Clinical

Sharps injuries and exposure to blood and high risk body fluids SOP:

<table>
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<th>Document Control Summary</th>
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<tr>
<td><strong>Status:</strong> Replacement.</td>
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<tr>
<td>Replaces: Management of clinical sharps injuries and exposure to blood and high risk body fluids Policy</td>
</tr>
<tr>
<td><strong>Version:</strong> v1.0</td>
</tr>
<tr>
<td><strong>Date:</strong> January 2016</td>
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<td><strong>Approved by:</strong> Policy and Procedures Committee</td>
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<tr>
<td><strong>Ratified:</strong> Policy and Procedures Committee</td>
</tr>
<tr>
<td><strong>Related Trust Strategy and/or Strategic Aims</strong></td>
</tr>
<tr>
<td><strong>Implementation Date:</strong> January 2017</td>
</tr>
<tr>
<td><strong>Review Date:</strong> January 2020</td>
</tr>
<tr>
<td><strong>Key Words:</strong> Needlestick injury, bites, scratches</td>
</tr>
<tr>
<td><strong>Associated Policy or Standard Operating Procedures</strong></td>
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<td>• Infection Prevention and Control Policy</td>
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1. Introduction

It is impossible to identify all those with infections, BBV or otherwise. Health care workers and others who come into contact with blood, secretions and excreta may be exposed to pathogens, including BBV such as Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV).

Exposure to possible BBV may occur from percutaneous exposures, where the skin has been broken by a needle / other sharp object, human scratch or bite and mucocutaneous exposure, where the mucus membranes (mouth, nose or eyes) or non-intact skin have been contaminated.
Contamination incidents can occur to any person, staff, patient, visitors or contractors. This policy is to be followed if such an event occurs.

The management of incidents to non-members of staff may need minor modification further advice can be obtained from the Consultant Microbiologist.

Incidents where significant exposure to the patient may have occurred must be managed appropriately to control risk of infection of a blood borne virus from the attending health care worker e.g. exposure prone procedures.

Incidents involving Healthcare workers must be reported to the line manager and OH Service if any of the following occur:

- Needlestick or sharp injury with a used needle or instrument
- Body fluids over uncovered cuts/or breaks in the skin
- Bites and scratches that break the skin
- Splashes in the eye and/or mouth

If the source patient is known or highly suspected of being HIV positive, then the post exposure prophylaxis (PEP) treatment should be accessed as soon as possible and up to 48 to 72 hours.

2. Purpose

South Staffordshire and Shropshire Healthcare Foundation Trust (SSSHFT) aims to minimise the risks to employees of contracting a Blood Borne Virus (BBV) due to blood borne pathogens in the workplace. The Trust ensures practice to meet current standards in accordance with Department of Health (DoH) and the UK Chief Medical Officers’ Expert Advisory Group on AIDS (EAGA) guidelines.

Accident and Emergency departments have a responsibility for the initial administration of preventative (post exposure prophylaxis-PEP) drug therapy to individuals presenting to the service following occupational or accidental exposure to the Human Immunodeficiency Virus (HIV).

3. Scope

This document applies to all employees of SSSHFT and extends to service users, visitors, contractors, volunteers and others carrying out activities within the Trust.

4. Definitions

Blood Bourne Viruses (BBV)

Blood Bourne Viruses are pathogenic micro-organisms that may be present in human blood or other potentially infected materials and can infect and cause disease in persons who are exposed to blood containing the virus. These viruses include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV). BBV are spread through percutaneous or mucocutaneous exposure with contaminated blood and bodily fluids.

