Deep Tissues ☐	Gloves worn: YES ☐	NO ☐		
Type of body fluid: (see below)	Low Risk ☐	High Risk ☐	Anatomical site ☐				
Hep B Immunisation: (tick)	complete ☐	incomplete ☐	non responder ☐	non immunised ☐	NK ☐		
Tetanus immunisation: (tick)	complete ☐	incomplete ☐	Not known ☐				

Further details of injury
(use ED notes if more space is required)

Recipient Risk Assessment Tick any boxes which apply - if only LOW RISK exposure boxes ticked then there is no need to risk assess donor; Hep B or HIV prophylaxis unnecessary; no need to store blood for future testing. If any medium risk or higher risk exposure boxes ticked then assess donor risk over the page and act accordingly.

Lower Risk Exposure	Medium Risk Exposure	Higher Risk Exposure
Intact skin contact only	Mucous membrane or broken skin	Device with visible blood
Small volume of fluid (few drops, short duration)	Large volume (major splash, long duration)	Large bore hollow needle (green needle or larger)
	Percutaneous exposure (e.g. solid needle or scratch)	Device used in patient's artery or vein

If HIV PEP is being considered then complete ßhCG result (if ♀ 12-55yrs) positiive ☐ negative ☐

Taking any of these? Anti-epileptics ☐ St.John's Wort ☐ Statins ☐

HIGH RISK FLUIDS:	Blood, Amniotic fluid, Vaginal Secretion, Semen, Breast Milk, CSF, Peritoneal / Pleural / Pericardial / Synovial fluid, Saliva (in dentisty) Unfixed tissues / organs.
LOW RISK FLUIDS:	Urine, Vomit, Saliva, Faeces (unless any of these visibly contaminated by blood) **Recipients** who have had a full Hepatitis B course and a booster at 5 years with good response are considered to be fully protected. **Risk of exposure** following percutaneous injury, especially from deep penetration with a hollow-bore needle or one visibly contaminated with blood from a known infected source is 1 in 3 for hepatitis B virus, 1 in 30 for Hepatitis C virus (HCV) and 1 in 300 for HIV.

Completed by:
Signature:_____ Print Name:_____ Designation: _____

A~Inpatient~WR2239~Version 1~Page 1 of 2

Affix Patient Label here or record

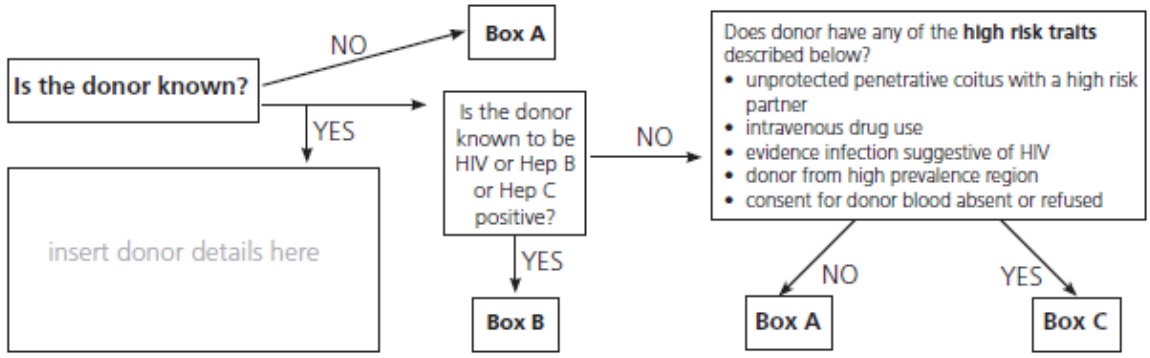
NAME: . . . . . .

