**Policy: ICP7**

**Bloodborne Virus Policy**

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<th>Version:</th>
<th>ICP7/07</th>
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<tr>
<td>Ratified by:</td>
<td>Trust-wide Clinical Governance Group</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>1st October 2018</td>
</tr>
<tr>
<td>Title of Author:</td>
<td>Senior Clinical Nurse Specialist Infection Control</td>
</tr>
<tr>
<td>Title of responsible Director</td>
<td>Director of Nursing and Patient Experience</td>
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| Key Stakeholders | Senior Clinical Nurse Specialist Infection Control  
|                  | Infection Control Doctor  
|                  | Members of the Infection Control and Patient Environment Group (Medical Devices) |
| Date issued:   | 30th October 2018 |
| Review date:   | October 2021     |
| Target audience: | All clinical staff and Managers |
| Disclosure Status | B: Can be disclosed to patients and the public |

**EIA / Sustainability**

| EIA / Sustainability | n/a |

**Other Related Procedure or Documents:** ICP14, ICP6
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<td>The Trust strives to ensure its policies are accessible, appropriate and inclusive for all. Therefore all relevant policies will be required to undergo an Equality Impact Assessment and will only be approved once this process has been completed</td>
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## Version Control Sheet

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<td>July 2004</td>
<td>Nursing directorate</td>
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<td>Oct 2007</td>
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<td>Policy Revised</td>
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<td>12.06.09</td>
<td>Deputy Director of Nursing and Senior Clinical Specialist</td>
<td>Policy reviewed in May 2009, no changes required to content. Approved at May 09 CSSG and issued</td>
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<td>May 2013</td>
<td>Senior Clinical Nurse Specialist Infection Control</td>
<td>Updated policy</td>
<td>Under consultation ending 28.06.13 \hspace{2.5em} To be presented to Sept 2013 TMT - Approved</td>
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INOCULATION INJURY OR OTHER SIGNIFICANT BODY FLUIDS EXPOSURE

**FIRST AID MEASURES**

- Needle sticks, cuts & bites
  - Squeeze to make bleed
  - Wash under running water
  - Cover with dressing

- Splashes into eyes, mouth, cuts, abrasions
  - Irrigate with copious amounts of water

**REPORT THE INCIDENT**

Seek immediate advice/treatment at

- Occupational Health Dept. (normal working hours)
  - at Broadmoor (01344 754310)
  - or contact St. Bernard’s (020 8354 8919)

- Accident & Emergency Depts. (outside normal working hours)
  - at Frimley Park Hospital
  - Heatherwood Hospital
  - or the nearest A&E dept. to your location

Inform A&E staff that you are a WLMHT employee and your reason for attendance

**Risk assessment of source by clinical team**

- Low risk – advice, no treatment
- High risk – initial advice and treatment
- Attend Occupational Health next working day (if not attended already)

**Follow-up and appropriate referral**
INOCULATION INJURY OR OTHER SIGNIFICANT BODY FLUIDS EXPOSURE

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**REPORT THE INCIDENT**

Seek immediate advice/treatment at

- **Occupational Health Depts.**
  - (normal working hours)
  - at
  - St. Bernard’s site (020 8354 8919)
  - Charing Cross (020 8846 1134)
  - West Middx (020 8565 5044)

  NB. For those working at the Cassel Hospital, please attend Kingston A&E. For those in the community, attend your nearest dept or A&E.

OR

- **Accident & Emergency Depts.**
  - (outside normal working hours)
  - at
  - Ealing Hospital (General)
  - Charing Cross Hospital
  - West Middx Hospital
  - Kingston Hospital
  - or
  - the nearest A&E dept. to your location

  Inform A&E staff that you are a WLMHT employee and your reason for attendance

**Risk assessment of source by clinical team**

- Risk assessment

  - Low risk – advice, no treatment
  - Follow-up and appropriate referral
  - High risk – initial advice and treatment
  - Attend Occupational Health next working day (if not attended already)
2 Introduction

2.1 Human Immunodeficiency Virus (HIV), Hepatitis B (HBV) and Hepatitis C (HCV) are all blood borne viruses. These viruses can be transmitted when a needle or sharp object contaminated with infected blood or body fluid penetrates the skin in the health care setting. These viruses can also be contracted through sexual contact with an infected person because of its presence in semen and saliva (DOH 2000).

2.2 The risk of transmission to a susceptible HCW from an infected patient following such an injury has been shown to be around:
   - 1 in 3 when a source patient is infected with HBV and is `e' antigen positive
   - 1 in 30 when the patient is infected with HCV
   - 1 in 300 when the patient is infected with HIV

2.3 There is no evidence that these infections can occur through social contact such as sharing telephones or other office equipment.

2.4 The outcome of these infections depends on the particular virus: in the case of HIV, it can progress to Acquired Immune Deficiency Syndrome (AIDS). Hepatitis B and C infections may clear up completely or lead to a chronic carrier, which can progress to cirrhosis of the liver.

2.5 Using sterile needles, avoiding unsafe sexual practices and wearing protective equipment when handling blood/body fluids achieve prevention of transmission of blood borne viruses.

2.6 HIV infections in psychiatric patients present the mental health services with a number of challenges. Firstly, it is important that patients with HIV infection receive the same standard of care as any other individual suffering from mental disorders. This means that mental health workers should be educated and trained to manage, treat and prevent HIV.

2.7 In addition, mental health workers should not display negative attitudes or have any fears when caring for HIV positive patients. These patients should be cared for in the normal way.

