

Immunisation & Screening of Healthcare Workers Standard Operating Procedure

Issue Date	Review Date	Version
November 2016	November 2021	1

Purpose

This Standing Operating Procedure (SOP) sets out the standards to be followed in the Immunisation & Screening of Healthcare Workers (HCWs) who are operational within the auspices of the Trust especially those who;

- work in close proximity to patients, clients or service users
- handle pathogens or potentially infected specimens.

In addition, this SOP sets out the standards to identify those:

- with active conditions;
- at increased risk of having acquired latent disease (such as in TB) and;
- identified are appropriately cared for; either by means of further investigation of symptoms, immunisation against disease or in the case of refusal of immunisation that restrictions are put in place to protect that member of staff, colleagues and patients.

In keeping with current national guidance HCWs will be advised of individual needs in order that the risk of infection transmission to patients and staff can be minimised.

Who should read this document?

This document is applicable to Healthcare Workers; PHNT staff, Ministry of Defence personnel, contractors; those employed on a fixed term contract, honorary contract, agency or locum staff, Volunteers and students affiliated to educational establishments etc. and those who fall under the auspices of the Trust. ***Not all HCWs will work with, or in close proximity to patients, service users or clients so if there is any doubt about individual situations please contact OH&WB for advice.***

Key messages

This Standing Operating Procedure (SOP) sets out the standards to be followed in the Immunisation & Screening of Healthcare Workers (HCWs) who are operational within the auspices of the Trust.

Core accountabilities

Owner	Alison Williams, Clinical Manager
Review	Infection Prevention & Control Committee
Ratification	Dr Peter Jenks Director of Infection Prevention and Control
Dissemination	Infection Prevention and Control
Compliance	<ul style="list-style-type: none"> • The Health and Safety at Work etc. Act 1974 • The Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended) • NHSLA • CQC Essential Standards of Quality & Safety • The Health and Social Care Act 2008 / The Hygiene Code Criterion 5.1, 5.2, 5.3, 9.3e, 9.3r, 9.3y, 10.1, 10.2, 10.3

Links to other policies and procedures

- Health and Safety Policy
- Management of Health and Safety Procedure
- Risk Assessment Procedure
- Control of Substances Hazardous to Health (COSHH) Policy & Procedure
- Recruitment and Selection Policy
- Guidance for Departments Employing Children or Young People
- Handling of Cadavers Policy
- Outbreak Policy for Clinical Areas
- Management of Contamination Incidents SOP
- Guidelines for the Exclusion of Healthcare Workers with Conditions and/or Infectious Diseases SOP

Version History

V1	Nov 2016	Development from previous Policy to Trust Wide SOP
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The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

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Standard Operating Procedure (SOP) Immunisation & Screening of HCWs

1 Introduction

This Standing Operating Procedure (SOP) sets out the standards to be followed in the Immunisation & Screening of Healthcare Workers (HCWs) who are operational within the auspices of the Trust especially those who;

- work in close proximity to patients, clients or service users
- handle pathogens or potentially infected specimens.

In addition, this SOP sets out the standards to identify those:

- with active conditions;
- at increased risk of having acquired latent disease (such as in TB) and;
- identified are appropriately cared for; either by means of further investigation of symptoms, immunisation against disease.

The Immunisation Programme is provided by PHNT at no cost to the HCW (apart from Agency Workers) and all HCWs should engage in the Immunisation Programme unless they produce documentary evidence of their immunisation status or there are contraindications. Where evidence cannot be produced or where updating is required, the HCW will be informed of the process to rectify this.

If HCWs choose not to engage in the Immunisation Programme, they must understand that to decline will weaken the overall infection control defences to patients, service users, clients and other employees or staff operational within the auspices of the Trust and that their role within the Trust may be affected. This decision will be communicated to the Manager in order for them to undertake appropriate risk assessment.

2 Definitions

Occupational Health & Well-being Department ~ OH&WB

Infection Prevention and Control Team ~ IPCT

HCW ~ Healthcare Worker ~ This term applies to PHNT staff, Ministry of Defence personnel, contractors; those employed on a fixed term contract, honorary contract, agency or locum staff, Volunteers and students affiliated to educational establishments etc. and those who fall under the auspices of the Trust. ***Not all HCWs will work with, or in close proximity to patients, service users or clients so if there is any doubt about individual situations please contact OH&WB for advice.***

HCWs likely to work in close those who work in close proximity to patients, clients or service users or likely to handle potentially infected specimens and samples

- Ancillary staff
- Cleaners
- Dieticians
- Doctors & Dentists
- Laboratory workers
- Mortuary staff

- Nurses & Midwives
- Occupational therapists, Physiotherapists, Speech & Language Therapists
- Porters
- Radiographers
- Receptionists
- Renal Unit staff
- Security staff
- Students and trainees
- Technical staff
- Venepuncturists
- Volunteers (dependant on individual risk assessment)
- Ward clerks

DATIX ~ PHNT Incident Reporting System

EPPs ~ Exposure Prone procedures are those in which there is a risk that injury to the HCW could result in exposure of the patient's open tissues to the blood of the HCW.

Such procedures include where the workers gloved hand may come in to contact with sharp instruments, needle tips and sharp tissue (spicules of bone or teeth) inside a patients open body cavity, wound or confined anatomical space where the hand or fingertips may not be completely visible at all times.

IVS ~ Identity Validated Sample - defined by Association of NHS Occupational Physicians (ANHOPS) and the Association of NHS Occupational Health Nurses (ANHONS) as meeting the following criteria:

- a) the healthcare worker should show a proof of identity with a photograph – Trust identity badge, new driver's licence, passport or national identity card – when the sample is taken;
- b) the sample of blood should be taken in the occupational health department;
- c) samples should be delivered to the laboratory in the usual manner, not transported by the healthcare worker;
- d) when results are received from the laboratory, the clinical notes should be checked for a record that the sample was sent by the occupational health department, at the relevant time.

UKAP ~ United Kingdom Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses

UKAP-OHR ~ United Kingdom Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses-Occupational Health Monitoring Register

3 Regulatory background

The Health and Safety at Work etc. Act 1974 states that an employer must make provision for securing the health, safety and welfare of persons at work and for protecting others against risks to health or safety in connection with the activities of persons at work.

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended) represents the main piece of legislation covering control of the risks to employees and other people arising from exposure to harmful substances generated out of or in connection with any work activity under the employer's control.

The Health and Social Care Act 2008 provides a Code of Practice and related guidance for health and adult social care on the prevention and control of infections.

4 Key Duties

The Director of Nursing has responsibility for:

- Seeking assurance that the Immunisation & Screening of HCWs is managed in accordance with the SOP

All Employees have a responsibility for:

- Ensuring they are familiar and comply with this SOP and associated policies/guidance.