NHS NO: | | | | | | | | | | |

HOSP NO: | | | | | | | | | | |

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

DONOR RISK ASSESSMENT



BOXES A,B & C

- Start accelerated Hep B vaccine course if victim not previously immunised.
- Discuss with on-call microbiologist if victim is a Hep B non responder, partially immunised or has had a high risk exposure
- First HepC and HIV blood tests at 6 weeks via GP / Occ H if donor is unknown or is Hep C / HIV positive

BOXES B & C - Contact on call microbiologist (via switchboard) for advice regarding HIV PEP

Adult Accelerated Hep B immunisation (eg. Engerix B) course	**Hepatitis B Immunoglobulin**
First dose now, second dose in one months time, third dose in two months time. Possible fourth dose in 12 months time. 20mcg IM deltoid muscle.	(on-call microbiologist will arrange supply) >10yrs 500u IM 5-9yrs 300u IM <5yrs 200u IM

Has the clinician responsible for the **donor** been contacted re; counselling and specimen collection? (insert name in box opposite)	Yes No n/a	If No, why
Has **donor** specimen of blood been taken and sent* for testing for Hep B, C and HIV?	Yes No n/a	If No, why
Has **recipient** specimen blood been taken and sent* for storage?	Yes No n/a	If No, why
Has the case been discussed with senior ED doctor or microbiology consultant? (If so, which?)	Yes No	
HIV PEP NB Consent must be gained for PEP. HIV anti-viral drugs are not licensed for this use.	requested by recipient offered not required	Given / Not given
Hep B PEP	offered not required	Hep B immunisation: Started/not started Hep B immunoglobulin: Given/Not given

*Label blood samples DONOR or RECIPIENT (include donor's name if known) NEEDLESTICK SPECIMEN (one yellow top bottle to microbiology)

Patient advice leaflet: Needlestick Injury HIV PEP	YES / NO YES / NO	Faxed referral to Occupational Health This must be done for all trust employees	YES / NO
Recipient advised re: sexual contact & risk behaviour	YES / NO	Follow up with: (all patients given HIV PEP must go to BBV Clinic)	Occ H GP Blood Borne Virus Clinic

Print Name:_____ Signature:_____

Designation:_____ Date:_____

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Appendix 2a

WRH ED FAX SHEET

FAX - Confidential

From	To
Emergency Department Worcestershire Royal Hospital Charles Hasting Way Worcester WR5 1DD	Occupational Health Department Worcestershire Royal hospital Tel (9) 760693 Ext 34752 Fax (9) 760121

The following **TRUST EMPLOYEE** attended the Emergency Department of the Worcestershire Royal Hospital after sustaining an

Affix Addressograph label here

Inoculation Injury

on (insert date below ↓)

Please arrange an outpatient appointment for further assessment

tick appropriate column	Yes	No
The emergency department inoculation injury proforma has been completed – this must be ticked yes		
HIV post exposure prophylaxis was prescribed		
Hep B post exposure immunisation was prescribed		
The patient consents to their emergency department notes being reviewed by the Occupational Health department		

The case was discussed with (tick which applies)	Yes	No
On call MICROBIOLOGIST consultant (insert name below)		
On call INFECTIOUS DISEASE consultant (insert name below)		
On call GENITOURINARY MEDICINE consultant (insert name below)		
No one		

Comments

Requesting health professional

NAME Designation Date

Tick when Faxed	

Appendix 2b

ALX ED FAX SHEET

FAX - Confidential

From	To
Emergency Department The Alexandra Hospital Woodrow Drive Redditch B98 7UB 01527512762	Occupational Health Department Worcestershire Royal hospital Tel (9) 760693 Ext 34752 Fax (9) 760121

The following **TRUST EMPLOYEE** attended the Emergency Department of The Alexandra Hospital after sustaining an

Affix Addressograph label here

Inoculation Injury

on (insert date below ↓)

Please arrange an outpatient appointment for further assessment

tick appropriate column	Yes	No
The emergency department inoculation injury proforma has been completed – this must be ticked yes		
HIV post exposure prophylaxis was prescribed		
Hep B post exposure immunisation was prescribed		
The patient consents to their emergency department notes being reviewed by the Occupational Health department		

The case was discussed with (tick which applies)	Yes	No
On call MICROBIOLOGIST consultant (insert name below)		
On call INFECTIOUS DISEASE consultant (insert name below)		
On call GENITOURINARY MEDICINE consultant (insert name below)		
No one		

Comments

Requesting health professional

NAME Designation Date

Tick when Faxed	

Appendix 3

Human immune deficiency virus (HIV) – are you at risk?

Certain viruses like HIV are carried in the blood. If a nurse, doctor, other healthcare worker or other person is exposed to blood from an infected person (eg a needlestick injury, or contamination of broken skin or mucous membranes), then it is possible for the infection to be passed on.