2.8 The transmission of blood borne viruses, from patient-to-patient, or patient to health care workers can have serious consequences not only for the person infected but also for the trust because of health and safety legislation. In spite of guidance and education, many health care workers continue to be exposed to blood borne viruses from needlestick, sharp injuries and mucosal exposure, (Evans et al 2001).

2.9 Research indicates that the prevalence of infection has increased in drug users and residents of long term institutions and those certain occupational groups have a higher risk of infection. In 2015, there were 182 new cases of human immunodeficiency virus (HIV) infection thought to be a result of injecting drug use; this is an increase from 146 new cases in 2014. The overall prevalence of HIV amongst people who inject drugs (PWID) in 2015 was similar to that seen in recent years and remains higher than in the late 1990s. It is estimated that around 90 % of all cases of hepatitis C virus (HCV) infection in the United Kingdom are a result of injecting drug use. The prevalence of HCV infection among PWID remains relatively high and has changed little in recent years; in 2015, 6 out of 10 PWID
were HCV positive. There are marked geographical variations in HCV prevalence across the United Kingdom, and prevalence is lower in Northern Ireland than in the rest of the UK (Public Health England 2017). Hepatitis B is a preventable disease and the Department of Health recommends that staff at risk should be vaccinated. This Trust encourages both staff and patients to be immunised against Hepatitis B, (HSC 1998/063).

2.10 Significant findings of Eye of the Needle, 2014 are as follows:

Data submitted to the significant occupational exposures surveillance system between 2004 and 2013 indicates that:

2.10.1 4830 significant occupational exposures to a bloodborne virus (BBV) were reported among healthcare workers; the annual number of exposures increased from 373 in 2004 to 496 in 2013

2.10.2 Of healthcare workers reporting a significant occupational exposure, half were exposed to hepatitis C (HCV), a third to HIV and one in ten to hepatitis B (HBV)

2.10.3 seven in ten (71%, 3396/4766) exposures involved a percutaneous needlestick injury, the majority of which were sharps injuries involving a hollowbore needle; the annual number of reported percutaneous injuries increased by 22% over the ten year period from 283 to 344 whereas mucocutaneous injuries increased by 61% from 90 to 145

2.10.4 Two-thirds (65%, 2490/3816) of exposures occurred in wards, theatres and A&E; the annual number of exposures increased over time both in theatres and A&E but declined in wards

2.10.5 Four in five (81%, 3926/4830) injuries were sustained by doctors, nurses and healthcare assistants; among all occupational groups, two-thirds (65%, 2288/3494) of injuries occurred during a clinical procedure

2.10.6 Of healthcare workers exposed to HBV and for whom immunisation status was reported (data limited to 2009 to 2013), 96% (300/313) were known responders to the HBV vaccine; no HBV seroconversions have been reported

2.10.7 Occupational exposures to HIV are well managed; 97% (580/598) of healthcare workers exposed to HIV who started post-exposure prophylaxis (PEP) did so within 72 hours of exposure; 89% (535) started PEP within 24 hours; no HIV seroconversions have been reported

2.10.8 Nine HCV seroconversions following occupational exposure were reported in England, Wales and Northern Ireland; eight of the nine healthcare workers received antiviral therapy of whom seven are known to have achieved viral clearance

2.11 Legislation and Guidance

2.11.1 In addition to the need to reduce the risk of infection there are legal duties to protect the patients, staff and visitors from harm; -
a) **The Health and Safety at Work-Act 1974**

All employers have 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 to health and safety risks.

Employers and employees are accountable through the Health and Safety at Work Act 1974 to ensure that the workplace is free from hazard, and it also imposes specific obligations to ensure the microbiological safety of the hospital environment.

b) **The Control of Substances Hazardous to Health Regulations 2003**

This covers pathogenic microorganisms as hazards, which may require risk assessments and instruction on how to avoid contact, or lower the risk of infection as far as is reasonably practicable.

c) **HIV Post-Exposure Prophylaxis: Guidance from the Chief Medical Officers Expert Group on AIDS**

This guidance is to be applied to health care workers who are occupationally exposed to material which is known to be, or has the potential to be, a source of HIV infection.

d) This policy is for the management, control and prevention of Hepatitis C, which is an important public health problem as large numbers of people are affected who continue to harbour the virus and many will go on to develop chronic liver disease.

2.12 **Principles**

2.12.1 This policy is devised from government legislation, national and professional guidance and best practice.

- West London Mental Health NHS Trust believes that prevention and control of infection is part of the overall risk management strategy of the health care environment, be it hospital or community care.

- The Occupational Health Department is proactive in providing immunisation to protect staff from disease and they also provide post incident advice.

- The Clinical staff offer immunisation to patients to protect them from Hepatitis B and pre and post test discussion is provided within the Trust.

- Routine screening is offered on admission and screening is carried out as appropriate.
3. **Scope**

3.1 All NHS organisations are required to put infection control and basic hygiene at the heart of good management and clinical practice to ensure effective protection of health, with particular regard to the prevention of hospital acquired infection. This policy is primarily to guide against the transmission of Blood-borne Viruses from patient to health care worker however, it is equally applicable to patients where exposure to them from a health care worker’s body fluids occurs.

4. **Definitions**

4.1 **Human immunodeficiency virus (HIV):** A retrovirus that causes AIDS by infecting helper T cells of the immune system.

4.2 **Acquired immunodeficiency syndrome (AIDS):** A severe immunological disorder caused by the retrovirus HIV, resulting in a defect in cell-mediated immune response that is manifested by increased susceptibility to opportunistic infections and to certain rare cancers, especially Kaposi’s sarcoma.