Contaminated Injury

Contaminated Injury is an injury where a needle or other sharp contaminated with blood or other high risk body fluid penetrates the skin percutaneously. It also includes bites, scratches which breaks the skin and splashes of body fluids to eyes and mouths. The most important factors when considering the risk from such an injury are the volume and the viral load from the penetrating injury.
Injuries may be caused by:-
- Needlestick or sharp injury with a used needle or instrument
- Body fluids contaminating uncovered cuts/or breaks in the skin
- Bites and scratches breaking the skin
- Splashes in the eye and/or mouth

**Source Individual**
A source individual is any individual, living or dead, whose blood or body fluid is the source of contaminated exposure.

**Recipient**
The recipient is any individual who has been put at risk of contamination from a BBV as a result of contaminated exposure.

**Occupational exposure**
An occupational exposure is a contaminated injury resulting from work practices

**Significant Exposure**
A significant exposure is a percutaneous or mucocutaneous exposure to blood or other body fluids from a source that is known to be, or as a result of the incident found to be, HIV surface antigen (HbsAG), HCV, or HIV positive.

**High Risk Source**
A high risk source is either:
- Known to be blood borne virus positive
- In a risk category for being blood borne virus positive
- Source unknown but the sharp involved probably used in one of these categories above
- Clinical suspicion is of a high risk source

**High Risk Group for HIV infection**
This includes individuals who:
- Are known to have HIV or AIDS. If the source has received recent antiretroviral therapy then specialist advice needs to be sought from the department of Genito-Urinary Medicine (GUM)
- In whom there is a strong clinical suspicion of HIV infection but where the HIV status risk is not known
- Suffering from a terminal HIV related illness
- A current / ex IV drug user
- Sex worker
- Born outside the UK, Republic of Ireland, Western Europe or North America
- History of blood transfusions or injections abroad or in the UK before 1992
- Known to have another blood borne virus
- Has ever been the sexual partner of one of the above or someone known to be HIV+
- Material is a lab specimen from someone with one of the above risk factors
- Sharp is likely to be contaminated with HIV

**High Risk Exposure Incident**
A high risk exposure incident is one when there is:
- a deep injury and/or with a hollow bore needle
- visible blood on the device which caused the injury
- injury with a device which had been in the patient’s artery or vein
• contamination with blood or other high risk body fluid (see below)

5. Responsibilities and process to be followed for management of the incident

Managers

Managers will:

• Manage accidents /incidents within the workplace and undertake necessary follow-up actions. The manager or senior person on duty must ensure that the recipient has received the appropriate first aid attention (as in appendix 1); arrangements are made for base line bloods obtained for storage and that the OCCUPATIONAL HEALTH Service has been informed of the incident. (Tel 01785 221212 or ext 5212)

• Arrange the supporting medical officer to assess the infection risk of the source individual. With informed consent, arrange for a sample of blood to be taken from the source individual for storage, Hepatitis B antigen, Hepatitis C antibody and HIV. Blood samples should be 10mls of clotted blood in a plain tube and forwarded to the local Microbiology department. Ensure sample is clearly labelled and identified Contamination Injury

• If a significant risk incident is identified occupational health to be informed immediately, if out of office hours refer to A&E and liaise with consultant microbiologist immediately as PEP may be required, then inform OH as soon as possible

• Undertake an investigation of the incident and implement actions to reduce the likelihood of a repeat occurrence so far as is reasonably practicable, seek advice from infection prevention and control team when required

• Ensure an incident form has been completed. Ascertain and record the following information: date and time of exposure, name of source individual and clinical details relevant to risk, details of exposure especially the amount of fluid or material injected or contaminating broken skin or mucus membrane, type of fluid or material and severity of exposure e.g. for needlestick injury the depth of injury and whether fluid was injected/ for skin or mucus membrane exposure the extent and duration of contact and condition of skin

• Arrange to have bloods for storage and immunity assessment for the healthcare worker by occupational health. If this is not possible it may be undertaken by a local A&E department

• Some contamination injuries will be reportable to the enforcing authority (generally the Health and Safety Executive) under RIDDOR. Those which result in an absence from work for more than 3 working days will be reportable, as will those where the source patient is known to carry a blood-borne virus e.g. Hepatitis B, Hepatitis C or HIV.