Whenever a member of staff or other person has an injury involving another person's blood or other fluids / tissues, it is routine practice to assess the risk of HIV infection in that person. It is also recommended that in all incidents of this kind we ask for permission to perform an HIV test. This is done to enable appropriate protection to be offered to the member of staff / person exposed, but it also helps patients too. If you have HIV, then it is important for you to know. Beneficial treatments are available, and you will be able to help other members of your family or other close contacts.

Please read the following carefully, and if you fall into any of the groups described, tell the person who has given you this card (you do not need to give specific details if you do not wish to). If you have any further questions, please feel free to ask.

- You, or your partner, are known to be HIV positive
- You, or your partner, have ever injected yourselves with drugs
- You, or your partner, have been advised not to give blood
- You, or your partner, have had tattoos, acupuncture, or body piercing performed
- You, or your partner, have haemophilia or a related blood clotting disorder needing clotting factor concentrates
- You, or your partner, have been sexually active ca), Far East or Indian Sub-continent
- You, or your partner, have visited a STD, GUM, or VD Clinic
- You, or your partner, have been homosexually active
- You, or your partner, have received multiple blood transfusions, or received a blood transfusion abroad

We would like, with your consent, to test a sample of your blood for the human immunodeficiency virus (HIV).

You do not have to do this, but if you have identified yourself to be at risk, it would be very much in your interest to be tested.

All tests are done in strict confidence, and you will be informed of the result.

APPENDIX 3 continued

Counselling services available for follow-up support And hiv pre-test information

(**NB:** Referral available during office hours only and if a member of staff, after risk assessment by the on-call Occupational Health Adviser.)

Clinical Nurse Specialist
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Tel: (01905) 763333 Ext: 33113 or 01905 733240 Mobile: (07778) 196778 or 07501487655

Clinical Nurse Specialist
Sexual Health Unit
Worcestershire PCT
Isaac Maddox House
Worcester

Tel: (01905) 681744

The Health Adviser
Arrowside Unit – Department of Genito-Urinary Medicine
Worcestershire PCT
Woodrow Drive
Redditch
B98 7UB

Tel: (01527) 516480 (direct line)

Tel: (01527) 516398 (reception / appointments)

Senior Nurse
John Anthony Centre
Newtown Road
Worcester
WR5 1HN

Tel: 03001231731 or 01905 763333 ext 38400

Appendix 4

Use of anti-viral prophylaxis for potential HIV exposure incidents information for ED / MIU staff

1. If risk assessment concludes that the source may be HIV positive, the need for PEP for the exposed person should be considered.

2. The following action should only be taken after consultation with the designated person on call, ie Microbiology / GU Medicine / Infectious Diseases Consultant. It is therefore essential that they are contacted without delay whenever the possibility of occupational or other HIV exposure is being seriously considered.

3. Subject to informed verbal consent, obtain blood specimen from source person and arrange for HIV testing.

4. Arrange specialist counselling for exposed person (via a Consultant Physician, Consultant in GU medicine or other appropriate person). Apart from discussing the risk of infection from the incident, this should include discussion of sexual contact, pregnancy, breast feeding, and being a blood, semen or organ donor in the period until follow-up blood tests show that infection has not occurred.

5. Subject to informed consent obtain blood specimen from exposed person and arrange for storage.

6. A healthcare worker will not normally be required to modify their work practices after such an incident, pending results of the follow-up blood tests.

7. Initial prophylactic treatment should include the following :

Truvada (tenofovir 245mg & emtricitabine)
Plus
Raltegravir

8. The prophylaxis should ideally be initiated **within 1 or 2 hours** of the incident occurring, although undefined benefit may result from initiating therapy after a longer interval in cases of the highest risk exposure.

9. Ensure an Incident Reporting has been made using the electronic reporting system, Datix.

Appendix 4 Continued

Background information on post exposure prophylaxis (PEP)
After exposure to HIV

1. The average risk for HIV infection from all types of reported percutaneous exposure to HIV infected blood is 0.3%.

2. This risk is increased for exposures involving:
(i) a deep injury to the HCW,
(ii) visible blood on the device causing injury,
(iii) a device previously placed in the source patient's vein / artery,
(iv) a source patient with late stage HIV disease (ie high titre HIV).

3. The risk after mucous membrane exposure to HIV infected blood is approximately 0.1%.

4. The risk after exposure of non-intact skin to HIV infected blood is < 0.1%.

The risk is probably higher for exposure that is:
(i) prolonged,
(ii) involves an extensive area,
(iii) involves a higher HIV titre.