4.3 **Hepatitis B Virus (HBV):** A form of hepatitis caused by a virus transmitted by infected blood (as in transfusions), contaminated hypodermic needles, sexual contact, or by contact with any other body fluid.

4.4 **Hepatitis C (HCV):** An infection of the liver that is caused by an RNA virus transmitted primarily by blood and blood products, as in blood transfusions or intravenous drug use, and sometimes through sexual contact.

5. **Duties**

5.1 **Chief Executive**

The Chief Executive is responsible for ensuring that the Trust has policies in place and complies with its legal and regulatory obligations.

5.2 **The Trust Board**

The Trust Board is responsible for ensuring that:

- Effective arrangements are in place for Infection Control within the Trust and these will include the provision of an appropriately constituted and functional Infection Prevention and Control Team which reports on adverse events/incidents to the Infection Control Committee and in the annual report to the Trust Board.

- The Infection Control Team has direct access to appraise of adverse events/incidents.

5.3 **Accountable Director**

The Director of Nursing and Patient Experience is the Accountable Director for this policy and is the DIPC (The Director of Infection, Prevention and Control) for the Trust as delegated by the Trust Board.
5.4 Infection Control Committee

- The Senior Clinical Nurse Specialist Infection Control is responsible for 24 hour on call cover which ensures that expert infection control advice is provided.

- The Director of Infection Prevention and Control is responsible for ensuring that the Infection Control Team receives regular up to date training to ensure that they can provide expert advice on matters relating to inoculation injuries on a day-to-day basis.

- The Infection Control Team, (ICT), reports to the Chief Executive on all aspects of surveillance, prevention and Infection Control.

- There is an appropriately constituted and functioning Infection Control Team which includes the Infection Control Doctor, (ICD), and the Infection Control Nurses, (ICN).

- The Infection Control Team provides expert advice to Key Trust Committees.

- The Infection Control annual programme is developed with support and monitoring from the Infection Control Committee, (ICC), and approved by the board.

- The Infection Control Team report adverse incidents to the Infection Control Committee Meetings and in the annual report.

- The Infection Control Team develops policies for the Trust, which reflects national and professional guidance and relevant legislation for the prevention and control of infection across the Trust.

- There is an annual programme, for the audit of Infection Control Policies and Procedures, including the safe use and disposal of sharps, infectious waste and the containment and decontamination of blood spillages.

- The Infection Control Team liaises with the Trust’s Occupational Health Department regarding infection control advice relating to the health and safety of health care workers and the transmission of infections.

5.5 Managers and Supervisors

- Clinical Managers are responsible for ensuring that any member of staff who sustains a contaminated sharps injury is referred promptly for an assessment of their risks of acquisition of a blood borne virus. Occupational Health is responsible for carrying out risk assessments, counselling and management of staff member.
• Clinical Managers are responsible for ensuring that any service user who sustains a contaminated sharps injury is referred promptly for an assessment of their risks of acquisition of a blood borne virus. Infection Control and any competent professional is responsible for carrying out risk assessments, counselling and management of service user.

5.6 Employees

• All staff are responsible for adhering to this Policy.

5.7 Professional Responsibilities

5.7.1 To ensure that the policy is effectively implemented, staff must work to their professional guidance.

5.7.2 Nursing, Midwifery and Health Visiting

5.7.2.1 Nurses are bound by the Code of Professional Conduct to protect patients and colleagues from risks of cross infection. A vital tool for all health care employees, which embodies the principles of good practice, is to follow Standard Precautions which was devised to protect staff against the transmission of infection from HIV and Hepatitis viruses.

5.7.3 General Medical Council (GMC)

5.7.3.1 Doctors’ responsibilities to protect patients from infection "You must protect patients from unnecessary exposure to infection by following safe working practices and implementing appropriate Infection Control measures. This includes following the Control of Substances Hazardous to Health Regulations 1994 and other Health and Safety at Work legislation."

5.7.3.2 "You must follow the UK Health Departments’ advice on immunisation against Hepatitis B. If you are in direct contact with patients you should protect yourself and your patients by being immunised against serious communicable diseases where vaccines are available."

5.7.3.3 "If you have any reason to believe that you have been exposed to a serious communicable disease you must seek and follow professional advice without delay from a Consultant in Occupational Health, Infectious Diseases or Public Health."

5.7.4 General Dental Council (GDC)

5.7.4.1 This guidance maintaining standards to Dentists on Professional and Personal Conduct 2016/17 was issued, and acknowledged that: -

5.7.4.2 "There has always existed the risk of cross infection in dental treatment. Therefore a dentist has a duty to take appropriate precautions to protect patients and colleagues from risk."
5.7.5 The Microbiology Advisory Committee to the Department of Health

5.7.5.1 Provide guidance on Decontamination, Sterilisation, Disinfection and Cleaning of Medical Equipment (2014), and the Use and Management of Sharps containers guidance is written by the Medical Devices Agency (2014).

5.7.5.2 All employees new and existing (including bank, agency, locum, or visiting staff), should be made aware of government guidance, professional regulatory bodies statements, ethical responsibilities and Occupational-Health guidance through Induction Training and updating of West London Mental Health Trust Infection Control Policies in accordance with the Health and Safety at Work Act 1974, and the Control of Substances Hazardous to Health (COSHH) Regulations 1994.