• The medical staff responsible for obtaining consent for the blood sample is responsible for ensuring that the patient receives the result of the tests in a timely fashion. If the consent/blood test is obtained out of hours or the results are available the following day, the medical staff should inform the medical staff who are responsible for the patient the following day of the incident and ask them to give the results to the patient
**Employees**

Dispose of the causative sharp safely and attend to the injury

Carry out first aid treatment. See Appendix 1

Percutaneous injuries:

- Encourage bleeding, preferably under running water, but not by sucking
- Then wash the wound with soap and water without scrubbing for at least five minutes. Antiseptics and skin washes should not be used.
- Dry and cover the wound with a waterproof plaster.

Splashes onto non-intact skin (e.g. abrasions, cuts, and eczema):

- Wash liberally with water.

Splashes into the eyes, mouth or other mucous membranes:

- Irrigate with copious amounts of clean water. If contact lenses are worn, eye irrigation should take place before and after removing the lenses

Next steps:

- Notify immediately the person in charge of your work area
- Complete an incident form; include details of the source individual involved if available.
- Report to Occupational Health Service immediately. Out of hours support for significant risk incidents is available from the Consultant Microbiologist Burton 01283 566333. Report to Occupational Health the next working day.
- Reporting all contamination injuries including needlestick/ bites / splash / scratch incidents promptly. If there is significant risk of HIV from the source reporting to Occupational Health or A&E immediately, as PEP may be required
- If there is a high risk of HIV transmission, post-exposure prophylaxis (PEP) should be commenced as soon as possible following the incident but may be commenced up to 48 to 72 hours post injury and can be accessed from a local A&E department

**Attending Medical Officer**

Assess the clinical risk of BBV diseases of the source individual by the medical history and clinical records.

The source individual should be counselled regarding the incident and informed consent obtained to take a blood sample for Hepatitis B antigen, Hepatitis C antibody and HIV. Blood samples should be 10mls of clotted blood in a plain tube and forwarded to the local Microbiology department. Ensure the sample is clearly labelled and identified Contamination Injury. Request forms must be signed by the medical officer, as failure to do so will delay processing whilst a signature is obtained.
See Appendices 2 and 3 for guidelines on seeking consent for blood borne virus testing from a source individual

**Blood sample and consent must not be obtained by the recipient of the contamination injury.**

**Occupational Health Service**
The Occupational Health Services will support the Trust in:

- The management of reported inoculation incidents to employees and others undertaking work activities within the Trust.
- Liaising with the Consultant Microbiologist and local Genito-Urinary Medicine Departments for ongoing advice for management and follow-up
- Liaising with the Health and Safety Advisor as appropriate in accordance with RIDDOR 1995. (Trust’s Health & Safety Advisor will take responsibility for reporting)
- Offering counselling and support to employees relating to inoculation incidents

**Consultant Microbiologist**
The Consultant Microbiologist will:

- give expert advice on management of incidents on an individual basis
- obtain specific immunoglobulin for hepatitis B as required from a specialist centre

### 6. Risk Assessment

In the event of an inoculation injury the Inoculation Incident Procedure should be followed without delay see appendix 1. Arrange prompt follow up for recipient as appropriate.