5. Healthcare workers exposed to high risk body fluids or tissues which are known to be, or strongly suspected to be, infected with HIV through percutaneous exposure, mucous membrane exposure or through exposure of broken skin, should be recommended to commence PEP.

6. PEP Drugs – There is limited information on the potency and toxicity of anti-retroviral drugs in uninfected persons receiving PEP.

Factors for Consideration:

Any drug regimen will have to take into account the following factors:

* whether the exposed healthcare worker is allergic to one of these drugs,

* whether the healthcare worker is pregnant or breastfeeding,

* interactions with other medication,

* when there is a possibility that the virus may be resistant to one or more of the drugs or where the exposed healthcare worker has been handling resistant virus in a laboratory.

Normally, in all these circumstances expert advice should be sought.
The drugs discussed above have all been licensed for the treatment of HIV infection but not for its prevention. For this reason they may be prescribed only on "a named patient basis". As more anti-retroviral drugs are developed it is likely that other drugs or combinations of drugs will become the preferred regimen for PEP.

At present the starter drugs for PEP are Truvada and Kaletra.

PEP pack contains: 5 Truvada (tenofovir 245mg/ emtricitabine 200mg) labelled "take one tablet ONCE a day" **and** 10 x Raltegravir 400mg tablets labelled "take ONE tablet TWICE a day"

Short term toxicity with PEP medications with higher doses includes:

- GIT symptoms, fatigue, headache, anaemia, neutropenia
- NB: Interaction with anti-epileptic medications

Short term toxicity of other drugs in this situation is not well characterised, however when used in patients who are known to be HIV infected the following have been reported:

Raltegravir: GIT symptoms
Hepatic dysfunction
Rash, pruritus, Stevens Johnson syndrome
Headache, dizziness, abnormal dreams, insomnia, vertigo
Lipodystrophy
Metabolic disturbance
Decreased appetite
Fatigue, Asthenia, pyrexia, paraesthesia, myalgia, myositis, rhabdomyolysis.
Pancreatitis, hepatitis, gastritis Taste disturbance
May also interact with omeprazole

Truvada: **Diarrhoea, nausea, vomiting**
Rash

Hypophosphataemia
Hyperglycaemia, hypertriglyceridaemia
Neutropaenia
Renal impairment

Use of Drugs in Pregnancy

The department of health guidance states "Pregnancy does not preclude the use of HIV PEP" and that "there have been no indications of particular problems for the babies of HIV-infected women who have become pregnant while already on antiretroviral medications, but it should be noted that there is limited information for some of the newer drugs"

Further Discussion with Microbiology / Gu Medicine /
Infectious Diseases Consultant Recommended

Appendix 5

Information for healthcare worker / person exposed to HIV infected blood (see also appendix 10, leaflet for staff)

1. Most occupational / needlestick or other inoculation injuries resulting in exposure to HIV do **not** result in transmission of infection.

2. There is evidence that antiviral drugs given **soon** after exposure significantly decrease this small risk but infections have still occurred despite these drugs being given.

3. Much of the information we have is based on single drug treatment with Zidovudine but evidence suggests that combination therapy with 2 or 3 drugs has better anti-viral activity. This updated protocol has been adopted in June 2010.

4. Knowledge about efficacy and toxicity of these drugs used in this way is limited.

5. If you are or if you may be pregnant, (ie more than 10 days since onset of last period and not using adequate contraception), then knowledge about toxicity is even more limited

6. The final decision as to whether you take these drugs or not is yours.

7. Whether or not you take PEP you should consider careful medical follow-up and blood tests for HIV antibodies at baseline and in 3 and 6 months. This can be undertaken by the Occupational Health Department / Sexual Health Unit.

8. You may wish to consider other issues such as avoiding possible sexual transmission to your partner during the period of follow-up and you can discuss these confidentially with staff at the Sexual Health Unit, Worcester on (01905) 681744 or contact staff in the Arrowside Unit, Redditch on (01527) 516398 (and ask for the Health Adviser or Sister).

9. The months following the exposure incident may be a time of uncertainty and anxiety and you may need help – this is available from staff in the Occupational Health Department or Sexual Health Unit at Worcester.