6. Systems and recording

6.1 Where recorded – Documented on Rio

6.2 When recorded – patient admission – if positive for a blood borne virus should be documented on RiO Patient screened whilst an in-patient – documented on Rio

6.3 Recorded by who – staff/Doctor

7. Infection control guidelines

7.1 Key Points to Minimise Infection

(i) All patients potentially present a risk of infection. Therefore, all blood and body fluids should be treated as infectious. When handling blood/body fluids one should be careful to avoid spillages.

(ii) Effective hand washing is the single most important factor in preventing infection. Use the soap provided, wash all areas of the hands, rinse thoroughly and dry with paper towels. Run the site of exposure under warm water and wash with soap and water without scrubbing. Bleeding should be encouraged. Cover cuts and abrasions with waterproof dressings.

(iii) Exercise great care with all sharps to prevent puncture wounds, cuts or abrasions. Protect existing wounds, skin rashes or lesions, conjunctivae and mucosal surfaces from all blood and body fluids. When the use of sharps is essential, exercise particular care in handling and disposal of same. Only use approved sharps containers. Never put needles or other sharps into hazardous or household waste bags. Never resheath needles.

(iv) Control surface contamination by blood or body fluids by containment and disinfection. Wearing a plastic apron and disposable gloves sprinkle response granules onto the spillage. Leave for 10 minutes. Remove soiled granules with care using a dustpan and brush, and put into an orange infectious waste bag or bin. Tag it and then
place in relevant place for collection. Then wash the dustpan and brush in hot soapy water, rinse and stand up to dry.

* Failure to dispose of infectious waste and sharps safely will be a breach of these regulations and could result in prosecution.

7.2 Occupational Risk

7.2.1 Occupational risks of transmission of blood borne viruses arise from the possible exposure to blood or other body fluids or tissues 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 health care settings.

7.2.2 Many exposures result from a failure to follow Infection Control guidelines regarding the safe handling and disposal of sharps. Even when infection control guidelines and safe working practices are adopted there is still the possibility of accidents and malicious acts resulting in exposure to blood borne viruses.

7.2.3 Most cases of occupationally acquired HIV infection have arisen from percutaneous exposure to HIV infected materials, and of these the majority have followed injury from hollow needles in association with a needle or canula being placed in a vein, e.g. venepuncture. Others have arisen through exposure of mucous membranes or non-intact skin to blood.

7.2.4 Transmission of blood borne viruses may result from contamination of mucous membranes of the eyes or mouth, or of broken skin, with infected blood or other infectious material, and by human bites if the skin is broken (Refer to ICP6 appendix 2 protocol for human bites). There is no evidence of blood borne viruses being transmitted by contamination of intact skin or by inhalation.

7.2.5 Arrangements for post exposure prophylaxis for blood borne viruses please see ICP6

7.2.6 Please Note: Not all patients with blood borne viruses have had their infections diagnosed. Therefore it is important that all blood/body fluids and tissues are regarded as potentially infectious. Health care workers should follow Standard precautions routinely in all circumstances to avoid contact with blood/body fluids.

7.3 Safe Handling and Disposal of Sharps

7.3.1 Employers and employees are accountable through the Health and Safety at Work Act 1974 to ensure that the workplace is free from hazard. Any staff using or handling sharps has a duty under the Health and Safety at Work Act 1974 to work safely and dispose of sharps items correctly into the sharps boxes provided. Every ward and department that may handle sharps items including broken blood stained crockery and glass, must request the provision of sharps boxes and follow these guidelines.

Many needle stick injuries are preventable.

- place all disposable sharps into sharps containers immediately after use.
- needles must never be re-sheathed.
- Retractable needles must be used at all times except as agreed i.e. insulin pens, venepuncture
- discard disposable syringes and needles as a single unit into the sharps container, needle pointing downwards.
- discard blood stained broken crockery/glass and razor blades etc., into a sharps container.
- sharps containers must be puncture resistant, suitable for incineration and conform to British Standards 7320. They must be positioned safely and away from the general public. On assembling the sharps bin the lid has to be secure to avoid spillages. It needs to either be secured onto a bracket on the wall at waist height or stored on a work surface at waist height.
- sharps containers must be ordered to provide a ready supply.
- sharps containers must only be two thirds full. Once two thirds full the lid must be closed, the label completed to identify the date of disposal, and put out for collection by the porters.

7.4 Personal Protective Equipment

7.4.1 Standard Principles

7.4.1.1 Expert opinion suggests that the primary uses of personal protective equipment are to protect staff and reduce opportunities for transmission of micro-organisms in hospital, and community settings.

7.4.2 Gloves should comply with Class 1 Medical Devices Complies with BSEN455

7.4.2.1 Gloves should be worn to:

- Protect the hands from contamination with organic matter and micro organisms.
- Reduce the risks of transmission to both patients and staff.
- Gloves must be worn for invasive procedures, contact with sterile sites, non intact skin, mucous membranes, and all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions, and excretions, sharp or contaminated instrument.
- Gloves should be worn as a single use item. Put gloves on immediately before patient contact or treatment, and remove them as soon as the activity is completed. Change gloves between caring for different patients or between different care treatment activities for the same patient.
- Gloves must be disposed of as infectious waste, and hands should be decontaminated following the removal of gloves, which could have been punctured or torn during use.
- Gloves should be worn when in contact with any body fluid, when handling soiled linen, or removing used dressings.

7.4.3 Plastic Aprons

7.4.3.1 Are provided for basic protection from blood or body fluids. They are designed to be single use and should be changed after contact with infected patients.

- Disposable plastic aprons should be worn when there is a risk that clothing may become exposed to blood, body fluids, secretions and excretions.
• Full body water repellant coveralls should be worn when there is a risk of extensive splashing of blood, body fluids, secretions and excretions onto the skin of health care workers.