The Occupational Health & Wellbeing Department (OH&WB) has responsibility for:

- Screening HCWs as per this SOP.
- Organising the onward care of HCWs identified as having active or latent conditions.
- Referring where appropriate to specialist services or to the OHP.
- Informing relevant parties via DATIX where the policy has not been followed correctly.
- Reviewing and updating this SOP in line with national guidance.

The Infection Prevention & Control Team and Microbiologist have responsibilities for:

- Providing expert advice where appropriate on the clinical management when not covered by this SOP.

5 Procedure to Follow

5.1 Pre-Placement Screening

No HCW will start work until they have completed the Pre-placement Screening Process.

Pre-placement Screening is based on Risk Assessment, assessment of the HCW with guidance from DOH, PHE, Nice, Patient Group Directives (PGDs) and Patient Specific Directives (PSDs) etc.

5.2 Risk Assessment

Appointing Managers will risk assess all roles and the outcome sent to OH&WB via the Recruitment Team will indicate whether the HCW will be;

- working with or in close proximity to patients;
- handling samples and specimens in the course of their work
- an EPP worker
- a clinical worker on a Renal Unit

5.3 HCW Groups

PHNT HCWs ~ Screening will be carried out by means of an on-line Questionnaire through the OH&WB OPAS Portal.

The assessment of immunity and health is based on risk assessment and guidance from DOH etc. against the relevant pre-placement documentation and any associated serology results etc.

The outcome of screening including further guidance if required and any arrangements that need to be made will be sent via e-mail to the HCW, their Appointing Manager and the Recruitment Team within two working days of receipt of the pre-placement documentation.

Agency HCWs ~ All Agency HCWs will initially be screened to current standards by the employer or their own appointed occupational health care provider.

OH&WB will verify all immunisation and screening results to ensure compliance. The information will be sent via NHS e-mail to OH&WB via the Recruitment Team.

The outcome of screening including further guidance if required and any arrangements that need to be made will be sent via e-mail to the Recruitment Team within two working days of receipt of the pre-placement documentation.

OH&WB may carry out the additional immunisations/tests at cost to the Agency or Agency Worker.

Students Affiliated to Educational Establishments & Contractors ~ Students affiliated to educational establishments & contractors will be screened to current standards by their employer or their own appointed occupational health care provider.

Volunteers ~ Screening will be carried out by means of a Questionnaire sent confidentially to OH&WB.

A self-declaration of immunisation will be accepted for Volunteers in the following groups/areas; Mustard Tree, Ward Visiting, Work Shadowing Student, Work Experience, Pastoral Care, Hospital Radio, Coffee Shop Assistant, Shop Assistant.

Volunteers such as Breastfeeding Peer Support Worker, Play Centre Volunteer and Work Shadowing / Experience in Laboratories will be required to attend OH&WB if they are unable to produce evidence of the required immunisations.

The outcome of screening including further guidance if required and any arrangements that need to be made will be sent via e-mail to the Volunteer and their Appointing Manager within two working days of receipt of the pre-placement documentation.

5.4 Documentary Evidence of Immunisations and Screening

Documentary evidence of previous immunisations or tests (by an Occupational Health Provider or a GP) must be uploaded onto the OPAS Portal at the time of the completion of the pre-placement questionnaire or if not, within 10 days if not immediately available.

OH&WB will only accept documentary evidence that meets the following criteria for all immunity or health screening requirements.

- The results must be either the original or clearly visible copies of laboratory or x-ray results, or be a clearly visible printout from a previous OH Department, a Laboratory, Hospital or GP. The immunisation/test need not have been undertaken in the UK.
- The documents must be signed by a qualified practitioner or be on headed paper or clearly identifiable copies from a database or similar.
- The name and date of birth of the HCW is to be clearly visible.
- The date of the tests must be clearly visible.
- Hand-written or typed reports with no professional signature or heading will not be accepted.

Documentary Evidence for EPP Clearance

There are strict criteria for the clearance of workers who will undertake EPPs. An identified validated sample (IVS) is where the taking of a blood sample where specific additional criteria has been met for EPP clearance as follows:

- The HCW must have shown photographic proof of identity e.g. NHS Trust ID badge, photographic driving licence, passport, national identity card at the time of the test.
- Samples should not be delivered to the laboratory by the staff member themselves.
- 'IVS' or 'Identified Validated Sample' must be stated on any documents.

- The sample must be taken and reported through a UK OH department (England, Scotland, Wales & Northern Ireland).
- Where HCWs are **from outside of the UK**, it is recognised that blood tests will not be have been carried out to DoH standards. OH&WB would expect the samples to be undertaken as soon as possible on entry to the UK; either by another UK OH Department, an authorised UK Laboratory such as 'The Doctors Laboratory or by OH&WB.

5.5 Immunity, Health & Vaccination / Screening Protocol

5.5.1 Hepatitis B

Evidence of vaccinations administered or serological evidence of immunity must be provided if such interventions have previously taken place.

If not previously immunised or no evidence is able to be produced the vaccine or serology will be offered. If partial immunisation has been previously administered – the regime will be dependent on the HCW's individual immunisation history.

In addition, HCWs working clinically in **renal units** will be screened for negative Hepatitis B Surface Antigen within the last 12 months.

Ascertaining History of Vaccinations

A full history is required using documentary evidence where possible. In some cases, it may be difficult to ascertain the exact course of action. In this case the advice of the Clinical Manager / Senior Nurse or OH&WB Physician will be required.

i. 1st dose only administered

Check the amount of time elapsed since the first dose.

If **less than 6 months ago**, administer the 2nd dose immediately with the 3rd in a month's time with serological testing.

If **more than 6 months ago** recommend a 'reverse course'.

ii. 1st & 2nd doses only administered

Check the amount of time elapsed since the 2nd dose.

If **more than 6 months ago** recommend give 3rd dose immediately with serological testing.

iii. Primary course completed but no documentary evidence available

Check the amount of time elapsed since completion of the course and either;

Undertake serological testing as noted above or;

Offer a booster dose (which may serve as the usual 5 year Booster), then undertake serological testing as noted above.

Primary Hepatitis B Course

A routine primary course is administered as follows; Days 0 & 28 and Month 5.

Post vaccination serological test should be checked approximately two months after completion of

the primary course.

Accelerated Hepatitis B Primary Course

This accelerated schedule may be offered in some cases where employees are requiring more rapid immunisation such as those working abroad, or following exposure to the virus, when the third dose may be given at two months after the initial dose.

The vaccines are administered as follows; Days 0, 28 and 56.

Post vaccination serological test should be checked approximately two months after completion of the primary course.

- A booster dose should be offered at 12 months.
- The routine 5 year booster should be offered.