Appendix 6

Location Of Supplies Of Post-Exposure Prophylaxis (PEP)

Worcestershire Acute Hospitals

Alexandra Hospital, Redditch:	ED
Kidderminster Hospital:	Minor Injuries Unit
Worcestershire Royal Hospital:	ED

Community Trust Sites

PEP is available at the following sites after agreement with appropriate staff:

*****Evesham Community Hospital, Casualty Department

Malvern Community Hospital, PCC Room

The Cottage Hospital, Pershore, in the Pharmacy refrigerator

*****Tenbury and District Community Hospital, Main IM drug cupboard

***** Please note: Minor Injury Units are only available at these sites

Appendix 7

Strictly Confidential

Confirmation of telephone instruction to administer post Exposure prophylaxis following an inoculation incident

To: Manager / Person in Charge

…… (Department)

…… (Site)

Fax No: …… (If appropriate)

Re:

NAME ..... Date of Birth.....

SITE / WARD / DEPARTMENT / ADDRESS (if not a member of staff)

.....

.....

.....

I confirm my authority was given for the administration of a PEP pack to the above named individual on …… (date of telephone call).

Signed: ……

Print Name: ……

Date: ……

THIS COMPLETED AUTHORITY MUST BE SENT / FAXED WITHIN 48 HOURS OF ADMINISTRATION OF POST EXPOSURE PROPHYLAXIS FOLLOWING AN INOCULATION INCIDENT AND RETAINED WITH APPENDIX 1(a)

Appendix 8

Inoculation Incident Risk Assessment Tool

A **significant exposure** to risk of Blood Borne Virus transmission through an inoculation incident occurs where a **significant injury is associated with high risk material**.

1. **Significant injuries** include:

- Percutaneous injury involving visible damage to the skin with a needle or other sharp instrument sufficient to draw blood
- Contact of blood or bodily fluid with
  - mucous membranes or the eyes or the mouth
  - non-intact skin
- human bite where source had visible blood round mouth
- scratch where source had visible blood around fingers / nails prior to scratching

2. **Non-significant injuries** include:

- superficial graze not breaking the skin
- exposure to intact undamaged skin
- exposure to sterile or uncontaminated sharps

3. **High risk materials** include:

- Blood
- Amniotic fluid
- CSF
- Human breast milk
- Pericardial, peritoneal, pleural, or other fluids from burns or skin lesions
- Any other body fluid containing visible blood
- Saliva in association with dentistry
- Vaginal secretions / semen
- Unfixed tissues and organs

4. **Low risk materials** include:

- Urine
- Vomit
- Saliva
- Faeces

  Unless blood stained (see above)

5. **Non-significant exposures do not require any further action**, although opportunity should be taken to offer Hepatitis B immunisation if this has not already been undertaken.

6. If a **significant exposure** has occurred, the status of the source (if known) should be assessed with regard to Hepatitis B, C and HIV.

6.1 **Risk factors for Hepatitis B** include:

- Intravenous drug misuse
- Men who have sex with men
- People with Hepatitis B infected mothers or sexual partners

6.2 **Risk factors for Hepatitis C** include:

- Receipt of unscreened blood or untreated plasma products in the UK prior to September 1991 and 1995 respectively
- Intravenous drug misuse
- Involvement as a healthcare worker in exposure prone (invasive) medical procedures in parts of the world where infection control procedures may have been inadequate, or with populations with a high prevalence of Hepatitis C, eg Egypt