7.4.4 **Masks**

7.4.4.1 Are not normally required.

7.4.5 **Eye Protection**

7.4.5.1 Goggles or safety glasses are advised if there is a risk of conjunctival exposure or blood or body fluids, secretions and excretions.

7.4.6 **Coveralls**

7.4.6.1 Are to be worn when dealing with patients who have been involved in “faceal smearing”. Faecal smearing is when an individual has smeared a large area with faecal matter.

7.5 **Infectious Waste**

7.5.1 The Health and Safety at Work Act 1974 and the Control of Substances Hazardous to Health Regulations (COSHH) 2003 lay down a duty of care for employers which are essential to prevent risks from identified potential sources of harm. This duty is extended under the Environmental Protection Act 1990 to the safe disposal of waste.

7.5.2 All staff working in areas where infectious waste arises must adopt safe working practices and follow the infection control guidelines. Failure to do so may result in prosecution.

7.5.3 The person in charge of each ward and area has a duty to ensure that all infectious waste is bagged/binned, sealed, tagged and stored for collection.

7.5.4 Only infectious waste should be disposed of in orange bags or bins.

7.5.4.1 The following items must be disposed of as infectious waste:-

• Soiled dressings and swabs.
• Human tissue (e.g. teeth following extraction).
• Tampons and sanitary towels.
• Incontinence pads, catheters, urine bags, stoma bags.
• Response granules used on absorbing body fluid spillages.
• Gloves and aprons.
• Naso gastric tubes.

7.5.4.2 The following should be disposed of into sharps containers:-

• Needles and syringes.
• Glass ampoules.
• Razors.
• Blood stained crockery or glass
7.5.5 Infectious waste will only be collected from wards and departments if it has been secured and identity tagged. The Trust has a duty to ensure that all infectious waste is securely stored and transported and the identity tagging system is used in tracking and monitoring its disposal.

7.6 Contaminated Linen

7.6.1 Any staff handling contaminated linen has a duty under the Health and Safety at Work Act 1974 to work safely and ensure that the workplace is free from hazard.

7.6.2 All items of clothing or linen contaminated with blood or body fluids should be handled with caution. Wearing gloves the staff must put hospital linen into a red alginate bag secure and place inside a red linen bag; and arrange for transportation to the laundry. In the Trust’s High Secure Service (HSS) hospital linen in put into a red alginate bag secure, clear bag and place inside a red linen bag; and arrange for transportation to the laundry.

7.6.3 The Department of Health’s guidance Hospital Laundry Arrangements For Used and Infected Linen - annex one must be followed:

- items should be washed with detergent using the hot wash cycle to a temperature of 71 degrees C for a minimum of ten minutes.
- Infected linen must be placed in a red coloured water-soluble bag, which is to be transferred to the washing machine without opening.
- dry cleaning must be done at elevated temperatures or incinerated.
- washing machines must not be overloaded.

7.7 Decontamination of Spillages and Equipment

7.7.1 Staff MUST deal with body fluid spillages in the area in which they are working at the time of the spillage, unless the spillage covers a large area or is in connection with an unexpected death.

7.7.2 Any staff responsible for decontamination of spillages and equipment has a duty under the Health and Safety at Work Act to do so safely and correctly to ensure that the workplace is free from hazard. All areas should have spillage kits to clean up blood, urine and vomit these will consist of sachets of response granules easily accessible to use.

7.7.3 Empty a sachet of response granules onto any body fluid spillage and leave to absorb for 10 minutes. Then wearing disposable gloves brush the granules up and dispose of same into an orange infectious waste bag, which must be secured, tagged showing the date, ward and Hospital. The domestic staff can then clean the floor.

7.7.4 For soft furnishings you will need to follow the manufacturer’s guidance

7.7.5 Work surfaces can be cleaned by using household detergents wearing household gloves and using disposable cloths or paper towels clean the surfaces thoroughly.

7.7.6 Dispose of cloths or towels into an orange infectious waste bag, secure and tag it.
7.8 Specimens and Transportation

7.8.1 Any person responsible for handling specimens has a duty under the Health and Safety at Work Act to work safely, and to ensure that the workplace is free from hazard.

- Staff must wear gloves and aprons when handling specimens
- Only approved laboratory containers are to be used
- Containers must be labelled with the patient’s name and date of birth, date of specimen collection and specimen details
- Hazard labels must be applied on specimens from patients with known or suspected infections
- The specimen must be placed into a plastic transparent specimen bag as soon as it is labelled
- The bag must be sealed
- Request form must be fully completed.

7.9 Accidental Exposure – please refer to ICP6 Sharps Policy

7.10 Patient Care for Known Carriers of HIV/HBV/HCV

- No special toilet or bathing precautions are necessary except if the patient has diarrhoea when a separate toilet is recommended.
- Crockery and cutlery should be washed as normal in the dishwasher.
- Gloves must be worn when giving first aid, removing or changing wound dressings and handling dirty laundry.
- Masks and eye protection must be used when resuscitating patients.
- Patients should not share toothbrushes, razors, or nail scissors/clippers.
- Ear, body piercing and tattooing should be discouraged.