<table>
<thead>
<tr>
<th>Source Known</th>
<th>High risk source</th>
<th>Known, suspected or in a high risk group of HIV contamination</th>
<th>Post Exposure Prophylaxis (PEP) should be commenced as soon as possible- ideally</th>
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<tr>
<td>Known</td>
<td>n.b. If the source has received recent antiretroviral therapy then specialist advice needs to be sought from the Consultant Microbiologist</td>
<td>1 Is the source known to be hepatitis B surface antigen positive <strong>OR</strong> 2 Is the source from a ward or clinic where known hepatitis B surface antigen positive patients are known to be or are likely to be? <strong>AND</strong> 3 Does the recipient NOT have immunity to hepatitis B through natural immunity or proven response to vaccination (i.e. &gt;10 miu/L)</td>
<td>Administration of immunoglobulin will be considered in such cases and the Consultant Microbiologist should be contacted for specialist advice. A course of hepatitis B vaccine may also be commenced through Occupational Health</td>
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<tr>
<td>Known, suspected or in a high risk group of Hepatitis B contamination consider:-</td>
<td>There is no vaccine or post exposure prophylaxis for hepatitis C at this time. Recipients of such contamination injuries are offered serology at 6 weeks, 12 weeks and 24 weeks to: 1 identify at an early stage any disease onset to facilitate early treatment intervention 2 As reassurance to the recipient that there has been no sign of infection.</td>
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| Low risk source | ● The source is known not to have infection from hepatitis B, HIV or hepatitis C  
● A ward or clinic does not have known infected patients and are unlikely to have in that |

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environment

- A needle or other sharp known not to have been contaminated with blood.
- If source is hepatitis B surface antigen negative, treat as low risk.

| Source Unknown | If the source of the sharps injury is unknown and the staff member has not been vaccinated against Hepatitis B, an accelerated course of Hepatitis B vaccine should be commenced through the Occupational Health Service |

7. What is the risk of infection after exposure?

Most occupational exposures DO NOT result in infection.

**Hepatitis B Virus (HBV)**

Health care worker who have received hepatitis B vaccine and have developed immunity to the virus are at a very low risk of infection. For the unvaccinated person the risk from a single needlestick or cut exposure to HBV infected blood is 30%. If the recipient is a non responder and the source is unknown advice will be sought from the consultant microbiologist regarding the use of immunoglobulin.

**Hepatitis C Virus (HCV)**

Based on limited studies, the risk for infection after a needlestick or cut exposure to HCV infected blood is approximately 3%. The risk following a blood splash is unknown, but is believed to be very small.

**Human immunodeficiency Virus (HIV)**

The average risk of HIV infection after a contamination or exposure to HIV infected blood is 0.3% i.e. 1 in 300. The risk after exposure of the eye, nose or mouth to HIV infected blood is estimated to be on average 0.1%.

8. Consent

Testing of the source individual of a contamination incident will be undertaken in accordance with current guidelines and the Trust’s policies on obtaining informed consent. Samples must be obtained by a medical practitioner, other than the recipient of the injury. Whilst this need not be a specialist, (see appendices 2 & 3) adequate pre and post testing counselling and appropriate follow up must be provided.

If the source individual lacks capacity to consent his or her blood can only lawfully be tested for BBV if it is reasonably held to be in his/her best interests in accordance with the Mental Capacity Act 2005.

If the source individual is HIV positive or belongs to a high-risk category then specialist counselling through the GUM department should be provided. Initial counselling may be undertaken by qualified medical personnel-subject to professional accountability.

If the source individual refuses or is unable to give consent contact the Consultant microbiologist as soon as possible.
9. Confidentiality

There is a general duty to preserve confidentiality of medical information and records. Any individual who undergoes examination and/or treatment can expect their confidentiality to be respected. This duty continues after the death of the individual. Source individual’s results will be shared with Occupational Health and the Infection prevention and control team.

Whilst there is the duty to preserve the confidentiality of the healthcare worker this must be balanced by the responsibilities of the employer to any patients they have dealt with. In such circumstances the employer may be advised that a change of duties should take place but the diagnosis of a blood borne virus will not normally be disclosed without the consent of the affected health care worker. The health care worker would be counselled about the implications of this disclosure.

10. Post exposure prophylaxis- pep

(see appendix 4 Information For Health Care Workers Following An HIV Positive Inoculation Incident)

PEP should be considered:-
Following a contamination injury from a source where there is known or high risk of HIV infection

PEP should not be given routinely
- Low risk exposure
- Testing shows source to be HIV negative
- Risk assessment identifies that HIV infection of the source is unlikely
- Delayed presentation
- Likelihood of repeated exposure (e.g. sharing of injecting equipment, frequent unprotected sex with different partners)
- Recipient not in favour of PEP

Administration of PEP
Administration of PEP should be in accordance with current guidelines developed by the Expert Advisory Group on AIDS. Initial therapy may be commenced pending further serology results relating to the source individual. This will normally be commenced following a thorough risk assessment at a local A&E department.

11. Related sickness absence

Any need for sickness absence associated with adverse affects of PEP drugs following occupational exposure to HIV will not contribute to the individual’s sickness absence record. The individual will be classed as on medical suspension and will receive normal pay entitlement
THIS INFORMATION SHOULD NOT BE INTERPRETED AS NEEDING PEP DRUG THERAPY FOR ALL CONTAMINATION INJURIES

12. Help and further advice

Assistance may be sought from the Occupational Health Service, Consultant Medical Microbiologist, Infection Prevention and Control Nurses

Useful Contact numbers

- Occupational Health Service 01785 221659 or internal extension 5212 (voicemail facilities are available – please leave name and daytime contact number)
- Consultant Microbiologist Queen’s Hospital Burton-on-Trent via switchboard 01283 566333
- Infection Prevention and Control Team Mobile No 07971313156 or 01785 257888 ext or 8902, 8693, 8588.
- Mid Staffordshire General Hospital A&E Department via switchboard: 01785 257731
- Department of Genito-Urinary Medicine Sir Robert Peel Hospital 01827 263810
- Department of Genito-Urinary Medicine Queen’s Hospital Burton 01283 593212
- Department of Genito-Urinary Medicine Mid Staffordshire General Hospital 01785 230260

Help lines for general advice and information may also be accessed.
National Aids Helpline 0800 567 123 (24 hours free confidential advice)
Terrence Higgins Trust Helpline 020 7242 1010

13. Process For Monitoring Compliance And Effectiveness

This policy will be reviewed bi–annually or earlier in light of new national guidance or other significant change in circumstances.

Compliance with this policy will be monitored through the mechanisms detailed in the table below. Where compliance is deemed to be insufficient and the assurance provided is limited then remedial actions will be drawn together through an action plan. This progress against the action plan will be monitored at the specified committee/group. The results of the annual audit will be escalated to the appropriate committee/group where appropriate.
14. References

- Health Protection Agency (2008) Eye of the Needle
**Appendix 1  Management of clinical sharps injuries and exposure to blood and high risk body fluids**

Quick reference guide for further information please refer to policy

<table>
<thead>
<tr>
<th>Contamination incidents include:</th>
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<td>• Needlestick or sharp injury with a used needle or instrument</td>
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<td>• Body fluids over uncovered cuts/or breaks in the skin</td>
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<tr>
<td>• Bites and scratches that break the skin</td>
</tr>
<tr>
<td>• Splashes in the eye and or mouth</td>
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</table>

**(A) Immediately stop what you are doing:**
- Dispose of the causative sharp safely and attend to the injury
- Encourage bleeding of the wound by applying gentle pressure – do not suck
- Wash well under running water
- Dry and apply a waterproof plaster
- If blood and body fluids splash into the mouth, do not swallow. Rinse out several times with cold water
- If blood and body fluids to the eye irrigate with cold water

**(B) Report the incident:**
- To the person in charge/ manager and complete an incident form
- Occupational Health (OH), Tel 01785 221659. Out of hours hotline Tel 0800 413324
- Out of hours support for significant risk incidents is available from the Consultant Microbiologist  Burton 01283 566333

**(C) Follow up of the incident :**

**Manager**
Arrange for source individual’s clinician to assess the infection risk of Hepatitis B, Hepatitis C and HIV see notes (i) (ii) and (iii)

**Recipient**
Arrange to have bloods for storage obtained from the healthcare worker – By OH if possible- (but may be undertaken by a local A&E department in cases where attendance at OH is not possible)

**Source**
Arrange for a sample of blood from the source individual with their informed consent for storage, Hepatitis B antigen, Hepatitis C antibody and HIV. Ensure sample is clearly labelled and identified

Contamination Injury

Blood samples should be 10 mls of clotted blood in a plain Z 9 tube and forwarded to the local Microbiology department.

The recipient of the injury should not obtain the blood sample or the consent from the source individual

**(i) Hepatitis B** is more infectious and of greater prevalence. Vaccination and a satisfactory titre level offer good protection. For recipients who are non immune and the client is hepatitis B positive then specific immunoglobulin may be recommended

**(ii) Hepatitis C** —no vaccine or prophylaxis is available at this time. Follow –up via OH may be necessary to detect early signs of onset of disease

**(iii) HIV** –if the source individual is known, strongly suspected or in a high risk group to be HIV positive, antiviral post exposure medication is recommended. Ideally this should be commenced as soon as possible following the incident but may be commenced up to 48 to 72 hours post injury and can be accessed from a local A&E department
Appendix 2

Seeking consent to test a source patient for blood borne viruses

Consent should be obtained by a healthcare worker other than that who sustained the inoculation injury. Record the outcome of your discussion with the source patient in the individual’s medical records.

Information that will help gain consent for blood borne virus testing:

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

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

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

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

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

If you are happy to proceed, please let us know so that we can arrange for the blood tests to be done as soon as possible.’
Appendix 3

Commonly asked questions when counselling for blood borne virus testing

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

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

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

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

What are the consequences of being tested?
For most people the advantages outweigh the disadvantages, but it has to be your choice. If the tests are all negative, then that’s reassuring, and there are no drawbacks of having been tested. If one is positive, then this may come as a shock, but the specialist care is likely to be of benefit to you.

Do I need to decide whether to have the test straight away?
The sooner we know the result of your test, the sooner we can plan treatment, if necessary, for the healthcare worker who has been exposed to your blood or body fluids. We will try to answer any questions you might have in connection with the test.

What if I refuse the test?
No further action will be taken. It might be helpful to tell us why you don’t wish to have the test, so we can try and address any concerns that you may have.
Appendix 4

Information for Health Care Workers Following an HIV Positive Inoculation Incident

Most occupational exposures DO NOT result in infection.

The initial doses of Post Exposure Prophylaxis (PEP) may be administered before specialist confidential counselling is given, as it is necessary to commence treatment as soon as possible.

Any staff member who sustains a contamination incident with a source individual who is known or highly suspected of HIV infection must receive specialist counselling before making the decision whether or not to continue treatment with PEP. (Referral to A&E or GUM Department)

Knowledge about efficacy and toxicity of these drugs used this way is limited. The drugs do not have a licence for use in this context, but their use is still recommended by the Department of Health.

You should consider carefully the issues whether or not you decide to take these drugs. Medical follow-up and blood tests for HIV antibodies may be undertaken at 3 and 6 months. Follow-up must be undertaken if the employee undertakes exposure prone procedures Follow-up is prolonged to ensure that you have not acquired infection. This will be organised by the Occupational Health Service. Seroconversion will normally occur within the first three months but may take up to 6 months.

If you are pregnant, have known liver disease or are on cytotoxic therapy or need any advice out of hours then consult the microbiologist on call.

Additionally, you may wish to consider other issues such as avoiding sexual transmission to your partner during the period of follow-up and you can discuss these confidentially with the Occupational Health Service or local GUM Department. The general advice is that you use a barrier method of contraception with the use of condoms. In addition you should not donate blood, semen or breast milk during this time.

You are not at risk of transmitting HIV to your family or friends other than by blood or body fluids. The final decision as to whether you take these drugs or not- is yours.