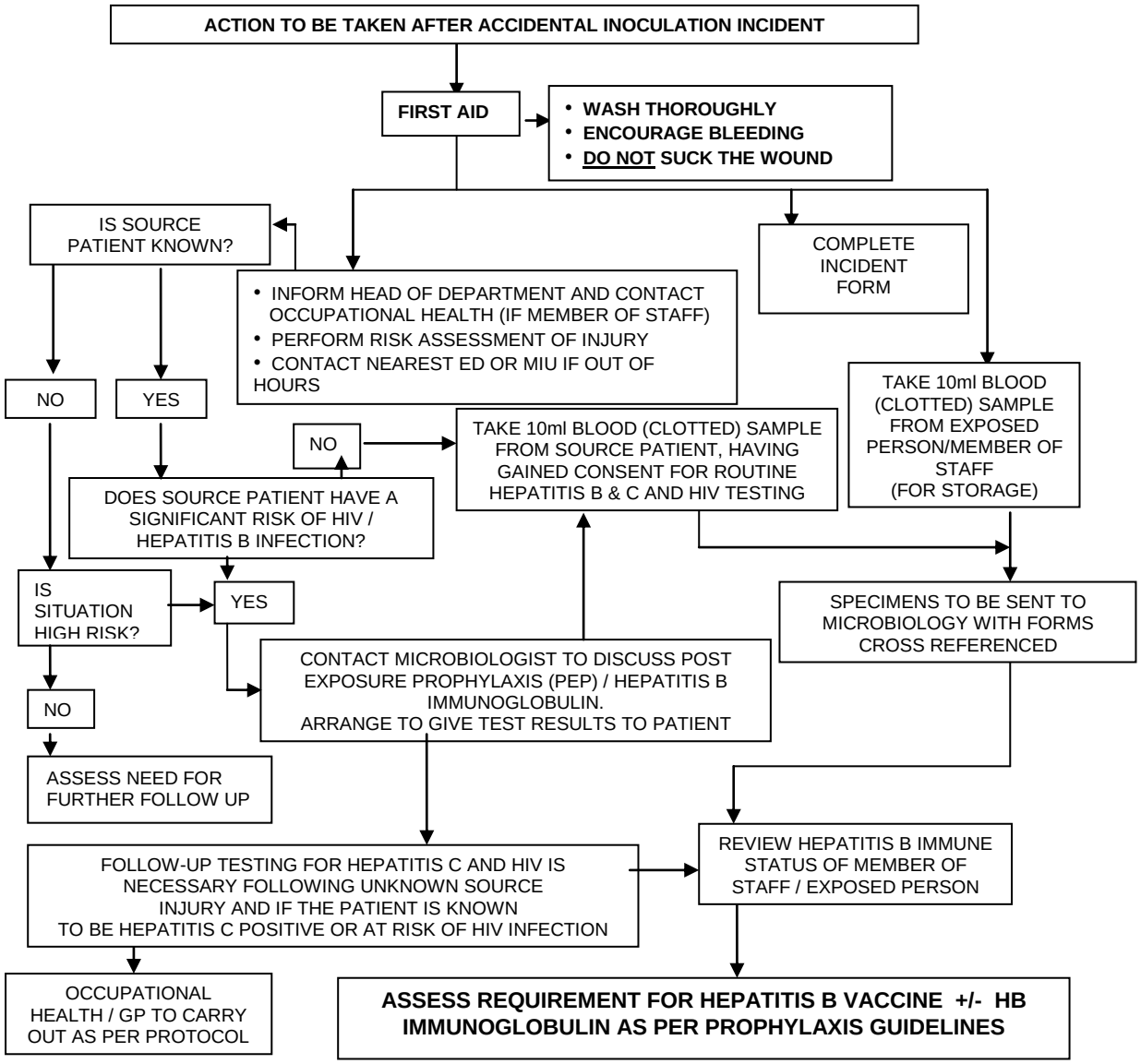
6.3 **Risk factors for HIV** include:

- Intravenous drug misuse
- Haemophilia or a related blood clotting disorder needing clotting factor concentrates
- People who have been sexually active in Africa (excluding North Africa), Far East or Indian Sub-continent
- Men who have sex with men
- Patient or partner has received multiple blood transfusions, or received a blood transfusion abroad
- People with HIV infected mothers or sexual partners

Appendix 9

INOCULATION INJURY FLOWCHART

This flow chart summarises the action to be taken in the event of an inoculation incident. You must ensure that all action is undertaken as soon as possible after the incident has occurred.



ADDITIONAL ACTION MAY BE TAKEN BY OCCUPATIONAL HEALTH / ED DEPARTMENT WHEN SOURCE PATIENT BLOOD RESULTS ARE KNOWN

APPENDIX 10

BLOOD CONTAMINATION INCIDENT

You have had an accident involving a patient's blood or body fluid. This could affect your health. The Trust has put in place a system to make sure the risk to you is minimized. This leaflet describes what you must do, and what will happen over the next few weeks.