Hepatitis B Booster Vaccinations

Hepatitis B boosters should be offered in the following circumstances;

- Routinely at 5 years after the primary course (usually 5 years after the date of the antibody result – this may differ if there has been a delay or break in the primary course).
- Where there has been a delay or break in the primary course – in this case, serological testing may be required as noted in **8.1.2**.

Criteria for Exclusion / Contraindications

- A confirmed anaphylactic reaction to a previous dose of vaccine or any component.
- Any illness with fever $>38.5^{\circ}\text{C}$
- Minor illnesses without fever or systemic upset are not valid reasons to postpone immunisation. If a HCW is acutely unwell, immunisation may be postponed until they have fully recovered. This is to avoid confusing the differential diagnosis of any acute illness by wrongly attributing any signs or symptoms to the adverse effects of the vaccine.
- Pregnancy; Caution should be exercised prior to vaccination. Immunisation should not be withheld from a pregnant woman if she is in a high-risk category. There is no evidence or risk from vaccinating pregnant or those who are breast-feeding with inactivated viral or bacterial toxoids. Since Hepatitis B is an inactivated vaccine, the risks to the foetus are likely to be negligible, and it should be given where there is a definite risk of infection. The HCW should be given information and make an informed decision.
- HCWs with an evolving neurological condition; immunisation should be deferred until the neurological condition has resolved or stabilised.
- Known acute or chronic Hepatitis B infection;
- Presence of any contra-indications as detailed in the current data sheet or Immunisation against Infectious Diseases

Hepatitis B Post Vaccination Serological Testing

- HB antibody levels ≥ 100 mIU/ml**
 - HCWs showing this level of antibodies do not need any further primary doses of HBV vaccine.
 - If the HCW is not immunosuppressed, their HBs antibody levels do not need to be checked again.
 - They should be offered a booster dose of HBV vaccine at five years.
- HB antibody level of ≥ 10 mIU/ml and ≤ 100 mIU/ml**
 - should be given an additional dose of HBV straight away
 - It is not necessary to repeat the anti-HBs test after this.

- They should also be offered a booster dose of HBV vaccine at five years.

iii. HB antibody levels of < 10 mIU/ml

- HCWs with these levels are classed as susceptible
- They should be tested for markers of current or past infection if this has not already been done.
- Those without evidence of infection should receive an accelerated course of HBV vaccine with testing of their HBs antibody levels approximately two months later.
- If they fail to respond to the repeat course of HBV vaccine, they will be described as ‘true non-responder’ and no further action will be necessary. Reasons for failing to seroconvert include male gender, age of over 40, obesity, smoking and genetic factors – being naturally immune.
- These true non-responders may require HBV immunoglobulin after a contamination incident.

Hepatitis B - Failure to Respond to Vaccine

There are many reasons for failure to respond to the vaccine (<10mIU/mL anti-HBs);

- being over the age of 40 years
- obesity
- smoking
- alcoholism
- advanced liver disease
- immunosuppression
- renal dialysis
- pre-existing Hepatitis B infection.

Vaccine non-responders who perform EPPs must be tested for evidence of Hepatitis B infection (HBsAg). Thereafter they are required to undergo annual testing for markers of infection.

5.5.2 Measles, Mumps and Rubella

Rubella vaccine was introduced in 1970, MR in 1974, MMR in 1988, and 2 dose MMR in 1996 so some HCWs will provide a mixture of evidence.

Ascertaining History of Vaccinations

Evidence of 2 MMR vaccinations administered or serological evidence of immunity must be provided if such interventions have previously taken place.

If not previously immunised or no evidence is able to be produced the vaccine or serology will be offered. If partial immunisation has been previously administered – the regime will be dependent on the HCW’s individual immunisation history.

Where 2 doses of MMR vaccine have not been administered:

- Administer 2 doses, four weeks apart
- If 1 dose previously administered – only 1 dose (2nd) is to be administered.

Post vaccination serological testing is not required.

Criteria for Exclusion / Contraindications

- A confirmed anaphylactic reaction to a previous dose of vaccine or any component.
- Allergy to neomycin or gelatine.

- Acute illness (postpone until the condition has resolved)
- Minor illnesses without fever or systemic upset are not valid reasons to postpone immunisation. If a HCW is acutely unwell, immunisation may be postponed until they have fully recovered. This is to avoid confusing the differential diagnosis of any acute illness by wrongly attributing any signs or symptoms to the adverse effects of the vaccine.
- Untreated malignant disease or impaired immunity - e.g., immunosuppression, steroids, radiotherapy, cytotoxic drugs or within six months of receiving such treatment. (Immunisation can still be possible in some circumstances depending on dosage and combination of drugs - check with the specialist treating the condition or the local community paediatrician.)
- Within three months of receiving blood products, such as immunoglobulin.
- If immediate protection against measles is required in someone who has recently received a blood product, MMR vaccine should still be given. To confer longer-term protection, MMR should then be repeated after three months.
- Pregnancy - but note that the Department of Health does not recommend termination, as studies failed to demonstrate a link between rubella immunisation in early pregnancy and foetal damage.
- Presence of any contra-indications as detailed in the current data sheet or Immunisation against Infectious Diseases

5.5.3 Varicella

Ascertaining History of Vaccinations

A history of chickenpox or herpes zoster is required to deem the HCW protected unless the HCW has originated from a tropical or sub-tropical area as the diseases are not usually associated with children.

Where there is an unclear history or the HCW has originated from a tropical or sub-tropical area, serological evidence must be sought.

Where no history or correct doses of Vaccines have not been administered:

If serological evidence suggests vaccination is required 2 doses of Varicella vaccine are administered four to eight weeks apart.

- If no previous doses, 2 doses to be administered.
- If only 1 dose previously administered – only 1 dose (2nd) is to be administered.
- Female HCWs must avoid pregnancy for 1 month.
- Post vaccination serological testing is not required unless the HCW will come into contact with highly vulnerable patients (e.g. transplant units). In this case, if the result indicates a susceptible status a further course of vaccine may be indicated. Advice from OH&WB may need to be sought at this time.

HCWs are advised to report any rashes post vaccination to OH&WB as this may restrict their ability to work.

Criteria for Exclusion / Contraindications

- A confirmed anaphylactic reaction to a previous dose of vaccine or any component.
- Allergy to neomycin or gelatine.
- Acute illness (postpone until the condition has resolved)
- Minor illnesses without fever or systemic upset are not valid reasons to postpone immunisation. If a HCW is acutely unwell, immunisation may be postponed until they have fully recovered. This is to avoid confusing the differential diagnosis of any acute illness by wrongly attributing any signs or symptoms to the adverse effects of the vaccine.

- Blood dyscrasias, leukaemia, lymphomas of any type, or other malignant neoplasms affecting the hemic and lymphatic systems.
- HCWs receiving immunosuppressive therapy (including high doses of corticosteroids).
- Severe humoral or cellular (primary or acquired) immunodeficiency, e.g. severe combined immunodeficiency, agammaglobulinemia and AIDS or symptomatic HIV infection.
- HCWs with a family history of congenital or hereditary immunodeficiency, unless the immune competence of the potential vaccine recipient is demonstrated.
- Active untreated tuberculosis.
- Pregnancy. Furthermore, pregnancy should be avoided for 1 month following vaccination.
- Presence of any contra-indications as detailed in the current data sheet or Immunisation against Infectious Diseases

5.5.4 Tuberculosis (TB)

Ascertaining History of Vaccinations

A BCG scar check by an OH professional or a record of the BCG vaccination being administered is required. If no evidence is supplied a Tuberculin skin test (Mantoux Test) is required (unless from a high risk area where Interferon-Gamma Testing will be required).

HCWs showing signs or symptoms of TB such as a cough for more than 3 weeks in duration, unexplained weight loss, fever or night sweats, loss of energy or haemoptysis and HCWs or members of their family having a history of having had TB will be further assessed which may involve:

- A clinical examination of sputum
- A chest x-ray (CXR)
- An interferon gamma test (Quantiferon Test)
- A referral to the Chest Clinic by OH&WB Clinicians

TB Risks to HIV Positive HCWs

The risk of TB for a new healthcare worker who is HIV positive at the time of recruitment will be assessed.

The employer, through OH&WB should be aware of the settings with increased risk of exposure to TB, and that these pose increased risks to HIV-positive healthcare workers.

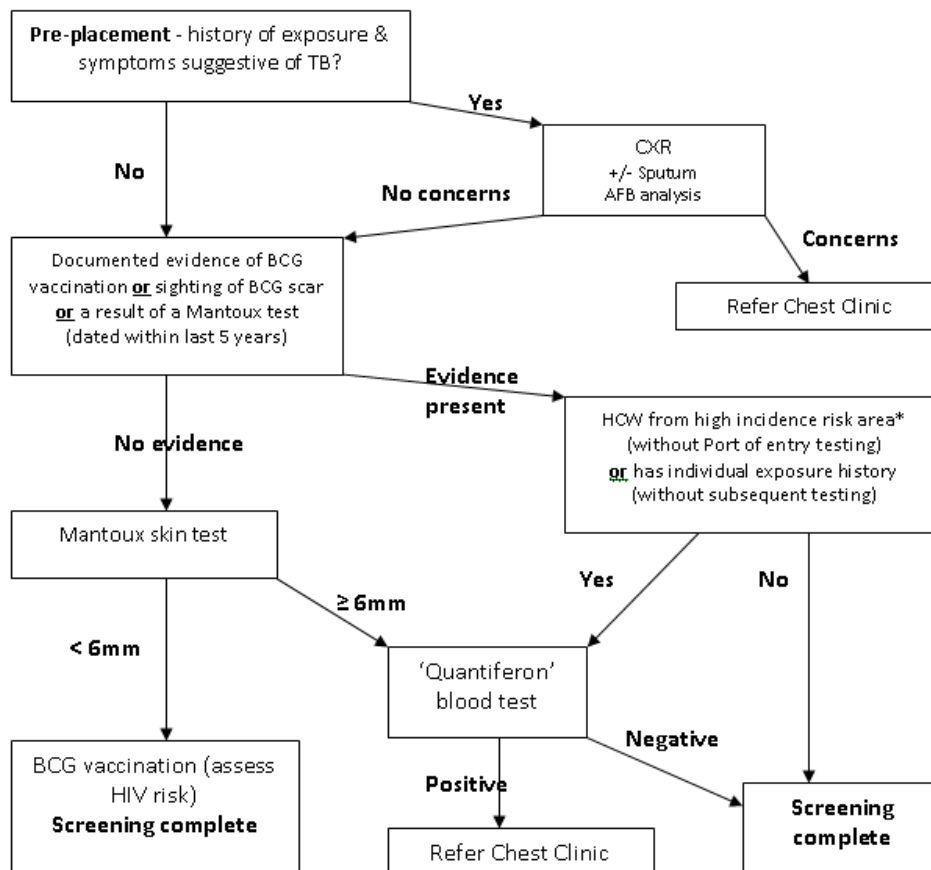
Enhanced Screening for Tuberculosis

Enhanced screening is carried out because clinical presentation is often delayed with TB infection lying dormant (latent disease), validity of BCG vaccination and a complicating factor of HIV.

All HCWs who were born in or have lived in a '*TB High Incidence Country*' or '*High Incidence Primary Care Organisation*' for more than 3 months will require enhanced screening.

A '*High Incidence Country*' or '*High Incidence Primary Care Organisation*' is one with more than 40 cases per 100,000 per year and are listed by Public Health England (PHE) (refer to current guidance WHO / PHE for full details).

TB Screening Algorithm



Mantoux Test

HCWs should be offered a Mantoux Test where there is no documentary evidence of BCG vaccination or no visible BCG scar.

Factors that May Affect the Result of the Mantoux Test

The reaction to tuberculin protein may be suppressed by the following:

- glandular fever
- viral infections in general, including those of the upper respiratory tract
- live viral vaccines (tuberculin testing should not be carried out within four weeks of having received a live viral vaccine)
- sarcoidosis
- corticosteroid therapy
- immunosuppression due to disease or treatment, including HIV infection.

Administration of the Mantoux Test

An Intradermal injection of PPD Tuberculin Vaccine PPD 2TU/0.1ml is administered into the flexor surface of left forearm. If a second test is necessary it should be carried out on the other arm.

The injection produces a bleb which is typically 7mm in diameter.

Criteria for Exclusion / Contraindications

- A confirmed anaphylactic reaction to a previous dose of vaccine or any component.
- Severe skin reaction to a previous test
- Allergy to neomycin or gelatine.
- Acute illness (postpone until the condition has resolved)
- Minor illnesses without fever or systemic upset are not valid reasons to postpone immunisation. If a HCW is acutely unwell, immunisation may be postponed until they have fully recovered. This is to avoid confusing the differential diagnosis of any acute illness by wrongly attributing any signs or symptoms to the adverse effects of the vaccine.
- A history of live viral vaccines in the preceding 4 weeks

Assessment of the Mantoux Test Result

The results should be read 48 to 72 hours after the test is taken, but in certain circumstances, a valid reading can usually be obtained up to 96 hours later. The transverse diameter of the area of induration at the injection site is measured with a ruler and the result recorded in millimetres.

As several factors affect interpretation of the test, the size of the induration should be recorded and NOT just as a negative or positive result. The area of erythema is irrelevant.

HCWs who have a **0mm** test result who may have had an upper respiratory tract or other viral infection at the time of testing or at the time of reading should be re-tested two to three weeks after clinical recovery before being given BCG.

If a second tuberculin test is necessary it should be carried out on the other arm: repeat testing at one site may alter the reactivity either by hypo- or more often hyper-sensitising the skin, and a changed response may reflect local changes in skin sensitivity only.

There is some variability in the time at which the test develops its maximum response. The majority of tuberculin-sensitive subjects will be positive at the recommended time of reading. A few, however, may have their maximum response just before or after the standard time.

Diameter of Induration	Positivity	Interpretation
Less than 6 mm	Negative ~ no hypersensitivity to tuberculin protein	Previously unvaccinated individuals may be given BCG provided there are no contraindications
6mm or greater, but less than 15mm	Positive ~ hypersensitive to tuberculin protein	Should not be given BCG.* May be due to previous TB infection or BCG or exposure to non-tuberculous mycobacteria
15mm and above	Strongly positive ~ strongly hypersensitive to tuberculin protein	Suggests tuberculosis infection or disease and will be clinically assessed by Interferon Gamma Test and possibly a CXR.

** When Mantoux tests are being performed as part of an immunisation programme, no further action is required for people with a reaction in this range. In other contexts (e.g. new immigrant screening, contact-tracing programmes), where the subject has not previously been vaccinated with BCG, and taking account of the precise size of the reaction and the circumstances of the case, referral to a chest clinic may be indicated for further investigation.*

BCG Vaccination

The BCG vaccine only gives around 50% protection to those younger than 35 years of age and as most HCWs will not have significant exposure (>8hrs in close proximity to high risk patients), Occupational requirements are deemed low risk by DoH.

BCG vaccination consists of an intradermal injection to the left upper arm and should be offered to HCWs irrespective of age who;

- are previously unvaccinated (that is, without adequate documentation or a characteristic scar), **and**
- will have contact with patients or clinical materials, **and**
- are Mantoux negative < 6mm (result dated within the last 3 months) **or**
- Interferon-Gamma negative (result dated within the last 3 months);

Criteria for Exclusion / Contraindications

The vaccine should not be given to HCWs:

- A confirmed anaphylactic reaction to a previous dose of vaccine or any component.
- who have already had a BCG vaccination
- with a past history of TB
- with an induration of 6mm or more following Mantoux (SSI) tuberculin skin testing
- who are immunocompromised by virtue of disease or treatment, e.g.: patients receiving corticosteroid or other immunosuppressive treatment, including general radiation (taking 40mg Prednisolone (or equivalent) daily for 1 week or more in the last 3 months). Inhaled steroids are not a contraindication those suffering from a malignant condition such as lymphoma, leukaemia, Hodgkin's disease or other tumour of the reticuloendothelial system.
- Who are HIV-positive
- Who are at risk of having HIV infection (offer HIV test)
- Presence of any contra-indications as detailed in the current data sheet or Immunisation against Infectious Diseases.
- Although no harmful effects on the foetus have been observed from BCG during pregnancy, it is wise to avoid vaccination, particularly in the first trimester, and wherever possible to delay until after delivery. A further tuberculin test may be required if more than three months has elapsed since the test on which a recommendation for BCG was based. Breast-feeding is not a contraindication to BCG.

Quantiferon

The Quantiferon test (**Interferon-Gamma Testing**) is performed in two stages. First, whole blood is collected into each of the Quantiferon blood collection tubes, which include a Nil Control tube, TB Antigen tube, and a Mitogen tube.

The tubes should be sent to PHNT laboratory and incubated at 37°C as soon as possible, and within 16 hours of collection where they are centrifuged and tested.

Results are usually available in 2 weeks.

Negative ~ screening complete and no further action

Positive ~ CXR to be requested by OH&WB Clinicians and a referral to PHNT Chest Clinic for further assessment.

Health Surveillance of HCWs Potentially Exposed to TB

Reminders of the symptoms of TB, and the need for prompt reporting of such symptoms (a cough for more than 3 weeks in duration, unexplained weight loss, fever or night sweats, loss of energy or haemoptysis) should be included with annual reminders about health and wellbeing for staff who:

- are in regular contact with TB patients or clinical materials, **or**
- have worked in a high-risk clinical setting for 4 weeks or longer.
- one-off reminders should be given after a TB incident on a ward.

TB Precautions

Whether a HCW is vaccinated or not, it is important to take the following precautions:

- Follow local guidelines and wear full PPE where advised.
- When examining patients, do so in a way to avoid being coughed over.
- Be aware of the symptoms of TB; persistent cough, night sweats, unexplained fever, weight loss or haemoptysis and report symptoms early to plh-tr.occhealthadvice@nhs.net

5.5.5 Seasonal Influenza (Inactivated Influenza Vaccine (Split Virion) BP)

Influenza vaccination for health care workers has been shown to reduce morbidity and mortality in patients in certain health care settings.

For this reason the Department of Health (DoH) recommends influenza vaccination for all health care workers and to protect them from contracting influenza as a result of caring for infected patients and to reduce the likelihood of illness and associated sickness absence.

In line with DoH guidance Influenza vaccines will be offered annually to HCWs.

Antibody response in patients with endogenous or iatrogenic immunosuppression may be insufficient.

Criteria for Exclusion / Contraindications

- A confirmed anaphylactic reaction to a previous dose of vaccine or any component.
- Allergy to neomycin or gelatine.
- Acute illness (postpone until the condition has resolved)
- Minor illnesses without fever or systemic upset are not valid reasons to postpone immunisation. If a HCW is acutely unwell, immunisation may be postponed until they have fully recovered. This is to avoid confusing the differential diagnosis of any acute illness by wrongly attributing any signs or symptoms to the adverse effects of the vaccine.
- Presence of any contra-indications as detailed in the current data sheet or Immunisation against Infectious Diseases

5.5.6 Tetanus / Diphtheria / Polio (Td/IPV) Vaccine

Laboratory & Mortuary HCWs and Estate Workers (Ground Workers, Maintenance Staff, Plumbers, Waste/effluent Workers etc.) may in the course of their work be handling potentially infectious materials. Individual risk assessments should be discussed with OH&WB to ensure HCWs are adequately protected in such cases.

Ascertaining History of Vaccinations

All HCWs should have received a primary course of three doses of Td/IPV and two subsequent boosters at five and fifteen years following completion of the primary course through their GP.

Laboratory Workers should be offered Td/IPV vaccination (dependant on local risk assessment);

- Where there is no documentary evidence of previous vaccination (**Laboratory & Mortuary HCWs** ~ after antibody test to confirm protective immunity)

- Where there is continued risk

Criteria for Exclusion / Contraindications

- A confirmed anaphylactic reaction to a previous dose of vaccine or any component.
- Allergy to neomycin or gelatine.
- Acute illness (postpone until the condition has resolved)
- Minor illnesses without fever or systemic upset are not valid reasons to postpone immunisation. If a HCW is acutely unwell, immunisation may be postponed until they have fully recovered. This is to avoid confusing the differential diagnosis of any acute illness by wrongly attributing any signs or symptoms to the adverse effects of the vaccine.
- Presence of any contra-indications as detailed in the current data sheet or Immunisation against Infectious Diseases.

Protective Diphtheria antibody levels:

Post vaccination serological testing is required to check protective immunity to Diphtheria where there is continued risk such as **Laboratory & Mortuary HCWs**. An antibody test should be performed at least three months after immunisation to confirm protective immunity and the individual should be given a booster dose at ten-year intervals after checking antibody levels.

> **0.01IU/ml** = (Microbiology ATOs with possible exposure)

> **0.1IU/ml** = (Microbiology BMSs with likely exposure)

A booster dose should be given where levels are below protected levels. Re-check immunity levels 3 months afterwards.

5.5.7 Hepatitis A

Ascertaining History of Vaccinations

Estate Workers (Ground Workers, Maintenance Staff, Plumbers, Waste/effluent Workers etc.) should be offered a course of Hepatitis A vaccination (dependant on local risk assessment);

- Where there is no documentary evidence of previous vaccination
- If not previously vaccinated - 1 dose then reinforcing dose 6-12 months after initial dose (this will give more than 10 years' protection).
- If previously vaccinated, establish history and time frame and consider administering a new course or booster doses.
- Consider booster at 20 years.
- Post vaccination serological testing is not required.

Criteria for Exclusion / Contraindications

- A confirmed anaphylactic reaction to a previous dose of vaccine or any component.
- Allergy to neomycin or gelatine.
- Acute illness (postpone until the condition has resolved)
- Minor illnesses without fever or systemic upset are not valid reasons to postpone immunisation. If a HCW is acutely unwell, immunisation may be postponed until they have fully recovered. This is to avoid confusing the differential diagnosis of any acute illness by wrongly attributing any signs or symptoms to the adverse effects of the vaccine.
- Presence of any contra-indications as detailed in the current data sheet or Immunisation against Infectious Diseases.

5.5.8 Typhoid

Ascertaining History of Vaccinations

Estate Workers (Ground Workers, Maintenance Staff, Plumbers, Waste/effluent Workers etc.) should be offered a course of Typhoid vaccination (dependant on local risk assessment);

- Where there is no documentary evidence of previous vaccination.
- If not previously vaccinated - 1 dose 0.5ml of Typhim Vi.
- Reinforcing dose at 3 yearly intervals in subjects who remain at risk.

Criteria for Exclusion / Contraindications

- A confirmed anaphylactic reaction to a previous dose of vaccine or any component.
- Allergy to neomycin or gelatine.
- Pregnancy and breastfeeding mothers – unless a clear indication exists. If the risk of typhoid is high, vaccination should be considered.
- Acute illness (postpone until the condition has resolved)
- Minor illnesses without fever or systemic upset are not valid reasons to postpone immunisation. If a HCW is acutely unwell, immunisation may be postponed until they have fully recovered. This is to avoid confusing the differential diagnosis of any acute illness by wrongly attributing any signs or symptoms to the adverse effects of the vaccine.
- Presence of any contra-indications as detailed in the current data sheet or Immunisation against Infectious Diseases

5.5.9 Additional Vaccines / Prophylaxis for Overseas Travellers

These vaccines can be administered without cost to the HCW where they volunteer or are going to be working abroad on behalf of the Trust in circumstances such as 'Operation Hernia' etc.

Managers must confirm in writing or by e-mail to OH&WB that their member of staff is working on behalf of the Trust whilst abroad.

Vaccines / Prophylaxis Available:

- Rabies
- Yellow Fever
- Cholera
- Meningitis
- Malaria prophylaxis
- HIV post exposure prophylaxis pack

5.5.10 MRSA (Meticillin Resistant Staphylococcus Aureus)

There should be no active infection or colonisation with MRSA.

Where there is a history reported, a full history of diagnosis, treatment etc. will be required. Dependent on the results of screening, advice may be sought from OH&WB Physician and/or the Infection Protection & Control Team and recommendations made.

5.5.11 Blood-Borne Virus (BBV) Screening

Screening for the blood-borne viruses; Hepatitis B, Hepatitis C and HIV can take place at any stage of a HCW's career. The tests are only carried out with the consent of the HCW, however declining tests can affect the HCW's employment.

Anonymity for the tests can be ensured if the HCW wishes it. A confidential code number and date of birth can be used to ensure confidentiality for any HCW regarding any serological test for Hepatitis B, Hepatitis C and HIV.

Any HCW found to be positive to a BBV should be referred to an Occupational Health Physician and subsequent specialist management. The offer of counselling should also be considered at this time.

Categories of HCW That Require BBV Screening

All HCWs who require BBV Screening are those that may have been exposed to; are positive to; or at risk of developing HIV, Hepatitis B or C by;

- Spending any time outside the UK through; MOD postings, work with medical charities, sabbaticals, voluntary service, extended Elective travel.
- Self-declaration or disclosure of a high risk incident or practice or positive result
- Declaration or disclosure by a colleague, representative of PHNT or other agency of an alleged high risk incident or practice or positive result
- Contamination by means of an inoculation injury or body fluid splash from a source positive to HIV, Hepatitis B or Hepatitis C positive
- Performing EPPs
- Working in a Renal Unit
- Being a non-responder to Hepatitis B vaccine (and an EPP worker)
- Having a positive result (but a non EPP worker)

EPP Workers

When there is any doubt about whether a procedure is exposure-prone or not, advice should be sought in the first instance from the Occupational Health & Wellbeing Department.

HCW Groups who are likely to perform EPPs:

- **Obstetrics and Gynaecology Staff:** Registered Nurses, Doctors and Midwives
- **Operating Theatre/Department Staff:** Registered Nurses, Doctors and Practitioners
- **Emergency Department Staff:** Registered Nurses, Doctors, Practitioners, Royal Navy Medical Assistants
- **Other Clinical Staff:** Physician Associates etc.
- **Dental Workers:** Dentists, Dental Nurses and Dental Hygienists
- **Foundation Year Doctors (F1s and F2s):** as they are highly likely to encounter EPP roles.

EPP Testing Standards

There are three instances where standards have altered over the years and HCWs need not be screened to 2007 standards (except Agency EPP Workers). This may be difficult to understand so where clarification is required, OH&WB should be contacted.

Where the criteria noted below have not been met, clearance for EPP work will not be given.

EPP Clearance '< 2002'

HCWs will be cleared to this standard where they have previously undertaken EPPs prior to August 2002.

They are required to produce documentary evidence (which need not be an IVS result) of immunity to Hepatitis B with antibodies above 10mIU/ml;

EPP clearance '> 2002'

HCWs will be cleared to this standard where they have previously undertaken EPPs between August 2002 and March 2007.

They are required to provide IVS results for the following;

- Hepatitis B Surface Antigen;
- Hepatitis C antibodies

EPP clearance '> 2007'

HCWs will be cleared to this standard where they have previously undertaken EPPs after March 2007 (or are new to EPPs).

They are required to provide IVS results for the following;

- Hepatitis B Surface Antigen;
- Hepatitis C antibodies and;
- HIV antibodies

EPP Workers Infected with Hepatitis B

EPP workers found or known to be infected with Hepatitis B virus (HBsAg positive) require further tests to determine whether they are carriers of the e-antigen (a marker of high infectivity) or carriers of a genetic variant of the virus.

HCWs with the following serology results will not be cleared for EPPs:

- HBsAg positive, HBeAg positive
- HBsAg positive, HBeAg negative – viral load $>10^5$ at any time.
- HBsAg positive, HBeAg negative – viral load $>10^3$ results within the last 12 months in the absence of antiviral treatment.
- HBsAg positive, HBeAg negative – viral load $>10^3$ results within the last 3 months if on antiviral treatment, assuming the viral load never exceeded 10^5

EPP Workers who are Hepatitis B Non-responders

Vaccine non-responders who perform EPPs must be tested for evidence of Hepatitis B infection (HBsAg). Thereafter they are required to undergo annual testing for markers of infection.

EPP Workers Infected with Hepatitis C

There is no vaccine available to protect against Hepatitis C so it is not possible to ensure permanent non-infectivity.

HCWs with the following serology results will not be cleared for EPPs:

- Anti HCV positive, HCV RNA positive
- Anti HCV positive, HCV RNA negative (but more than 6 months since the last test).

HIV (Human Immunodeficiency Virus)

There is no vaccine available to protect against HIV so it is not possible to ensure permanent non-infectivity.

However, HCWs infected with HIV may perform EPPs providing the criteria are met.

EPP Workers Infected with HIV

To perform EPPs HIV infected HCWs must meet the following criteria:

- Either:**
- a) be on effective cART, and
 - b) have a plasma viral load <200 copies/ml
- Or:**
- c) be an elite controller (1)
- And:**
- d) be subject to plasma viral load monitoring every three months and
 - e) be under joint supervision of a consultant occupational physician and their treating physician, and
 - f) be registered with UKAP-OHR

(1) An elite controller is defined as a person living with HIV who is not receiving antiretroviral therapy and who has maintained their viral load below the limits of assay detection for at least 12 months, based on at least three separate viral load measurements

Initial Health Clearance for HIV Infected HCWs

For HCWs wishing to perform EPPs, **two** Identified and Validated blood Sample (IVS) test results taken no less than three months apart (2) and with viral load levels below 200 copies/ml are required to ensure viral load stability.

At this point, a decision should be made as to whether health clearance could be given for the HCW to commence or resume EPP activities. For HCWs currently restricted from EPPs who are on combination cART with undetectable viral load (below 200 copies/ml), one IVS at least 12 weeks since their last undetectable viral load is sufficient proof on which to grant clearance for conducting EPPs.

The decision to clear individual HCWs for work involving EPPs is the responsibility of the consultant occupational physician in consultation with the treating physician. UKAP may be consulted on the application of the policy, as needed (see Appendix 1).

(2) For the purposes of initial health clearance, no less than 3 months apart is defined as between 12 and 16 complete calendar weeks

Ongoing Clearance

The model for allowing HIV infected HCWs to undertake EPPs whilst on therapy relies on continuing care and regular viral load monitoring by their treating physician and consultant occupational

physician. Effective monitoring requires close working between these two parties to ensure that the policy is being adhered to appropriately, thus minimising the risk of transmission.

HIV infected HCWs who are cleared to perform EPPs are subject to viral load testing every three months (3) while continuing to perform such procedures. The three month period should be taken from the date the previous IVS was drawn, and not from the date the result was received.

(3) Quarterly viral load testing can be performed no earlier than 10, and no later than 14 complete calendar weeks after the date of the preceding specimen taken for OH monitoring purposes

Blood testing for this purpose will usually be carried out by OH&WB but where this would give rise to duplication of testing, local arrangements will be made between the treating physician and OH&WB to ensure that blood drawn from HIV infected HCWs for viral load measurements in GUM or infectious diseases settings follows the principles of an IVS.

To support and monitor implementation of the policy and to ensure patient safety, all HIV infected HCWs, including locum and agency staff, who wish to perform EPPs, and who meet the criteria for clearance must have the outcome of their monitoring promptly reported by OH&WB to a central confidential register, the UKAP-OHR.

Each HCW must be recorded on the register by their designated consultant occupational physician. The ongoing viral load monitoring data will be updated by OH&WB on a regular basis via a web-based data entry system. Action taken as a result of an increase in viral load should be reported using the register to record that, restrictions on practice are put in place appropriately and, where necessary, risk assessments and patient notification exercises are carried out.

The UKAP-OHR will be securely and confidentially administered. Access to the individual records of the HCWs on the register will be strictly limited to the designated consultant occupational physicians responsible for the care, monitoring, management and EPP clearance of the HCW, and those who have delegated authority for this within OH&WB, and to those few authorised individuals, managing the register on behalf of UKAP.

Whilst it is important that UKAP should be called upon for advice on the application of the policy as needed, decisions to clear individual HCWs for EPP work will ultimately remain the responsibility of the treating and occupational health physicians.

Viral Load Monitoring

If the HCW's plasma viral load rises above 1000 copies/ml, they should be restricted immediately from carrying out EPPs until their viral load returns to being consistently below 200 copies/ml in at least two tests done no less than three months apart.

The significance of any increase in plasma viral load above 200 copies/ml and below 1000 copies/ml should be assessed jointly by the occupational health and treating physicians with input from appropriate local experts (e.g. consultant virologist or microbiologist).

The table below sets out the expected course of action for viral load test results below and above the level for EPP clearance (200 copies/ ml).

Viral load count test result	Action
<50 copies/ml or below	No action – retest in three months
50-200 copies/ml	A case-by-case approach based on clinical judgement would be taken which may result in no action (as above) or a second test may be done 10 days later to verify the first result. Further action would be informed by the test result.
>200 copies/ml but <1000 copies/ml	A second test should automatically be done 10 days later on a new blood sample to verify the first result. If the count was still in excess of 200 copies/ml, the HCW would cease conducting EPPs until their count, in two consecutive tests no less than three months apart, was reduced to <200 copies/ml.
1000 copies/ml or above	The HCW would cease conducting EPPs immediately . A second test must be done on a new blood sample 10 days later to verify the first result. If the count was still in excess of 1000 copies/ml, a full risk assessment should be initiated to determine the risk of HCW to patient transmission. At a minimum, this will include discussion between the
	consultant occupational physician and the treating physician on the significance of the result to the risk of HIV transmission. Following a risk assessment exercise, a Patient Notification Exercise (PNE) may be indicated ⁶ . UKAP advice may be sought at this stage.

Failure to attend or refusal to test

All HCWs performing EPPs should be advised by their consultant occupational physician and their treating physician of the importance of quarterly monitoring of their viral load and the implications of not doing so.

Where a HCW does not attend for their appointments, or refuses to have their viral load tested, the OH&WB Nurse Team will inform the HCWs manager that they are no longer cleared to perform EPPs, until it has been established that the HCW is continuing with cART and their viral load (measured within the past three months) does not exceed 200 copies/ml.

Resuming EPPs

Resumption of EPP activities following a period of interruption (for whatever reason) requires demonstration of consistent viral load suppression to very low or undetectable levels i.e. at least two viral loads below 200 copies/ml, no less than three months apart.

Elite Controllers

Elite controllers comprise a small proportion (0.2-0.55%) of all people living with HIV, who are not receiving antiretroviral therapy and have maintained their viral load below the limits of assay detection for at least 12 months, based on at least three separate viral load measurements.

A HCW who meets the definition of being an elite controller can be cleared for EPP activities without being on treatment, but remains subject to three monthly viral load monitoring to ensure they maintain their viral load below 200 copies/ml and to identify any rebound promptly. Any such cases should be referred to UKAP for advice on a case-by-case basis.

Guidance on performing a local risk assessment can be found at http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317133297795

Roles and Responsibilities

HCW

Must be under the care of a designated consultant occupational physician

Must accept that it is a condition of undertaking EPPs that they consent to ongoing monitoring while they continue to practise exposure-prone procedures, including:

- i. the registration of their details and monitoring data on the UKAP-OHR
- ii. the release of monitoring information to the consultant occupational physician and the treating physician
- iii. to provide an IVS for viral load monitoring at the appointed times
- iv. to seek advice if change in health condition may affect their fitness to practise or impair their health
- v. to notify OH when they are changing their practice or their place of employment

Thus, HCWs must agree that by seeking to and undertaking EPPs, they are giving implied consent to **i** and **ii** above and they are undertaking to satisfy **iii**, **iv** and **v** as well.

Consultant Occupational Physician

The consultant occupational physician is responsible for the monitoring of the infected HCW including:

- i. ensuring that the testing protocol and timings are followed
- ii. reacting promptly to any alerts received via UKAP-OHR
- iii. taking appropriate action when those who should present for tests do not do so e.g. notifying the relevant manager of the HCW's nonattendance and restriction from EPP practice
- iv. taking IVS samples, and ensuring samples are sent to laboratories;
- v. interpreting the viral load results in relation to clearance to perform EPPs
- vi. ensuring that the UKAP-OHR is updated in a timely manner
- vii. advising the HCW and the employer, on an ongoing basis, on whether the HCW is fit to perform EPPs
- viii. timely liaison with treating physicians

Treating Physician

The treating physician is responsible for:

- i. the clinical management and support of the seropositive HCW
- ii. advising and maintaining timely communications with the consultant occupational physician responsible for monitoring the infected HCW

Testing arrangements

Laboratory testing should be undertaken by a Clinical Pathology Accreditation (UK) Limited accredited virology laboratory.

The turnaround time (TAT) for an HIV viral load test is subject to local agreement and will vary between laboratories. OH physicians should consider the TAT of their local laboratory when scheduling appointments for OH monitoring to ensure viral load results are available no later than 14 complete calendar weeks after the date of the preceding specimen taken for OH monitoring purposes.

The use of personal identifiers in requests for laboratory tests should be avoided and care taken to ensure that the number of people who know the HCW's identity is kept to a minimum. However, full person identifiers must always be used when sending results to the national UKAP-OHR.

Where coding is used, the occupational health physician, who maintains a full identity record, should liaise with the lead consultant microbiologist/virologist in the local laboratory to ensure a consistent coding system unique to that laboratory is used, and that serial samples from the same HCW are identifiable as such.

Breaks in monitoring

HIV infected HCWs who take a career break from performing EPPs may wish to continue three monthly monitoring during this period to facilitate a return to EPP activities. Individuals with a break in their monitoring record must meet the criteria for initial clearance before returning to EPP activities.

Non-EPP HIV infected HCWs

HIV infected HCWs who do not perform EPPs but who continue to provide clinical care to patients, must remain under regular medical and occupational health supervision in accordance with good practice.

Treatment issues

It is for the HCW to decide, in collaboration with their specialist treating physician, whether they wish to take cART (combination antiretroviral therapy) for occupational health reasons when it is not clinically indicated, taking account of possible advantages and disadvantages.

HCWs should be advised by their treating physician of the importance of notifying them of missed doses, drug interactions or other factors that might influence their viral load, as soon as is practicable and before further EPPs are performed.

Management of Treatment Failure or Suboptimal Response

If there is any suggestion that the HCWs infection is no longer controlled by their antiretroviral treatment, the clinician overseeing their care may consider it appropriate that viral load tests are performed sooner than the next three month test.

A list of clinical experts who have agreed to provide advice to other treating physicians and consultant occupational physicians on the clinical management of HBV and HIV infected HCWs with breakthrough infection is maintained by the UKAP Secretariat (**Appendix 1**).

HCWs Working Clinically in Renal Units

All HCW working clinically in Renal units will be screened for **Hepatitis B only**; either evidence of immunity or a negative test for markers taken within the last 12 months.

6 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Infection Prevention and Control Committee and ratified by the Director of Infection Prevention and Control.

Non-significant amendments to this document may be made, under delegated authority from the Director of Infection Prevention and Control, by the nominated author. These must be ratified by the Director of Infection Prevention and Control and should be reported, retrospectively, to the Infection Prevention and Control Committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes

7 Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Director of Infection Prevention & Control and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

5 Monitoring and assurance

Reporting of infections or potential infections as outlined in this SOP will involve a review of DATIX Incident reports by the IPCT Infection Control Committee on a case by case basis.

There are currently no training requirements/elements related to this SOP. However it is important to emphasise that all HCWs must adhere to all relevant trust policies and procedures related to infection prevention and control.

- a) **Blood Borne Virus Infected HCWs** ~ managed by Public Health England and overseen by the UKAP www.ukap-ohr.org.uk e-mail: UKAP@phe.gov.uk
- b) **'Green Book'** <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>
- c) **NHSLA**
- d) **CQC Essential Standards of Quality & Safety**
- e) **The Hygiene Code** Criterion 5.1, 5.2, 5.3, 9.3e, 9.3r, 9.3y, 10.1, 10.2, 10.3
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf
- f) **HPA** http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317133297795