7.11 Death of a Patient with HIV/HBV/HCV

7.11.1 When the police or coroner give permission for the body to be moved, only heavily soiled areas of the body should be washed, and then placed into a body bag and marked to alert mortuary staff regarding the risk of infection, (CDSC 1999)

7.12 HIV/HCV Testing

7.12.1 All bloodborne virus testing is routinely offered on admission and is currently carried out by the Senior Clinical Nurse Specialist Infection Control or a competent healthcare professional. The UK National Guidelines for HIV Testing (2008) states that it should be within the competence of any Doctor, midwife, nurse or trained healthcare worker to obtain consent for and conduct an HIV test. The Senior Clinical Nurse Specialist – Infection Control will continue to offer this service to all admissions to the Trust and on a referral basis, Doctors within the Trust if they feel competent can also carry out this service. A surveillance report will form part of the quarterly Infection Control report of how many patients were offered testing and results.

7.12.2 All patients should be offered blood borne virus testing on admission, they should also be offered testing if there has been an incident where there has been blood to blood contact.
7.12.3 It must be emphasised that in the UK, HIV testing remains voluntary and confidential.

7.13 Pre-Test Discussion

7.13.1 Anybody who is to be tested for HIV or HCV should have the opportunity of pre and post test discussion. The aim of the discussion is to explain and discuss the implications and limitations of the test and to establish informed consent for HIV testing, which should fall in line with other tests being carried out.

7.13.2 Some patients may need additional help to make a decision, for example, because English is not their first language. It is essential to ensure that these patients have understood what is proposed, and why. It is also important to establish that the patient understands what a positive and a negative result mean in terms of infection with HIV as some patients could interpret ‘positive’ as good news.

7.13.3 The essential elements that the pre-test discussion should cover are:

- The benefits of testing to the individual
- Why you are offering the test
- Information on the viruses
- Any issues which may be raised by the patient as it’s important that patients are given the opportunity to make a decision with adequate information about the test and the viruses
- The window period
- Information on re-testing
- Details of how long the results take and how the results will be given

7.13.4 Children and young people, and those with learning difficulties or mental health problems, may need additional support and time to understand what is proposed and to make a decision.

7.13.5 As with any other investigation the offer of an HIV test should be documented in the patient’s multi disciplinary notes together with the relevant discussion. If a patient refuses a test the reasons for this should be documented.

7.14 Post-Test Discussion

7.14.1 As with any medical investigation it is essential that clear procedures are established as to how the patient will receive the result, with particular attention paid to the means by which a positive result will be delivered. Arrangements for communicating the results should always be discussed and agreed with the patient at the time of testing.

7.14.2 Face-to-face provision of HIV test results is strongly encouraged for:

- Ward-based patients
- Patients more likely to have an HIV-positive result
- Those with mental health issues or risk of suicide
- Those for which English is a second language
- Young people under 16 years
- Those that may be highly anxious or vulnerable.
7.14.3 Post-test discussion for individuals who test HIV negative

7.14.3.1 It is considered good practice to offer health promotion screening for sexually transmitted infections and advice around risk reduction or behaviour change.

7.14.3.2 The need for a repeat HIV test if still within the window period after a specific exposure should be discussed. Although fourth generation tests shorten the time from exposure to seroconversion a repeat test at three months is still recommended to definitively exclude HIV infection.

7.14.3.3 Occasionally HIV results are reported as reactive or equivocal. These patients may be seroconverting and management of re-testing may be complex and so such individuals should be promptly referred to specialist care.

7.14.4 Post-test discussion for individuals who test HIV positive

7.14.4.1 As is good clinical practice for any situation where bad news is being conveyed, the result should be given face to face in a confidential environment and in a clear and direct manner. If a patient’s first language is not English, consideration should be given to utilisation of an appropriate confidential translation service.

7.14.4.2 If a positive result is being given by a non-GUM/HIV specialist, it is essential, prior to giving the result, to have clarified knowledge of local specialist services and have established a clear pathway for onward referral.

7.14.4.3 It is recommended that any individual testing HIV positive for the first time is seen by a specialist (HIV clinician, specialist nurse or sexual health advisor or voluntary sector counsellor) at the earliest possible opportunity, preferably within 48 hours and certainly within two weeks of receiving the result.

7.14.4.4 More detailed post-test discussion (including assessment of disease stage, consideration of treatment, and partner notification) will be performed by the GUM/HIV specialist team.

8. Training

8.1 All staff employed on a permanent, part-time or bank contract must attend an infection control session on the Trust Mandatory Induction programme which covers blood borne virus training to raise awareness and reduce risk. This includes what the procedure is that needs to be followed regarding any type of outbreak, or isolated case of any infection.

8.2 Training is delivered as per mandatory training matrix – refer to M12 Mandatory Training Policy. This can be either classroom attendance or via e-learning. If staff complete e-learning then they have to attend the classroom session on next update.

8.3 Mandatory training attendance is monitored monthly by Learning and Development.

8.4 Non-compliance of attendance at mandatory training will be followed up by Local Managers through supervision and annual appraisal. The monthly compliance score sheets will be registering what staff have attended the relevant training and
this can be identified by CSU and corporate services. A rag system has been put in place to show compliance.

8.5 Outbreak incidents will be monitored on a quarterly basis by the Infection Control Team and findings will be reported at the quarterly Trust Infection Control Meetings. An annual report will be in cooperated into the Trust Infection Control Annual report.

9. **Monitoring**

9.1 For training requirements please refer to the mandatory passports within the M12 Mandatory Policy

10. **Fraud statement (if required)**

10.1 No fraud statement is required for this policy.

11. **References**

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Eye of the needle (HPA report) 2014
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UK Health Departments (1998), Guidance for Clinical Health Workers, Protection Against Infection with Blood Borne Viruses. DOH.

13. Supporting documents

Eye of the Needle
UK National Guideline for HIV Testing 2008
Getting ahead of the curve

14. Glossary of terms/acronyms

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<td>Human immunodeficiency virus</td>
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<td>HBV</td>
<td>Hepatitis B Virus</td>
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<td>HCV</td>
<td>Hepatitis C Virus</td>
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<td>HCW</td>
<td>Health Care Worker</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>HSC</td>
<td>Health Service Circular</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>RNA</td>
<td>ribonucleic acid</td>
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<td>National Health Service</td>
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<td>Director of Infection, Prevention and Control</td>
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<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<td>BBV</td>
<td>Blood Borne Virus</td>
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<td>PEP</td>
<td>Post-exposure prophylaxis</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>E-LEARNING</td>
<td>Electronic Learning</td>
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<td>HAART</td>
<td>Highly active anti-retroviral therapy</td>
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<td>CSU</td>
<td>Clinical Service Unit</td>
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<td>High Secure Service</td>
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<td>Men having Sex with Men</td>
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<td>World Health Organisation</td>
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<td>PWID</td>
<td>People who inject drugs</td>
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15. **Appendices**

**Appendix 1**

Human Immunodeficiency Virus (HIV)
Hepatitis B Virus (HBV)
Hepatitis C Virus (HCV)
Appendix 1

Human Immunodeficiency Virus (HIV)

HIV infection has been transformed from a fatal to chronic life-long infection due to the introduction of effective antiretroviral therapy (ART) in the mid-1990s. Consequently, the number of people living with diagnosed HIV has risen year on year, with an increase in number of new diagnoses among men who have sex with men (MSM) and people born in high prevalence countries.

By the end of 2011, an estimated 96,000 (95% credible interval 90,800 – 102,500) people were living with HIV in the UK; approximately one quarter (22,600, 24% [19%–28%]) of whom were undiagnosed and unaware of their infection. This is an increase from the 91,500 people estimated to have been living with HIV by the end of 2010. The estimated prevalence of HIV in 2011 was 1.5 per 1,000 (1.5–1.6) population of all ages, 2.1 per 1,000 (1.9–2.3) men and 1.0 per 1,000 (1.0–1.1) women

HIV or human immunodeficiency virus is a retrovirus that affects the immune system of the body which is responsible for fighting infection. This causes the effect of HIV in the body to take months or even years to show up. Someone infected with HIV may not show any signs of the virus for years and may be unaware that they are infected. They will still be carriers of the infection and are able to pass the infection on to others. Normally when someone has an infection their bodies have the ability to fight off and establish resistance in relation to the infection process. HIV affects the immune system and the body is unable to fight against the infection.

Keeping healthy and living positively with HIV can increase the time between infection and symptom development.

HIV Natural history:-

Viral transmission
After the initial infection with HIV an acute flu like illness may occur, and often the infected person is unaware of being unwell.

Primary HIV infection or acute seroconversion stage
In this stage, which may last from 6 months to 10 years the infected person often has no observable signs or symptoms of infection.

Seroconversion: Most patients convert to positive HIV serology within 4-10 weeks after infections and more than 95% seroconvert in 6 months.

Clinical latent period: The period of early HIV disease extends from seroconversion to 6 months following transmission.

Acquired Immune Deficiency Syndrome
AIDS is the case defined condition of an HIV infected person who develops one of a number of opportunistic infections that are associated with the syndrome e.g. Kaposi’s sarcoma.

Please note: Staff as well as patients could be HIV positive. To safeguard oneself standard infection control precautions must be followed at all times when dealing with blood/body fluids.
In the last 20 years, 4 NHS staff have died from HIV Virus and a further 9 have been infected after being injured by needles used on HIV patients. (Safety Practitioner 2003).

The risk of acquiring HIV infection following a needle stick injury or a bite is small. Although HIV transmission may occur in health care settings most transmission occurs:

- Unprotected penetrative sexual intercourse with an infected person (between men or between men and women).
- Blood transfusion
- Inoculation of infected blood. At present in the UK this results mainly from drug users sharing blood contaminated injecting equipment i.e., syringes and tattooing equipment.
- Infected mother to her baby before or during birth or through breast feeding.

There is no vaccine to prevent HIV. There is currently no cure for HIV, however, the use of HAART (Highly active anti-retroviral therapy) has enabled people with the virus to live longer and stay healthy.

**Hepatitis B Virus (HBV)**

Hepatitis means inflammation of the liver. Hepatitis B is an infection of the liver caused by hepatitis B virus; many new infections with hepatitis B are sub clinical or have flu like illness. Jaundice only occurs in 10% in children and 30-50% of adults. Acute infection can occasionally lead to fulminant hepatic necrosis, which can be fatal.

The World Health Organization (WHO) has estimated that over 350 million people worldwide are chronically infected with HBV. The WHO has categorised countries based upon the prevalence of HBsAg into high (more than 8%), intermediate (2 to 8%) and low (less than 2%) endemicity countries. In many high-prevalence countries, 10% or more of the population have chronic hepatitis B infection. High-prevalence regions include sub-Saharan Africa, most of Asia and the Pacific islands. Intermediate-prevalence regions include the Amazon, southern parts of Eastern and Central Europe, the Middle East and the Indian sub-continent. Low-prevalence regions include most of Western Europe and North America.

Hepatitis B is transmitted in the same way as HIV but it is far more infectious. Hepatitis B infection can vary from having unnoticeable symptoms to mild flu like symptoms, such as nausea, vomiting, fever, jaundice, hepatic failure coma and death within 8 weeks. Hepatitis B virus can be found in blood and virtually all body fluids of patients with Hepatitis B and carriers of the virus, but blood semen and vaginal fluids are the source of spread of HBV infection. Transmission usually occurs by:-

- unprotected sexual intercourse.
- injecting drug users sharing contaminated injecting equipment.
- from an infected mother to her baby before or during birth or through breast feeding.
- needlestick injuries.
- sharing of infected needles.

The incubation period ranges from 40 to 160 days, with an average of 60 to 90 days. Current infection can be detected by the presence of HBsAg in the serum. Blood and body fluids from these individuals should be considered to be infectious. In most individuals,
infection will resolve and HBsAg disappears from the serum, but the virus persists in some patients who become chronically infected with hepatitis B. Chronic hepatitis B infection is defined as persistence of HBsAg in the serum for six months or longer. Individuals with chronic infection are sometimes referred to as chronic carriers. Among those who are HBsAg positive, those in whom hepatitis B e-antigen (HBeAg) is also detected in the serum are the most infectious. Those who are HBsAg positive and HBeAg negative (usually anti-HBe positive) are infectious but generally of lower infectivity. Recent evidence suggests that a proportion of chronically infected people who are HBeAg negative will have high HBV DNA levels, and may be more infectious. The risk of developing chronic hepatitis B infection depends on the age at which infection is acquired. Chronic infection occurs in 90% of those infected perinatally but is less frequent in those infected as children (e.g. 20 to 50% in children between one and five years of age). About 5% or less of previously healthy people, infected as adults, become chronically infected (Hyams, 1995). The risk is increased in those whose immunity is impaired.

Around 20 to 25% of individuals with chronic HBV infection worldwide have progressive liver disease, leading to cirrhosis in some patients. The risk of progression is related to the level of active viral replication in the liver.

Individuals with chronic hepatitis B infection – particularly those with an active inflammation and/or cirrhosis, where there is rapid cell turnover – are at increased risk of developing hepatocellular carcinoma.

The most important measure that health care workers can take is to be vaccinated against HBV.

**Hepatitis C Virus (HCV)**

Hepatitis C was first identified in 1989, and it has emerged as a significant public health problem. There are an estimated 170 million carriers of HCV world wide. The most recent national estimates suggest that around 216,000 individuals are chronically infected with hepatitis C (HCV) in the UK. (Hepatitis C in UK, 2012 Report, HPA).

Hepatitis C Virus is a small enveloped single stranded RNA Virus. The nucleotide sequence of the HCV genome (the genotype) is variable. Different genotypes have distinct geographical distributions and response to treatment.

Infection with the hepatitis C virus (HCV) can result in both acute and chronic hepatitis. The acute process is most often asymptomatic; if symptoms are present, they usually abate within a few weeks. Acute infection rarely causes hepatic failure. Acute HCV typically leads to chronic infection; 60 to 80 percent of cases develop chronic hepatitis (abnormal liver enzymes). Chronic HCV infection is usually slowly progressive and may not result in clinically apparent liver disease in many patients if the infection is acquired later in life. Approximately 20 to 30 percent of chronically infected individuals develop cirrhosis over a 20- to 30-year period of time.

HCV is most frequently acquired by direct blood-to-blood contact, and the commonest mode of transmission in the UK is by sharing blood contaminated injecting equipment by injecting drug users. Both sexual and perinatal transmission can occur, though rarely. In the past transmission has occurred through transfusion of contaminated blood and organ transplant, but testing of blood donors and all products for HCV antibodies and heat treatment of blood products has greatly reduced transmission in this way, (PHLS 1999).
The Chief Medical Officer highlighted Hepatitis C in his infectious disease strategy “Getting ahead of the curve”, and the main proposal is to increase diagnosis of people at current or past risk of HCV infection and to assess and offer treatment. This strategy targets Prisons and Health Care settings. (DOH 2003).

**How can Hepatitis C be prevented or treated?**

Prevention is centred on stopping the blood from infected individuals from coming into contact with others. Injecting drug users are at high risk of infection and when injecting cannot be avoided, sterile injecting equipment should always be used; injecting equipment should never be shared. Similarly, individuals who undergo body piercing should ensure that disposable sterile needles are used. In the home, sharing of personal items, like toothbrushes and razors, should be avoided and all wounds and cuts should be cleaned and covered with waterproof dressings; blood spills should be cleaned-up with undiluted bleach. In a health care setting, standard precautions should be adhered to; all blood, body fluids and body tissues should be treated as potentially infectious at all times.

**Aims of Antiviral Treatment**

- To suppress viral replication
- To reduce liver inflammation
- To prevent development of liver fibrosis
- To prevent cirrhosis and liver cancer

The treatment of choice for individuals with chronic hepatitis C infection is a combination of two drugs: interferon and ribavirin. This combination therapy is successful in clearing virus from the blood of around 40% of those treated. However, not everybody is suitable for treatment or can tolerate it. Factors such as age, sex, duration of infection, the strain of the virus, and the degree of existing liver damage determine the effectiveness of treatment. New more effective treatments are likely to become available in the near future.

**Hepatitis B AND C – Who should be offered a HEPATITIS B AND/OR HCV test?**

- Past or current drug history or injecting drug use, irrespective of how long ago or how frequent the usage was.
- Babies of HCV infected mothers.
- Regular sexual partners of known HCV patients.
- Needlestick injury from known or likely HCV infected source.
- Attendees of renal dialysis units (past and present).
- Medical/Dental treatment abroad.
- Tattoos or piercing abroad, in poor infection control premises.