- By the time you are reading this leaflet, you will have already washed the area with lots of running water and applied a dressing if applicable. DO NOT suck the area.
- Tell your line manager/ supervisor immediately.
- Complete an Incident Report Form on-line at http://kktcdat03/datix/live/index.php
- Make sure a specimen of blood is collected from you either by Occupational health or, if out of hours, by A/E for storage in the laboratory, in case it is needed later.
- Contact Occupational Health (Outside Direct Dial: (01905) 760694 or Internal Extensions: 33650, 33651, 33652 and 33653 or email OHadmin@worcsacute.nhs.uk)

WHAT WILL HAPPEN NEXT?

Your manager will make arrangements to trace the patient whose blood or body fluid has caused the contamination incident. The patient (the source) will then be investigated.

IF THE SOURCE IS KNOWN

- The source will be tested and you will be informed of the need for any further investigation of yourself. If the source is negative, nothing more need happen.
- If the source is positive for any blood borne virus, Occupational Health will arrange to investigate you further and refer you for appropriate advice
- Remember that, as a healthcare worker, you will already have been offered immunization against Hepatitis B. Your immunisation status will be known.

IF THE SOURCE IS UNKNOWN

- You will be offered follow up for 6 months for a range of blood borne viruses through Occupational Health. It is however your responsibility to ensure that Occupational Health have up-to–date contact details, and to keep your appointments.

WHAT ABOUT HIV?

If the source is known and thought to be at risk of being HIV positive, you may be advised to take some protective tablets (PEP) for up to a month, depending on the degree of risk and the time interval between the incident and the treatment. This will be discussed in full with you at the time.

REMEMBER

Blood borne viruses are a significant risk to health. The chance that you will acquire one as a result of this incident is small but not negligible. You can help yourself by keeping in touch with Occupational Health and acting on their their recommendations

Monitoring Tool

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Investigation protocol	Collection of essential specimens from inoculation incident recipients and sources	Monitoring appropriate collection of these specimens	Monitored weekly, with biennial review	CMM	Weekly check reported to OHD Biennial review reported to TIPCC and OHD NSI monitoring group	Weekly and biennially
Section 3.5	Checking Datix reports of all needle-stick and sharps injuries	Monitoring Datix entries for needle-stick injuries	Daily	H&S Manager	Summary of Incident Reports submitted to H&S Committee and WODG	Quarterly
Section 2 Action to be taken if a needle stick occurs	Risk and action to be taken is included in the induction and annual risk update for all staff.	Monitoring attendance at training via ESR data.	Monitored bi-monthly.	Lead IPC Nurse	Compliance of attendance at induction and annual risk update reported to TIPCC	Bi-monthly
Action 2 OH Monitoring	Monitoring of Staff following NSI	Gathering of recipient and source bloods results and monitoring until investigation complete.	Monitored daily and weekly.	OH Nurse on duty, OH nurse responsible for NSI.	Daily gather of outstanding results entered into staff notes and input onto NSI Excel spreadsheet. Weekly gather generated by Dr Dyas and completed by OH Nurse responsible for NSI .	Daily and Weekly.

12. Contribution List

Key individuals involved in developing the document

Name	Designation
Chris Rawlings	Head of Clinical Governance and Risk Management
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Dr Claire Constantine	Consultant Microbiologist, Worcestershire Royal Hospital
Dr Jane Stockley	Consultant Microbiologist, Worcestershire Royal Hospital
Dr Mark Roberts	Consultant Physician, Infectious Diseases, Worcestershire Royal Hospital
Dr Sumit Bhaduri	Consultant in GU Medicine, Arrowside Unit, Redditch
Dr Chris Catchpole	Consultant Microbiologist, Worcestershire Royal Hospital
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Heather Gentry	Lead Nurse, Infection Prevention and Control
Paul Graham	Health, Safety and Security Manager

Circulated to the following individuals for comments

Name	Designation
Nick Hubbard	Director of Pharmacy

Circulated to the following CDs / Heads of department for comments from their directorates / departments

Name	Directorate / Department

Circulated to the chair of the following committees / groups for comments

Name	Committee / group
	Trustwide Infection Prevention and Control Committee

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**	No	
	Race		
	Ethnic origins (including gypsies and travellers)		
	Nationality		
	Gender		
	Culture		
	Religion or belief		
	Sexual orientation including lesbian, gay and bisexual people		
	Age		
	Disability		
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**		
6.	**What alternatives are there to achieving the policy/guidance without the impact?**		
7.	**Can we reduce the impact by taking different action?**		

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval