Brigstock Skin and Laser Centre

10. Management of Sharps Injuries and post exposure to blood and other body fluids

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To be read in conjunction with Infection Control Guidelines and Policy

Table of Contents

Policy and Procedures for the Management of Sharps Injuries and post exposure to blood and other body fluids.

1.0 Aim and scope of policy

This policy aims to offer advice and identify procedures for the management of sharps injuries and accidental exposure to blood and other body fluids. It is applicable to all Technicians, Agency health care assistants and Contractors carrying out duties on behalf of Brigstock Skin and Laser Centre

This policy must be read in conjunction with the Infection Control Policy and guideline. This can be found on the intranet under Policies & Procedures. Due to the need for prompt action following a sharps injury or exposure to blood and other body fluids the policy aims to educate staff to be aware of their clinical practice and take responsibility to minimise the risk of injury.

To ensure their clinic is up to date and to be familiar with the roles, responsibilities and actions required to be followed as outlined in this policy.

2.0 Definitions

2.1 **Recipient**- is the staff worker that has sustained a sharps injury or has been exposed to blood or other body fluid.

2.2 **Source**- refers to the person whose blood or body fluid is involved in the injury or has been exposed to a health care worker.

2.3 **Sharps**- are objects with sharp edges such as but not limited to needles e.g. suture needles, hollow, needles; scalpels, blades, lancets, surgical instruments, broken ampoules, bone, teeth or equipment used in dentistry e.g. burr which carry the risk of transmission of blood borne viruses.

2.4 **Blood borne viruses (BBV)** - is defined as any microbiologic capable of being transmitted via contact with the blood of an infected individual. Most notably this includes Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV).

2.5 **Body Fluids**- body fluid shown to transmit BBVs include:-

- cerebrospinal fluid
- peritoneal fluid
- pericardial fluid
- pleural fluid
- synovial fluid
- amniotic fluid
- human breast milk
- semen
- vaginal secretions
- saliva in association with dentistry

- any other body substance containing visible blood, e.g. faeces, urine, sputum
- unfixed tissues and organs
- exudates or other tissue fluid from burns or large skin lesions.

2.6 **Post Exposure Prophylaxis (PEP)-**

- Antiretroviral HIV medication given following exposure in high risk cases.

2.7 **Out of Hours-** this refers to bank holidays, weekends and any time before 09:00 am and after 16:30pm.

2.8 **Person in charge –** this is the most senior person in charge at the time of the incident e.g. Clinic manager, registered manager, principle or senior member of staff in charge on that day.

2.9 **Technician:** is defined as any member of staff providing direct physical patient care.

3.0 Legislative Framework

Under the Health and Safety at Work, etc. Act 1974; Management of Health and Safety at Work Regulations (1999) and Control of Substances Hazardous to Health Regulations (2002), employers have a duty to provide a safe working environment.

This include ensuring that activities that involve potential exposure to blood born viruses in the workplace are properly risk assessed and actions are taken to ensure that avoidable exposure is prevented.

4.0 General information

- Transmission of Blood Borne Disease may occur if blood or certain body fluids contact tissue under skin (percutaneous injury), non-intact skin or mucous membranes.
- There is extensive documentation of transmissions of HBV from patients to Health Care Workers; transmission of HCV has been documented as has transmission of HIV.
- Relative risk after percutaneous exposure has been reported as 2 – 40% for HBV, 3 – 10% for HCV and 0.2 – 0.5% for HIV.
- Infection with HBV is preventable with pre-exposure use of Hepatitis B vaccine and post-exposure use of Hepatitis B immune Globulin (HBIG) combined with vaccine.
- Post-exposure use of anti-retroviral agents has recently been recommended after exposure to HIV.
- There is no pre- or post-exposure prophylaxis available to prevent transmission after exposure to HCV.
- Outbreaks of HBV infection acquired by patients from their Health Care Worker have been documented. Most of these outbreaks have been associated with Health Care Workers who were Hepatitis B "e" antigen (HBeAg) positive. A few have been

associated with HBeAg negative Health Care Professionals who were infected with a strain of HBV with a precore mutation that prevents expression of HBeAg.

- HCV transmission has been documented from a cardiac surgeon to his patients.
- HIV transmission has recently been documented from an orthopaedic surgeon to at least one patient.
- The clinical stage of the infection and the titre of circulating virus in the Health Care Worker appear to be important in assessing risk of transmission.
- Transmission is associated with "exposure prone" procedures, and persists even with consistent use of the appropriate precautions. Exposure prone procedures are characterised by digital palpation of a needle tip in a body cavity or by the simultaneous presence of the Health Care Worker's fingers and a needle or other sharp instrument or object in a poorly visualised or highly confined anatomic site. In these procedures, the sharp object causing injury to the Health Care Worker will recontact the patient's open wound.

5.0 Roles and Responsibilities

5.1 **The health care worker (HCW)**: The Health & Safety at Work, etc. Act (1974) requires every employee to be responsible for their own safety and that of others whilst at work.

It is **mandatory** for the health care worker to:-

- take the responsibility to ensure that their immunisation status is up to date, for example a completed primary course of Hepatitis B and a validated blood test report of a satisfactory titre levels
- undertake relevant training
- follow procedures as identified by risk assessment
- make proper use Personal Protective Equipment (PPE) provided for their safety
- report concerns regarding Health & Safety to their manager, or Health & Safety manager

Post Injury or exposure to BBV the health care worker must:-

- complete Form OHD/CPCT/FORM1 – Post sharps injury or exposure to blood or body fluids form.
- immediately follow the appropriate first aid procedures using flow chart OHD/CPCT/FORM2
- inform the Person in Charge

For out of hours the health care worker must:-

- attend **Accident and Emergency at Mayday Hospital- 530 London Road Croydon CR7 7YE. Telephone 020 8401 3000 ext 3013. Fax number – 020 8401 3656.**
- contact the Occupational Health department to book an appointment the next working day.

Health care workers employed by our External Contractors please adhere to these policy requirements and those of their employer.

5.2 The Person in Charge :

- provide support and advise to the recipient
- confirm and arrange for the recipient to have an appointment at the Occupational Health department.
- risk assesses the incident based on the source patient medical history. Using OHD/CPCT/FORM3
- gain consent from the source and arrange for bloods to be tested for Hep B, Hep C and HIV using OHD/CPCT/FORM4 & OHD/CPCT/FORM5 liaising with the source's General Practitioner.
- the incident should be reported to the Risk Manager using an "Untoward Incident Form" (will be found on line at later date)

5.3 The Occupational Health department: The Occupational Health department (OHD)is based at:-

12-18 Lennard Road Croydon CR9 2RS; contact Sharps hotline 020 8274 6460 Fax number – 020 8681 0586.

The OHD is responsible for co-ordinating the overall management of occupational exposures and will offer advice, support and counselling to the recipient.

The Occupational Health Advisor (OHA) would ensure that the following activities are completed:-

- A clinical history is taken and assess the risk of the incident
- the recipient (HCW) is seen within 24 hrs of reporting the injury to the department on weekdays or the next OH working day.
- bloods are taken for storage from the HCW
- check the recipients Hepatitis B immunisation status and immunised appropriately as per standards from Immunisations against infectious disease – "The Green Book" found on http://www.dh.gov.uk
- arrange for client to have appointment at the Mayday OHD in high risked situations or in instances when Hepatitis B Immunoglobulin and PEP has been deemed necessary or requested.

- arrange follow up appointments for immunisations or blood tests are arranged and sent to the recipient in the post to their home address by the OHA who has been dealing with the incident.
- the Occupational health department will also be responsible for liaising with the CPCT Risk Manager over incidents relating to CPCT staff that require reporting to the Health and Safety Executive (HSE).
- this includes ensuring that an "Untoward Incident" form has been submitted to the CPCT Risk Manager. If the exposure is from Hepatitis B, C, or HIV positive source, RIDDOR form F2508 (https://www.hse.gov.uk/forms/incident/f2508.pdf) is completed by the Occupational Health Advisor once confirmation of the test result are known.

5.4 Accident and Emergency department- the Accident and Emergency department referred to in this policy is based at the

Mayday Hospital: - 530 London Road Croydon CR7 7YE; contact telephone number- 020 8401 3000 ext 3013. Fax number- 020 8401 3656.

At A&E the medical advisor:-

- Will undertake an initial risk assessment of the incident
- give emergency treatment as needed
- take a blood sample for storage
- administer Hepatitis B vaccinations as needed
- administer Hepatitis B Immunoglobulin as needed
- Administer antibiotics or Tetanus vaccination as needed
- Give recipient PEP 5 day starter pack as needed
- Advise recipient to book an appointment the next working day with the Occupational Health Department at:-12-18 Lennard Road Croydon CR9 2RS- **contact telephone number- 020 8274 6321.**
- Ensure that the recipient receives consistent follow up care a copy of the medical notes including the initial risk assessment, treatment administered and recommendations should be faxed the Occupational Health Department on **fax number– 020 8681 0586**

*(Accident and Emergency should be accessed by CPCT and its External Contracts health care staff that have sustained a sharps injury or had exposure to blood or other body fluids during '**out of hours'**. All health care workers should then contact the Croydon PCT Occupational Health Department at Lennard Road for continued follow up management*.)

5.5 **Microbiology department**-

- will test and store blood samples for 3 years
- will generate blood reports and give advice or support as necessary in cases of positive results.
- can be contacted regarding the arrangement of Hepatitis B immunoglobulin as deemed necessary for the management of the recipient.

5.6 **GUM clinic**-

- Will give advice and supportive counselling following exposure in positive and high risk cases.

5.7 **HIV Specialist Pharmacist**-

- Will give specialist advice regarding PEP medication as needed and is located at Mayday Hospital contact telephone - 020 8401 3007 Bleep: 602
- Will update CPCT OHD regarding any changes to antiretroviral medication advising on side effects and adverse effects to other health conditions.

6.0 Immediate action in the event of a sharps injury or post exposure to blood or body fluids.

6.1 Immediate Action

- Wash the wound site or affected area under running water while encouraging bleeding by milking the wound site gently.
- The wound site ***must not*** be sucked, scrubbed or have an antiseptic applied to it.
- The wound must then be covered with a water proof plaster.
- If there has been splashing to the eye, nose or mouth they must be irrigated with copious amounts of running tap water. Eyes must be irrigated before and after removal of contact lenses.

6.2 Reporting steps to follow:-

- The health care worker should **immediately** report the incident to the person in charge for that day and inform them that they have arranged an appointment with the Croydon PCT Occupational Health department or will be visiting the Accident and Emergency department at Mayday Hospital during out of hours.

- The health care work needs to fill in a Sharp Injury Incident Report form OHD/PCT/FORM1 and take it with them to their appointment at Occupational Health or Accident and Emergency.

- The person in charge for that day must obtain the details of the source as follows:-
  - Name, date of birth
  - Diagnosis
  - General Practitioner address and contact number
  - Assess Risk factor of source in relation to their Hep C Hep B and HIV status.
- The source should be informed of the incident and the person in charge for that day should arrange for the source bloods to be tested for Hep C, Hep B and HIV in order to get an up to date status using OHD/CPCT/FORM4 and OHD/CPCT/FORM5.**This must not be done by the recipient and written consent must be obtained from the source.**

- Croydon PCT health care worker would also be required to complete a Trust Incident & Near Miss Reporting form which is located at the main reception area within the building and then send to the Health and Safety department at Lennard Road.

6.3 **Risk Assessment steps to follow:-**

It is essential that a risk assessment is undertaken at the earliest possible opportunity as delay in receiving prophylaxis (if required) could affect the outcome. Using OHD/CPCT/FORM3.

This needs to be undertaken at the time of the injury **Not** at the end of the shift. The management of the incident and the decision on whether prophylaxis will be offered following an exposure incident will be dependent upon number factors:-

- Type of injury sustained (i.e. ***mucocutaneous***- Splash of blood or any other bodily fluid into eye or mouth or nose **or *percutaneous*** such as Needle stick / sharps; puncture of skin with instrument contaminated with patient's blood or body fluid; bite which draws blood / penetrates the skin, scratch which draws blood / penetrates the skin; contamination of broken skin with blood or body fluid.
- Whether the source of the exposure is known to be HIV, Hepatitis B or Hepatitis C positive; if positive to any blood-borne infection, their stage of illness will affect their degree of infectivity.
- Whether the material to which the recipient has been exposed is blood or other potentially infectious body fluid (as listed in section 2.5 above).
- Size and volume of the inoculums, i.e. whether a needle is hollow etc.
- Depth of injury.
- Visible blood on the device that caused the injury.

- Whether the needle had been placed in an artery or vein.
- Whether the inoculum is fresh or dried.

Please refer to **OHD/CPCT/FORM6** which contains further background information into HIV, Hepatitis B and hepatitis C which can aid in the risk assessment process.

5.4 **Occupational Health department steps to follow**

- A history of the incident is documented.
- Explain to the healthcare worker steps involved post incident offering advice and support as necessary.
- Assess health care worker current Hep B, Hep C and HIV status
- Take bloods for storage which would be sent to Mayday Microbiology department and stored for 3 years.
- Give Hepatitis B booster as required
- Arrange for follow up appointment to be made in 6, 12, or 24 week.
- Give advice on prevention methods that can be used in future to prevent reoccurrence of incident.

IN HIGH RISK SITUATIONS:

For HIV

- Where PEP is recommended the first 5 days is dispensed by A&E
- To obtain the remaining 6-28 days contact the OHD at Mayday Hospital **on telephone number 020 8401 3000 ext 4351-** and speak to an OHD Advisor so as to arrange an appointment for the recipient to have PEP and counselling.
- Inform recipient of arrangements e.g. appointment date, time and location.
- Arrange follow up blood test on day 14 and 28 day from the start of PEP for:-
  - Full Blood Count
  - Urea and Electrolytes
  - Amylase
  - Liver Function Tests
  - Lipid profile
  - Blood glucose
- Review recipient post start of PEP at 14 and 28 days to check side effects of antiretroviral medications.

- Do blood test at 6; 12 and 24 weeks post incident for Hepatitis B, Hepatitis C and HIV.
- **NB: -** Pregnancy status of the Health care worker must be confirmed. If reports to be pregnant this will need to be discussed with the appropriate Gum consultant prior to commencement of any PEP.

For Hep B

- Where Hepatitis B Immunoglobulin (HBIG) is indicated contact Mayday Microbiology Department regarding availability and collection of the appropriate dose for the recipient.
- Inform recipient of arrangements e.g. appointment date, time and location.
- Contact Microbiology or A&E and arrange for recipient to be given HBIG.

For Hep C

- Where Source is Hep C positive new treatment is available refer to flow chart see appendix VII
- Referral to a Hepatologist - Interferon and ribavirin may be prescribed
- However the recipient should have the following follow up tests:-

-Hepatitis C RNA at 6 and 12 weeks post-exposure
-Hepatitis C antibody at 6, 12, 24 weeks (and up to 1 year in very high risk cases)

7.0 Training requirements

The Management of sharps injuries and post exposure to blood and other body fluids is covered at Infection Control training. Infection Control Training is mandatory for all staff as identified in the Training Needs Analysis. Non-Clinical staff are required to attend Infection Control training at Corporate Induction at commencement of employment. Clinical staff are required to attend Infection Control Training at corporate induction at commencement of employment and thereafter for updates annually.
All staff are educated about the sharps policy at induction by the OH department and given literature.

8.0 Review of Policy

This policy will be reviewed in response to changes in legislation, policy directives from department of Health and the Health protection Agency or that arises from any Occupational exposure.

9.0 Policy Audit

The role and responsibilities of each individual or department will be monitored following each sharps incident to ensure compliance and ease of use of this policy.
Any gaps will be reviewed by the OH manager and team and subsequently the CHS Health & Safety committee and appropriate adjustments implemented.

10.0 Immunization Screening Process

Although the clinic has no plans for to conduct any invasive surgical procedures if it were to begin doing so all clinicians taking art in this work would be required to provide documentation of the following: Their 2-step tuberculin skin teststatus, varicella serological status and immunization history for measles, mumps, rubella, diphtheria, tetanus and Hepatitis B. These Clinicians would also be required to attend at their Family Physician, or Public Health to be screened or to enter an immunization schedule. Vaccination occurs at the clinician's cost. For Hepatitis B vaccine, documentation of receipt of all three doses by the physician or Health Unit as well as laboratory evidence of immunity (i.e. positive serology for antibody to Hepatitis B surface antigen 2 to 3 months post vaccination (HBsAg) would be required to be submitted to the clinics Registered manager.

For clinicians who were anti-HBs positive, no further action would be required.
For clinicians who were anti-HBs negative, screening for HBsAg would be done; if they were HBsAg positive they would also be screened for HBeAg.

Appendix I- OHD/CPCT/FORM1

Croydon NHS
Primary Care Trust

Incident Report Form:- Post Sharps injury or exposure to body fluids.
This risk assessment form is to be completed as soon as possible after an incident and must be taken to the Occupational Health department in normal hours or in out of hours taken to Accident and Emergency.

Name of Employee:	**Place of Work:**
DOB:	**Job Role:**
Hep B Vaccinations Up to Date?	**Yes □No □ Don't Know □**

1. Date and Time of Incident:-

2. Nature of Incident (please give brief description of the incident)

3. Where did Incident take place?
a) Clinic □ **b) Patient's Home** □ **c) Other (please state)…**

4. Name of the patient (if known) from whom the body fluid was contracted i.e. the source.
Age/date of birth **Diagnosis (if known)**

Address, if known **Patient's GP, if known**

5. Did the Incident involve: **a) Blood/high risk body fluids** □
b) Low risk body fluids? □
c) Not known? □

High-risk fluids **include blood, semen, vaginal secretions, human breast milk, saliva in association with dentistry.**

Low risk fluids **(unless blood stained) include urine, faeces, sweat, tears, saliva.**

Nb:- Please use in conjunction with OHD/CPCT/Form 3.

6. Did the Incident involve: **a) broken skin exposure** □
(i.e. body fluid in contact with broken skin)
b) Mucous membrane exposure □
(E.g. splashes in eye or mouth)
c) Sharps injury □
(i.e. injury by contaminated needle/ sharp object.

7. If Sharps Injury, was the injury a) deep b) superficial c) not known
Superficial = light scratch or small pin prick, deep = a puncture wound

Did the needle or sharps contain a) blood b) drugs c) not known

8. Was the blood/body fluid from a person with:
a) Known history of HIV, Hepatitis B or Hepatitis C? □
b) Strongly suspected of HIV, Hepatitis B or Hepatitis C? □
c) Not suspected of HIV, Hepatitis B or Hepatitis C? □
d) Unknown source? □

High risk indicators include history of multiple/same sex partners, IV drug user, resident of sub Saharan Africa or Far East, history of multiple blood transfusion.

Form completed by (recipient): **Date**
Signed:

GUIDANCE NOTES FOR ACCIDENT & EMERGENCY (outside normal office hours)

1. **Check the information provided on the form.**
2. **Risk assess the severity of the incident**
3. **Check the employee's history of Hepatitis B vaccination**
4. **Take base line blood sample and send to Microbiology for storage and Hep B_s Abs (ensure result is sent to Occupational Health Department, at above address. Croydon Primary Care NHS Trust).**
5. **If source is known to be Hep B_s Ag positive, contact on-call Consultant Microbiologist.**
6. **If source known or strongly suspected of HIV infection refer employee to on-call Medical Registrar who can initiate 'Post Exposure Prophylactic Medication' available from Mayday Pharmacy.**
7. **Complete information below and return this form to the employee with instructions to report to the Occupational Health Department as soon as it re-opens.**

DATE AND TIME RECIPIENT SEEN:

Signed:

For Occupational Health Department use only:- Date and Time Seen:

Flow Chart for the Management Of Sharp Injuries and Exposure to Blood or Other Bodily Fluid

Croydon PCT, Croydon General Practices & Dental practices

Needle stick injuries, cuts or bites that break the skin

↓

Apply first aid
Wash under running water.
Cover wound with dressing

↓

Body fluid splashes into the eyes or mouth, or onto a cut or skin abrasion

↓

Apply first aid
Wash with copious amounts of water

↓

THE MEMBER OF STAFF MUST :

IN NORMAL WORKING HOURS (Monday-Friday 09.00 – 16.30)
Attend Occupational Health at :
12 – 18 Lennard Road, Croydon CR9 2RS
SHARPS HOTLINE 020 8274 6460

OUT OF NORMAL WORKING HOURS (Weekends & Evenings)
Attend the nearest Accident & Emergency Dept at Mayday Hospital :
530 London Road , Croydon CR7 7YE
020 8401 3000 ext 3013
Always inform the triage nurse that you have sustained a sharps injury / exposure to blood or other body fluid.

↓

Initial advice and Risk Assessment
Occupational Health / A&E will need source patient details: Name, DOB and brief medical history
(Use Form: OHD/CPCT/FORM1)

↓

Complete Incident & Near miss form IN ALL INSTANCES

↓

Person in charge or Line Manager

Croydon PCT Occupational Health Department on the next working day
Tel no: 020 8274 6321

All follow up arrangements will be co-ordinated by Occupational Health Dept

Appendix III- OHD/CPCT/FORM3

RISK ASSESSMENT GUIDANCE FOR FOLLOWING SHARP INJURIES AND EXPOSURE TO BLOOD AND OTHER BODY FLUIDS

The source person.

High risk.

- The source has had a positive HIV test.
- The source has an HIV related illness diagnosed.

Moderate risk.

- Is an injecting drug user who has shared needles.
- Is a man who has had sex with other men.
- Has lived in an area of high HIV prevalence.
  E.g. sub-Saharan Africa, Cambodia, Thailand and some areas of central and South America (Panama, Belize, Guatemala, Honduras), Russia.
- Has received an unscreened blood transfusion or blood products in a country of high HIV prevalence (or pre 1990 in the UK).
- Has a sexual partner or has a parent of any of the above groups.

Low risk.

- Is a UK blood donor –i.e. for blood transfusions (blood is screened for HIV and Hepatitis B and C).
- Has had a negative HIV test within 3 months and does not have any above factors.

Nature of the injury.

High/ Moderate risk.

- The recipient's skin was broken (e.g. needlestick, percutaneous or deep injury).
- The recipient's skin was broken before the exposure (e.g. abrasions, cuts, eczema etc).
- The exposure was to a mucous membrane (e.g. eyes, mouth etc).
- There was visible blood on the device which caused the injury.
- The device had been placed in the donor's artery or vein.
- The injury caused extensive, deep wound on the recipient.

Low risk.

- The recipient's skin was not broken.
- No high-risk body fluid was involved.
- No mucous membrane was involved.

NB the risk may be lower if the exposure is through clothing or gloves, depending on the nature of the material. This is due to a wiping effect.

High-risk body fluids.

- blood
- amniotic fluid
- cerebrospinal fluid

- human breast milk
- pericardial fluid
- peritoneal fluid
- pleural fluid
- saliva in association with dentistry/ trauma (as this is likely to be contaminated with blood.)
- semen
- vaginal fluids
- synovial fluid
- unfixed tissues or organs
- exudates or tissues from burns or skin lesions
- any other body fluid visibly blood stained

Action.

High Risk.

BODY FLUID high risk + SOURCE high risk + NATURE high/ moderate risk = HIGH RISK

Highly recommend post exposure prophylaxis medication (PEP).

2. Moderate Risk.

BODY FLUID high risk + SOURCE moderate risk + NATURE high/ moderate risk = MODERATE RISK

Discuss and offer PEP.

3. Low Risk.

BODY FLUID high/ moderate/ low risk + SOURCE low risk *and/ or* the NATURE low risk = LOW RISK

PEP is **not** recommended for low risk donor/ sources irrespective of the nature of the injury and vice versa.

PEP is available via A&E department.

HBV Prophylaxis for reported exposure incident

	Significant Exposure		Non- significant exposure		
HBV status of person exposed	**HbsAg Positive source**	**Unknown source**	**HbsAg negative source**	**Continued risk**	**No further risk**

≤ 1dose HB vaccine pre-exposure	Accelerated course of HB vaccine* HBIG×1	Accelerated course of HB vaccine*	Initiate course of HB vaccine	Initiate course of HB vaccine	No HBV prophylaxis Reassure
≥ 2 doses HB vaccine pre exposure (anti-HBs not known)	One dose of HB vaccine followed by second dose one month later	One dose of HB vaccine	Finish course of HB vaccine	Finish course of HB vaccine	No HBV prophylaxis Reassure
Known responder to HB vaccine (anti – HBs> 10mIU/ml)	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	No HBV prophylaxis Reassure
Known non-responder to HB vaccine (anti-HBs<10mIU/ml 2-4 months post immunisation)	HBIG×1 Consider booster dose of HB vaccine A second dose of HBIG should be given at one month	HBIG×1 Consider booster dose of HB vaccine A second dose of HBIG should be given at one month	No HBIG Consider booster dose of HB vaccine	No HBIG Consider booster dose of HB vaccine	No HBV prophylaxis Reassure

- Accelerated course of vaccine consists of doses spaced at zero, one and two months.
- A booster dose may be given at 12 months to those at continuing risk of exposure to HBV.

Source: PHLS Hepatitis Subcommittee (1992)

Immunisation against Infectious diseases- Green Book pg 176

Croydon NHS
Primary Care Trust

Appendix IV- OHD/CPCT/FORM4

Strictly Confidential

Date: ……..

To GP of patient: Dr

A member of staff at (Clinic Name, team /service) ……..…. sustained an Sharps injury whilst caring for your patient named:

Name (donor): ……..……..……..……...

D.O.B: ……..……..

If the above is infected with:

- Hepatitis B
- Hepatitis C
- HIV

There is a risk that this may be passed on to the member of staff.

We request that the above, with their written consent (Appendix V OHD/CPCT/FORM5), is risk assessed and tested, for the above by an appropriate health professional, e.g. GP or GUM. Any delay in testing may result in the staff member not receiving appropriate treatment.

Thank you for your assistance, if you have any queries please do not hesitate to contact us.

Please inform us of the risk assessment outcome and when the bloods have been taken.

Yours Sincerely,

Occupational Health Team
12-18 Lennard Road
Croydon
CR9 2RS

Fax 0208 681 0586
Email occupationalhealth@croydonpct.nhs.uk
Tel 0208 274 6321

Croydon NHS
Primary Care Trust

Appendix V- OHD/CPCT/FORM5
***(For use by Person in Charge*)**

Date:

Dear sir/madam,

DONOR BLOOD BORNE INFECTION TESTING CONSENT LETTER

An accident has occurred in which a doctor, nurse or other health care worker involved in your care has been in contact with your blood e.g. pricked themselves with a needle or other sharp instrument.

This places the health care worker at risk of illness if your blood happened to be infected with a virus, mainly Hepatitis B, Hepatitis C and HIV virus. These viruses are carried in the blood and in some people can cause an infection of the liver (Hepatitis). Not everyone who carries the virus is aware of it.

It would greatly help the medical team now caring for the member of staff who has been injured, if your blood could be tested for Hepatitis B, Hepatitis C and HIV.

Since these tests will help another person rather than yourself, your specific permission is being requested. You and your doctors would be informed if any of the tests proved positive. We will not test your blood without this written consent.

I agree to my blood being tested for Hepatitis B; Hepatitis C and HIV

- o **Yes**
- o **No**

If you would like to discuss any of these tests prior to testing, please contact your local genitourinary medicine (GUM) clinic. Your local GUM clinic will be able to provide testing, further information discussion and support.

If you are declining these tests or have any particular concern about your risks for these infections, please could you tell the person who has given you this form, as this may change the treatment of the member of staff.

Signed: **Date:**

Print Name:

Witness:

Appendix VI- OHD/CPCT/FORM6

Background Information for Health Care Professionals to consider while carrying out the Risk Assessment

HIV

The risk of HIV transmission following a significant percutaneous exposure to HIV-infected blood is about 3 per 1,000 injuries. The risk of contracting HIV from a mucocutaneous exposure is less than 1 in 1,000.

Treatment should be started within one hour of the exposure (but may be worth considering up to two weeks from exposure), and will need to be taken for four weeks following exposure. Therefore it is **extremely important** that the HIV risk is assessed **immediately** following an exposure.

Post Exposure Prophylaxis (PEP) should be considered following significant exposure of the recipient to blood or other high-risk body fluid known to be, or strongly suspected of being, infected with HIV.

Post Exposure Prophylaxis is **not** usually indicated following a human bite unless there has been blood visible in or around the mouth of the source patient.

Risk factors for HIV infection in source patient:

- Homosexual / bisexual
- Intravenous drug use (previous or current)
- Many sexual contacts (heterosexual and / or homosexual)
- Haemophiliac exposed to blood products before 1985
- Sexual contact / blood transfusion in a country with high HIV prevalence

Unknown source

PEP is not usually indicated for an 'unknown source' (e.g. discarded needle and syringe) unless the sharp is visibly contaminated with blood or there is reason to suspect the needle may have been used by an IV drug user or the needle was found in an area where patients with HIV are treated. However, each incident will be assessed for risk and PEP will be recommended if appropriate.

Source patient – known HIV positive / high risk for HIV infection

If the source patient is identifiable and is deemed to be high risk, and the nature of the injury is also high risk, then post-exposure prophylaxis may be recommended whilst awaiting the HIV test / further assessment.

The following information should be obtained regarding the source patient:

- Current viral load
- Current CD4 count
- Patient's current drug regimen, including previous resistance to antiretrovirals
- Resistance assays (if available)

If the source patient is HIV positive and is likely or known to have a virus resistant to any of the standard PEP drugs, the PEP regimen may need to be modified. It is therefore essential that a thorough drug history of the source patient is obtained.

All health care workers occupationally exposed to HIV should have follow-up counselling, post-exposure testing and medical evaluation, whether or not they receive PEP, and should be encouraged to seek medical advice about any acute illness that occurs during the follow-up period.

Post-exposure prophylaxis (PEP)

Post Exposure Prophylaxis (PEP) may be prescribed by HIV specialists, Genito – Urinary Medicine Clinic, medical teams, Accident and Emergency or Occupational

Health Physicians and Advisers. The standard PEP regimen within the Croydon Occupational Health Department is currently as outlined below (please note that if attending an A&E Department, this may vary slightly) :
Standard PEP

Drug	**Strength & Form**	**Dose**	**Length of course or Quantity**
Combivir (Ziovudine/lamivudine)	Combined tablet (300mg/150mg)	ONE (1) tablet TWICE a day	28 days
Kaletra (Lopinavir/Ritonavir)	Combined tablet (200mg/50mg)	TWO (2) tablets TWICE a day	28 days

In addition an anti-emetic and an anti-diarrhoeal will be prescribed:

Drug	**Strength & Form**	**Dose**	**Length of course or Quantity**
Domperidone	10mg	ONE (1) tablet THREE times a day when needed for nausea or vomiting	Pack of 30
Loperamide	2mg tablet	TWO (2) tablets at the first sign of diarrhoea or loose bowel motion then ONE (1) tablet when needed thereafter. Maximum 8 tablets in 24 hours	Pack of 30

Recipients will usually be provided with a 'starter pack' by either the Accident and Emergency department at the Mayday Occupational Health department, and further prescriptions will be supplied as appropriate. The drugs may be changed on the advice of an HIV Consultant (i.e. if the source patient has developed a resistance to the 'triple therapy').

It is recommended that PCT staff are fully aware of the implications and potential side effects of PEP, so that they can decide in advance whether or not they would take it if it was recommended.

The recipient must be given written information on PEP and advised that the course of PEP is usually four weeks. The possibility and nature of side effects of the drugs should be discussed, as well as any drug interactions.

Recipients who develop severe side effects may need time off sick. Therefore, there may need to be some discussion with the manager and Human Resources as to how this should be recorded on the sickness record. Any discussion with the manager /

HR should be agreed with the recipient in advance, and confidentiality will be maintained.

Prior to PEP being commenced, the recipient should have baseline serology for:

- Full Blood Count
- Urea and Electrolytes
- Amylase
- Liver Function Tests
- Lipid profile
- Blood glucose

PLUS a pregnancy test in females (urine test) if indicated. If the pregnancy test is positive this will need to be discussed with the appropriate Gum consultant prior to commencement of any PEP.

The recipient will need serology checked weekly / fortnightly depending on PEP prescribed and these tests will normally be carried out in the appropriate Occupational Health or HIV PEP clinic.

Follow Up- The recipient will be offered a follow-up appointment every week by Occupational Health or PEP Clinic until the course of prophylaxis has been completed. An HIV antibody test will be offered at 6, 12, and 24 weeks post-exposure. At least 6 months should elapse after cessation of PEP before a negative antibody test is used to reassure the recipient that infection has not occurred.

There are no work restrictions during the follow-up period, but the recipient should be advised: to use barrier methods of contraception; not to donate blood; to discontinue breast-feeding if applicable; to avoid pregnancy if applicable.

In the event of the recipient testing positive for HIV antibody, he / she will be seen by the Occupational Health manager/advisor for advice regarding working practices and onward referral to the Specialist HIV Team.

Hepatitis B

The prevalence of hepatitis B within the UK is not known with certainty, but recent figures suggest that approximately 1 in 2,500 new blood donors are hepatitis B positive. Antenatal clinics in certain inner-city areas report hepatitis B carriage in up to 1 – 5% of women.

The risk of transmission of hepatitis B following a percutaneous injury has been shown to be approximately 30% when the source patient is infected with hepatitis B and is ‘e’ antigen positive.

All staff who come into contact with blood and other body fluids must be protected by immunisation against hepatitis B via the Occupational Health Department (including all domestic and portering staff, and any other staff who handle blood or body fluids, specimens, sharps / sharps containers or clinical waste).

Risk factors for hepatitis B include:

- Homosexual men/ bisexual
- Previous residence in a country where hepatitis B is prevalent

- Previous or current intravenous drug use

Unknown source
If the source patient is unidentified (e.g. discarded needle and syringe), hepatitis B should be considered a risk if there is reason to suspect the needle might have been used by an IV drug user.
Follow-up of the recipient

The recipient's immunity to hepatitis B (surface antibody) must be assessed at the time of the incident. Individuals who have responded to hepatitis B vaccine (surface antibody >100miu/ml) in the past are considered immune.

Booster doses should be given if the recipient's hepatitis B status is unknown or if the individual has a hepatitis B surface antibody level of 10-100 miu/ml.

Recipients who are not known to be immune to hepatitis B

Specific hepatitis B immunoglobulin (HBIG) is normally used to confer passive immunity after exposure to blood or body fluids from a patient who is known to be infected with hepatitis B or who is deemed to be high risk for hepatitis B. The dose of HBIG for adults is 500iu given preferably within 48 hours, and not later than a week after exposure. Immunoglobulin is available through Microbiology at Mayday.

If the recipient is previously unvaccinated and is not naturally immune, a hepatitis B vaccination course should be commenced at the same time as HBIG is given. An accelerated immunisation schedule should be followed with doses given at 0, 1, 2 months and a booster dose after one year.

Recipients who are 'non-responders' to hepatitis B vaccine should be given HBIG as detailed above. The recipient will be offered testing for the presence of hepatitis B infection at 6, 12 and 24 weeks, following exposure to a source known to be infected with hepatitis B.

There are no work restrictions during this follow-up period.

Although the Department of Health does not currently recommend restrictions regarding pregnancy or breast-feeding for individuals who are actually infected with hepatitis B, the recipient may wish to consider delaying pregnancy and using barrier methods of contraception during the 6 month follow-up period. Blood and organ donation is likely to be contra-indicated during the follow-up period.

In the event of the recipient testing positive for hepatitis B infection during the follow-up period, he / she will be seen by the Occupational Health manager/advisor for advice regarding working practices and referral to a hepatitis B specialist.

Hepatitis C

Studies suggest that the prevalence of hepatitis C in Western Europe is below 2.5% of the general population. It is estimated that a recipient who has received a significant inoculation injury from a source who is hepatitis C positive, has

approximately a 3% chance of developing the infection themselves. New post-exposure prophylaxis for exposure to hepatitis C can be prescribed by a hepotologist, it is important that appropriate follow-up of the exposure is carried out, in order that an appropriate specialist referral and possible treatment for the recipient can be commenced if necessary.

All source patients should be tested for hepatitis C antibody and, if this is positive, a viral load RNA test should be carried out by PCR.

Risk factors for hepatitis C include:

- Intravenous drug use – either past or present
- Previous residence in a country where hepatitis C is prevalent
- Blood transfusion before screening introduced in UK / abroad

Follow-up for the recipient

The current Department of Health guidance advises the following:

Source patient – hepatitis C antibody positive:

- Liver function tests
- Hepatitis C RNA at 6 and 12 weeks post-exposure
- Hepatitis C antibody at 6, 12, 24 weeks (and up to 1 year in very high risk cases)

Source known not to be infected with hepatitis C*:*

- Recipient to be followed up if symptoms of liver disease develop

Hepatitis C status of source patient unknown:
High risk – manage as known positive source

If the source patient is unidentifiable (e.g. discarded needle and syringe), hepatitis C should be considered a risk if there is reason to suspect the needle might have been used by an IV drug user.

- Low risk – follow-up blood test for hepatitis C antibody at 24 weeks

Advice to be given to recipient during follow-up period:

There are no work restrictions during the follow-up period.

Although the Department of Health does not currently recommend restrictions regarding pregnancy or breast-feeding for individuals who are infected with hepatitis C, the recipient may wish to consider delaying pregnancy and using barrier methods of contraception during the 6-month follow-up period. Blood donation is likely to be contra-indicated during this period.

In the event of the recipient becoming infected with hepatitis C during the follow up period, he / she will be seen by the Occupational Health manager/advisor for advice regarding working practices and referral to a hepatitis C specialist.

Appendix VII

Useful contact telephone numbers

Croydon Primary Care Trust	**SHARPS HOTLINE**
Occupational Health Department	**020 8274 6460**
Olivia Nunn –OH Manager	
Out of hours contact A&E	**020 8401 3013**
	fax- 020 8401 3656
Mayday Microbiology enquiries – (Dr Mary Twagira)	**020 8401 3421**
Mayday Occupational Health Department	**020 8401 3000 ext 4351**
Consultants in HIV/GUM	**Extension 020 8401 3006 (secretary) or 3002 (clinic reception**
Out of hours: via Mayday switchboard	**020 8401 3000**
Specialist HIV Pharmacist	**Extension: 020 8401 3007 Bleep: 602 Out of hours: via Mayday switchboard *Emergency Duty On Call Pharmacist.***

Clinical Negligence Standards-

Criteria- The organisation has *approved* documentation which describes the process for managing the risks post Sharps Injuries and exposure to blood and body fluids

Requirements As a minimum, the *approved* documentation must include the:	**Evidence within Policy**	**Within the policy info could be found at points**
duties	Roles and responsibilities	4.1 to 4.7
reporting arrangements in relation to Sharp Injuries and exposure to blood or body fluids.	Role and responsibility of OHD Reporting steps to follow	4.3 5.2
process for the immediate management of an Sharps Injury or exposure to blood or body fluid.	Immediate action Reporting steps to follow Risk assessments steps to follow At the OHD steps to follow	5.1 5.2 5.3 5.4
support available for those who are involved in or affected by a sharps injury or exposure to blood and body fluids	This policy offers support , advice and guidance. At the OHD GUM Clinic	5.4
organisation's requirements in relation to staff training, as identified in policy	Training	6
process for monitoring the effectiveness of all of the above	Review of policy Policy audit	7 and 8

14.20 Display Screen Equipment (DSE)

14.20.1 Purpose

1 To ensure compliance with recent legislation.

2 To ensure that none of the staff designated as "users" of DSE will knowingly be subjected to possible hazards associated with such equipment.

14.20.2 Procedures

1 All work stations will be examined to assess the risks to the Health and Safety of every user. The intention is to reduce the risks to the lowest possible level.

2 A "user" is considered to be anyone who uses DSE continually for periods in excess of one hour at a time on a daily basis.

3 To help achieve policy on DSE each work station will be examined, adopting an ergonomic approach to office furniture, office equipment and the immediate work environment relating to the operator. (A set of self-assessment forms to assist this is included Appendix 36)

4 Users will have their work routines set up such that changes in work activity will reduce the time periods spent operating the DSE.

5 A way of achieving this would be to work at DSE equipment for approximately 50 minutes in any one hour period then to carry out some other work for the remaining period. This would be repeated every hour.

6 Note that the breaks away from DSE cannot be accumulated to give lower breaks and a break in this context does not mean the operator does no work at all during this period aware from DSE.

7 Although there is no evidence linking work involving DSE with eye damage or deterioration of eyesight, employees who are users are entitled, but not obliged, to undergo eye tests.

8 These eye tests will be repeated at regular intervals on the advice of the optician who has been asked to give employees the eyesight test for DSE users.

9 The eyesight test is specifically designed for DSE users and should not be confused with the normal eyesight test.

10 When spectacles are prescribed specifically for work with DSE the clinic will provide them at the basic cost of suitable lenses and frames. This

will not include 'designer frames', the extra cost of which will be funded by the employee.

11 Office lighting will be maintained at the highest possible standard and glare or reflections on screens will be eliminated, if possible, either by changing the work station arrangement or the provision of glare inhibitor screens.

12 Users will be advised as to why it is necessary to make such changes and of their responsibilities in properly using the DSE supplied.

13 Each work station will require to be set to suit individual needs, requiring the co-operation of the users.

14.21 Drugs and Prescription Management

14.21.1 Procedures

1 All drugs contained within and outside the clinic will be appropriately secured. If controlled drugs are kept, the PCT pharmaceutical adviser should be informed.

2 All controlled drugs will be kept securely locked in a cabinet screwed into the wall and access will be controlled by a nominated person. Entry, running totals and exits should be meticulously recorded in a Controlled Drug Register.

3 Patients wishing to return unwanted or unused drugs will be encouraged to take them to a pharmacy. However, if drugs are returned to the Clinic, the drugs should be secured prior to disposal.

4 Used, unwanted or returned drugs will be collected by or delivered to a local pharmacist for disposal on a regular basis (see Section 15: Clinic Waste).

5 All unused prescription pads, with special attention being paid to pre-stamped prescription pads, will be kept secured in a locked drawer or cabinet. Access will be controlled by a nominated person. Records of arrival of prescription pads will be kept.

6 Pre-printed 'fanfold' prescription papers, together with uncollected repeat prescriptions, will be secured at the end of each day.

7 In respect of both drugs management and prescription management, the Health and Safety Administrator will ensure that, in the absence of the nominated person, another person is deputised and staff are informed of the arrangement.

8 Vaccines must be kept in a special lockable refrigerator equipped with a minimum and maximum thermometer. Min and max temperatures must be read weekly and the readings recorded in a book kept for the purpose. The times of onset and ending of power cuts should be recorded. The door of the fridge should be opened only briefly.

The person nominated for drug security is:

__Ruth Neal_____

Acknowledged by:

___Dr N Vajpeyi_____

Date:

_____2/12/08_____

The person nominated for prescription security is:

___Natasha Deacon_____

Acknowledged by:

____Dr N Vajpeyi_____

Date:

____2/12/08_____

14.22 Health & Safety and Cross-Infection Committee

14.22.1 Purpose

The Health & Safety and Cross-Infection Committee is part of the consultative process which exists within the Clinic to assist in the process of accident prevention and improvement of safety standards.

14.22.2 Membership

The Safety and Infection Committee will normally have a complement of about five members, depending on the size of the Clinic, and be chaired by a senior member of staff, the latter to show Dr N Vajpeyi's commitment to safety.

14.22.3 Safety & Infection Committee Members

1 Partner: Responsible individual

2 Designated Safety Manager: Registered Manager

1 Health and Safety Administrator: Registered Manager

4 Staff Member: Rozina Hassan Kabani

5 Staff Member: Natasha Deacon

14.22.4 Objective and Functions

1 This will be laid down in the Health and Safety Commission Booklet – Safety Representatives and Safety Committees ISBN 0 11 883954 4.

2 A copy of this booklet is issued to each member of the committee.

14.22.5 Frequency of Meetings

1 Initially it is suggested that meetings are held once per month. After the implementation of the Health and Safety Management System the frequency can be made less, subject to local agreement, the interval being not more than 6 months. Meetings should be linked to the 6 monthly formal Safety Inspections.

2 The date and time of meetings, for a twelve-month period, will be drawn up in a schedule and publicised.

3 Members not able to attend will ask a deputy to attend on their behalf.

4 Extraordinary meetings can be called outside of the schedule

5 Minutes shall be kept, and a summary of the actions of the committee shall form part of the annual Health & Safety report to Dr N Vajpeyi.

14.23 First Aid

First aid is normally given by a doctor or clinic nurse in the treatment room, which is well supplied with equipment. However in case there are no nurses or doctors on the premises, and to comply with HSE regulations, a first aid kit is available at reception. It is planned that at least one and preferably two staff members will attend an FAW course.

All incidents requiring first aid treatment will be recorded in the Accident and First Aid book by the first aider (see Section 13).

14.24 Ladders and Stepladders

14.24.1 Procedures

1 Ladders used by the clinic personnel will be of sound construction with no missing steps or rungs and will remain unpainted so that cracks and other faults can be easily recognised.

2 Defective ladders will be reported to the clinic Manager as soon as possible.

3 Ladders in use must be positioned at the correct angle (4 up for 1 out) on a firm base and be tied at the top for support. The ladder will be supported by a second person until tied.

4 Alternatively, if the ladder cannot be tied a second person will act to 'foot' the bottom of the ladder and act as a look-out.

5 Not more than one person at a time will be allowed on a ladder and, if the ladder is the actual work platform, then the ladder should extend at least 1.5m above the highest rung on which the employee has to stand.

6 Similarly, when using stepladders the user will not use the top step as a platform.

7 Employees must not overreach when using either a ladder or stepladder.

14.25 Manual Handling and Lifting

14.25.1 Procedures

1 Employees are reminded that lifting, pushing or pulling even light loads incorrectly can put severe strain on the back muscles.

2 Employees are encouraged to employ correct handling methods using the strong leg muscles where possible and not just the arms.

3 A load which is large, though perhaps light in weight, should not be carried by one person if it obscures their vision.

4 Employees who regularly lift loads should wear protective footwear and, if the load is metallic with possible sharp or jagged edges, gloves.

5 No untrained person will be allowed to direct a lifting operation involving hoists, pulleys or cranes.

6 See Appendix 35 -the Good Handling technique charts.

7 It is important to get help when lifting a patient.

14.26Play Area

14.26.1 Procedures

1 A poster will be visibly displayed warning parents/carers about the need for adequate supervision.

2 The Health and Safety Administrator or the Senior Clinic Nurse will make a regular check of all equipment for deterioration and potential hazards.

3 After an infectious child has played with a toy, it will be removed and washed or sprayed with antiseptic, and kept overnight to dry, before being returned to the play area.

Doctors & nurses should liaise with receptionists on this subject on a regular basis.

14.27 Risk Assessments

14.27.1 Procedures

The risk assessment procedure has been sub-divided into distinct progress

Sections:

Stage 1 Tasks which employees conduct within the Clinic will be given a reference number and will be considered on the basis of whether a known potential hazard exists or not. Generic tasks e.g. giving injections will only require one risk assessment to be done.

Stage 2 A job safety analysis will then be conducted for each task determined at Stage 1 to have known hazard(s).

Stage 3 Using the job safety analysis, the hazards, the potential harm and an estimation of risk are noted and a risk factor figure recorded for each task.

Stage 4 Actions should be taken, where possible, to reduce risks, giving the highest risks the first priority.

Note 1: If the task changes, an update risk assessment must be carried out.

Note 2: It will be necessary to audit the system, say once per year, to ensure this updating is accomplished.

14.27.2 Responsibilities

1 The Health and Safety Administrator will be responsible for ensuring the risk assessments are carried out. However, the assessment itself should be carried out by a person familiar with the task.

2 The Designated Safety Manager will assist and advise on any stage of the procedure.

3 The Health and Safety Administrator will be responsible for filing the completed assessments and arranging training needs where identified.

Timescale

1 To achieve all stages of the programme will take some time.

2 The target must be to complete the assessment in as short a time as possible, allowing for the priorities of the Clinic.

3 Stages 3 and 4 above will enable the prioritisation of all risks in the Clinic. A risk control programme should be introduced which methodically addresses risks, enabling them to be controlled over a defined time period.

14.28 Smoking

No smoking is permitted in any part of the building or anywhere within the boundaries of the site.

14.29 Stress

14.29.1 Purpose

1 To help prepare staff to understand stress, to identify it and to help them develop appropriate coping mechanisms.

2 To have in place suitable back-up/support procedures that might assist staff in dealing with stressful situations.

14.29.2 Procedures

1 A system/culture of supervision, teamwork and staff meetings will be developed which aims to support and protect staff.

2 Training and other opportunities will be provided to assist staff in identifying and helping prepare them towards coping with stressful situations. This will include training in dealing with aggression and violence, assertiveness and time management.

3 Staff will be provided with additional relevant written information/contacts that might assist in coping with stress. It will be desirable to inform staff members of the phone number of a confidential counselling service.

4 Dr N Vajpeyi will be made aware by the Health and Safety Administrator of any member of staff who appears to be having difficulty coping with everyday work and also of any work processes that appear to be putting undue stress on staff.

5 Effective arrangements will be in place in the event of a crisis, including consistent and supportive follow-up. A therapeutic debriefing, which does not allocate blame or fault, should be conducted on an individual or group basis by a senior person after traumatic incidents.

6 At every annual staff appraisal, these questions shall be asked;

- Do you feel able to ask for advice and help?
- Do you feel that you have been included in discussions about changes to your work or your workload?
- Are you being bullied or harassed?

The answers and any agreed actions should be recorded.

14.30 Substance Abuse and Misuse

It should be noted that abuse of drugs or alcohol on company premises or working while under the influence of alcohol or drugs will result in summary dismissal without prior warning. It may also result in referral to the GMC or the GNC.

Exceptions to this rule require the approval from Dr N Vajpeyi.

Dr N Vajpeyi has a duty to the employee to treat him or her with care, consideration and confidentiality, ensuring that the employee is able to access all necessary medical care and counselling. However, when there is a conflict, their duty to patients must override their duty to an employee.

!4.31 Occupational Health Services:

14.31.1 Introduction

The Clinic's registered manager is responsible for the Clinic's occupational Health Services. Basic Occupational Health Services are an application of the primary health care principles in the sector of occupational health. Primary health care definition can be found in the World Health Organisation Alma Ata declaration from the year 1978 as the "essential health care based on practical scientifically sound and socially accepted methods, (…) it is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work (…)".

A joint effort was launched by the World Health Organisation (WHO), the International Labour Organisation (ILO), and the International Commission on Occupational Health (ICOH) to develop Basic Occupational Health Services, since occupational health services are available to only 10-15% of workers worldwide. Even where services are available, their quality and relevance may be low. Basic Occupational Health Services are most needed for countries and sectors that do not have services at all or which are seriously underserved.

14.31.2 Objectives

To provide occupational health services for all personnel working in the Clinic

14.31.3 Surveillance of work environment and risk assessment

The surveillance of the work environment is one of the key activities of Basic Occupational Health Services. It is carried out for the identification of hazardous exposures and other conditions of work, identification of exposed workers and assessment of the levels of exposures for various groups of workers. Surveillance surveys must include the assessment of:

- Ergonomic factors which might affect worker's health
- Conditions of occupational hygiene and factors such as physical, chemical, biological exposures which may generate risks to the health of workers
- Exposure of workers to adverse psychological factors and aspects of work organization
- Risk of occupational accidents and major hazards
- Collective and personal protective equipment
- Control systems designed to eliminate, prevent or reduce exposure

Information from surveillance of the work environment is combined with information from health surveillance, and other relevant available data are used for risk assessment. It includes:

- Identification of occupational health hazards
- Identification of workers or groups of workers exposed to specific hazards
- Analysis of how the hazard may affect the worker
- Identification of individuals and groups with special vulnerabilities
- Evaluation of available hazard prevention and control measures
- Making conclusions and recommendations for the management and control of risks
- Documenting the findings of the assessment
- Periodic review and, if necessary, reassessment of risks
- The results of risk assessment must be documented

14.31.4 Health surveillance and health examinations

The surveillance of worker's health is made through various types of health examinations. The main purpose of health examinations is to assess the suitability of a worker to carry out certain jobs, to assess any health impairment which may be related to the exposure to harmful agents inherent in the work process and to identify cases of occupational diseases which may have resulted from exposures at work. The following types of health examinations are carried out either on the basis of regulations or as a part of good occupational health practice:

- Pre-assignment (pre-employment) health examinations
- Periodic health examinations
- Return to work health examinations
- General health examinations
- Health examinations at termination or after ending of service

14.31.4 Advice on preventive and control measures

Occupational health services should propose appropriate prevention and control measures for the elimination of hazardous exposures and for protecting workers' health. Control measures should be adequate to prevent unnecessary exposure during normal operating conditions, as well as during possible accidents and emergencies. Guidelines

for preventive actions for management and control of health and safety hazards and risks:

- Control of hazards at the source
- Ventilation or control technology
- Dust control
- Ergonomic measures
- Use of personal protective equipment
- Regulation of thermal conditions
-

14.31.5 Health education and health promotion, and promotion of work ability

Information on identified workplace health hazards and risks must be communicated to the Clinics Registered Manager who is responsible for implementing prevention and control measures. To ensure proper understanding and use of information the employer is responsible for education of his or her workers on risks and hazards at work and on their avoidance, prevention and protection, as well as on safe working practices. Such information and education tasks can be delegated to occupational health experts. The information and education include the following aspects:

- The workers have a right to know and get continuously information and training on hazards related to their own work and the workplace.
- Confidential health information of an individual worker is subject to special legislation and practices and to informed consent.
-

14.31.6 Maintaining preparedness for first aid and participation in emergency preparedness

The Basic Occupational Health Services personnel need to be able to provide first aid and train the workplace personnel in first aid activities. The role of Basic Occupational Health Services in first aid and emergency preparedness:

- Providing first aid services at the workplace when appropriate
- Introducing and training first aid practices to workers and supervisors
- Maintaining and periodically inspecting the first aid readiness and facilities
- Participating from the health point of view in emergency planning and organising the health elements in emergency response

14.31.8 Diagnosis of occupational diseases

Many occupational diseases can be diagnosed in the Basic Occupational Health Services service but many of them need to be referred to specialized occupational medicine Practices. In both instances, the diagnostics follows a special scheme:

- Identification of exposure which may cause the disease
- Examination of Clinic findings which are known to be associated with the specific exposure
- Exclusion of non-occupational factors as a possible cause of disease
- Statement on occupational disease for worker's compensation
- Proposals for preventive actions to the workplace of the worker in concern
- Notification of occupational diseases to authorities
-

14.31.9 Record keeping

As a health service Basic Occupational Health Services have a general obligation to keep record on health services provided to the workers. The record-keeping obligations are:

- General health record if the workers are treated as patients or health service clients
- Data on surveyed, detected and measured occupational exposures and risk assessments which have been made
- Statistics on occupational diseases and injuries
- Data on health examinations
- Documents on proposals for preventive and control measures

There is no trade-off between health and productivity at work. A virtuous circle can be established: improved conditions of work will lead to a healthier work force, which will lead to improved productivity, and hence to the opportunity to create a still healthier, more productive workplace. The idea of providing basic occupational health services deserved special attention, as it would provide countries with a practical tool for identifying priorities and pooling scarce resources to develop an integrative and effective occupational health system and services, tailored according to the national conditions and needs of each country.

14.32 C.O.S.H.H

DEFINITION

- A Hazardous Substance is any natural or artificial substance whether in solid, liquid or
- Gaseous form (including microorganisms) that has the potential to harm the health of an individual.

OBJECTIVES

The primary objective of COSHH Regulations is to control the identification, provision and safe use of all hazardous substances by ensuring that:

- The provision of appropriate instruction and training in hazard recognition and in handling procedures for all staff.
- All substances used in the provision of the service are of the lowest risk available.
- The processes on which they are used, or from which they are produced, follow the safest possible procedures.
- The safest possible working conditions and procedures are provided and followed.
- All hazardous substances are properly assessed and accurate records of assessment maintained.
- To contain the spread of biological agents through control of infection / cross Infection procedures as well as effective treatment and isolation nursing.
- To comply with current legislation.

INTRODUCTION

There are a wide range of chemicals and other substances capable of damaging the health of people at work. Substances hazardous to health as defined by the Control of Substances Hazardous to Health Regulations (COSHH) 2002, cover virtually all materials capable of causing ill health in a work situation including:

- Substances defined as very toxic, toxic, harmful, corrosive or irritant under the Chemicals
- Substances allocated a Workplace Exposure Limit (WEL),
- Biological agents that are hazardous to health,
- Substantial concentrations of dust.

The Control of Substances Hazardous to Health Regulations (COSHH) 2002 lay down the essential requirements and a step-by-step approach for the control of hazardous substances and for protecting people exposed to them whether employed or not.

The Regulations apply to all substances hazardous to health with the exception of:

Biological agents that are outside the employers control e.g. catching an infection from a work colleague.

POLICY STATEMENT

Brigstock Skin and Laser Centre accepts its responsibility in accordance with the Health and Safety at Work Act (1974) and subordinate legislation to ensure that systems of work involving substances hazardous to health are safe, as far as is reasonably practicable, for staff, patients and public.

The Clinic acknowledges that there is potential for injury to employees from substances and processes used whilst carrying out their work. The Clinic is committed to removing/reducing such risks as far as is reasonably practicable by the provision of training, information, instruction and supervision of staff, specific substance assessment and elimination or substitution of hazardous substances with less hazardous alternatives.

Where this is not possible, the Clinic will undertake to control exposure hazardous substances to within statutory limits by engineering means where reasonably practicable.

The aim of this policy is to provide advice, guidance and information on statutory requirements; best Practice and supports the implementation of the Clinic health and safety policy.

Under the health and Safety at Work Act (1974), it is the responsibility of all employees to follow the Clinic

policies and procedures. All employees have a duty to take reasonable care for the health and safety of themselves and of other persons who may be affected by their acts or omissions at work and to co-operate with their employer.

Where necessary, safety and personal protective equipment will be provided for the
benefit of employees and it shall be the responsibility of each employee to ensure
the maintenance and safe working condition of all such equipment.

All employees are required to follow the procedures for the reporting of accidents and dangerous occurrences immediately in accordance with the accidents/Incident reporting Policy, reporting any areas of concern.
It is the responsibilities of all managers who commission, support and manage independent contractors ensure that:

- This policy is brought to the attention of all independent contractors, where any activity on the Clinic's premises undertaking service, maintenance and planned work activities.

- That independent contractor is aware of their legal responsibilities regarding COSHH.

- That the independent contractors make suitable provision for protection against unauthorised intrusion to all work areas involving hazardous substances, processes or activities, and to ensure adequate provision for the protection of all other persons in the close vicinity of such work areas.

- Doctors, Nurses and Clinicians are responsible for ensuring that the requirement of this policy is implemented within all Clinic areas.

- Shared workplaces/presence of visitors/guests or members of the public.
  Managers should bring this policy and local arrangements to the attention of staff and to new staff during their local induction into the workplace.

- Ensure that suitable COSHH training is included in the Training Log Sheets ensuring that employees is provided with the appropriate level of training relevant to their work role and environment.

ASSESSMENT

A COSHH register of all hazardous substances used in the workplace should be developed and maintained. Safety data sheets must be obtained from the manufacturers or suppliers for all hazardous substances and attached to the relevant completed substance assessment form.

The basic principles of occupational hygiene underpin the COSHH Regulations. They are:

- Assess the risk to health arising from work and decide what precautions are required.
- Introduce appropriate control measures to prevent or control the risk.
- Ensure that control measures are used, that equipment are properly maintained
- The Employer will take all precautions to reduce the risk to employees by Informing, instructing and training.
- Where necessary, monitor the exposure of the workers and carry out an appropriate form of surveillance of their health.

RECORDS

Brigstock Skin and Laser Centre is to ensure that suitable and sufficient records are maintained such that information is available as detailed within the policy.

Comprehensive log records are maintained of all substances, procedures and assessments as required by the Regulations.

Record all occurrences of all incidents and accidents affecting and involving staff is maintained and monitored.

Records of both theoretical and practical training given to staff are recorded.

TRAINING

All staff will receive appropriate training on the requirements of COSHH. This will include:

(a) An appreciation of the COSHH Regulations (1999) As Amended
(b) An understanding of the purpose and goals of the Regulations.
(c) Knowledge of which substances are covered by the Regulations and which substances are not covered.
(d) An understanding of their role and responsibilities under COSHH.
(e) Familiarity with hazard warning symbols and package labelling.
(f) Understanding of safe working procedures and processes.
(g) Understanding of safe storage, handling, use and disposal of newly introduced hazardous substances.

REVIEW

This policy will be reviewed every 2 years or at a change in legislation or plant /equipment whichever is the sooner.

8 Steps to comply with COSHH

To comply with COSHH the following eight steps should be followed:

Step 1: **Assess the risks**
Assess the risks to health from hazardous substances used in or created by your -workplace activities

Step 2: **Decide what precautions are needed**
You must not carry out work, which could expose your employees to hazardous -substances without first considering the risks and the necessary precautions

Step 3: **Prevent or adequately control exposure**
You must prevent your employees being exposed to hazardous substances. Where preventing exposure is not reasonably practicable, then you must adequately control it.

Step 4: **Ensure that control measures are used and maintained**
Ensure that control measures are used and maintained properly, ensuring that safety procedures are followed.

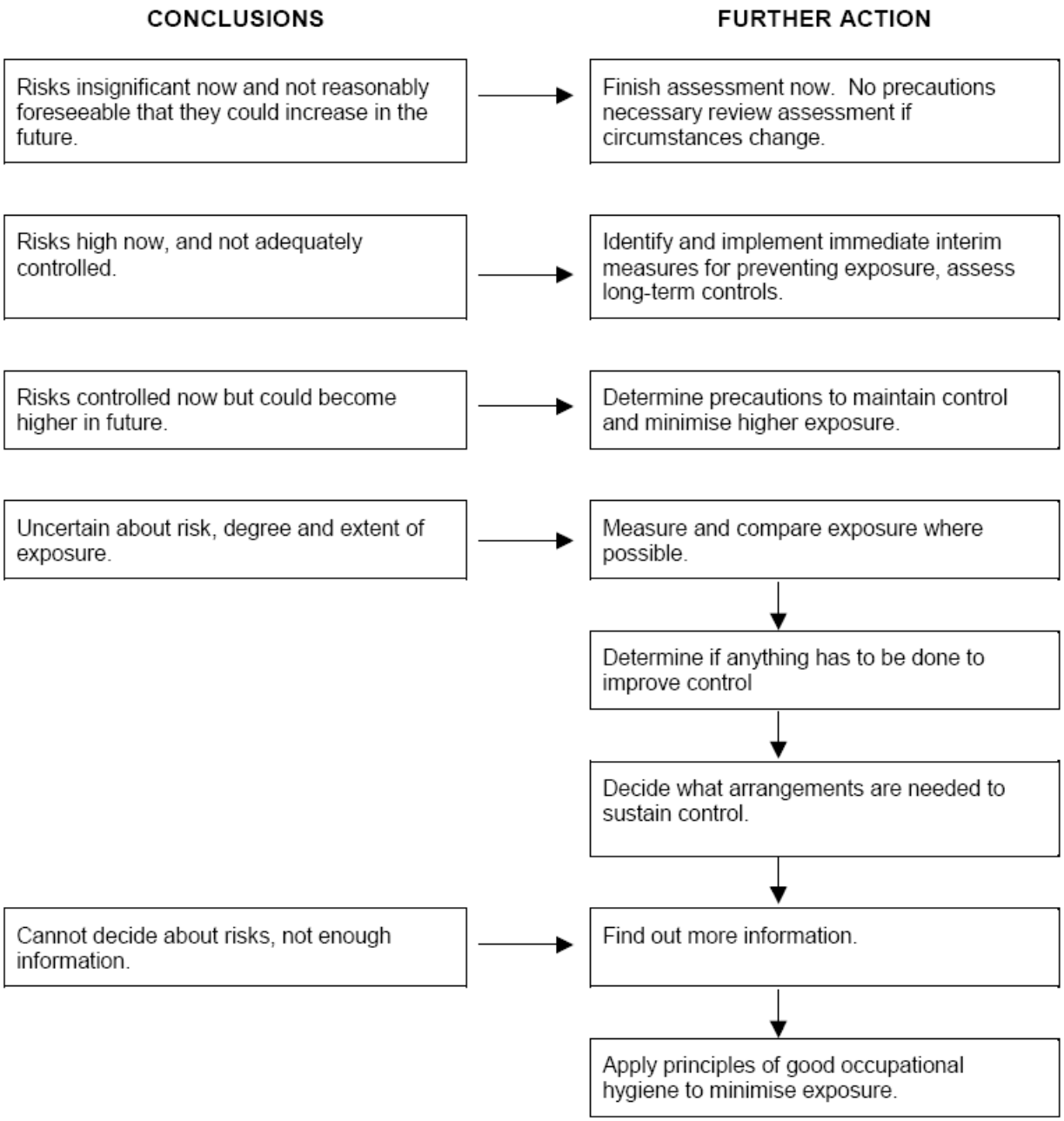
Step 5: **Monitor the exposure**
Monitor the exposure of employees to hazardous substances, if necessary.

Step 6: **Carry out appropriate health Surveillance**
Carry out appropriate health surveillance where your assessment has shown this is necessary or where COSHH sets out specific requirements.

Step 7: **Prepare plans and procedures to deal with accidents, incidents and emergencies**
Prepare plans and procedures to deal with accidents, incidents and emergencies involving hazardous substances, where necessary.

Step 8: **Ensure employees are properly informed, trained and supervised**
Provide employees with suitable and sufficient information, instruction and training.

COSHH ASSESSMENT



COSHH ASSESSMENT FORM

CLINIC SERVICE:			
LOCATION		DATE	
PRODUCT		PROCESS:	
ASSESSOR:		SIGNATURE	

GENERAL INFORMATION	YES	NO
Can the product or processes be eliminated or replaced?		
Can a less hazardous substance substitute any substance? If YES state which		
Is there a copy of the Safety Data Sheet held?		
Are personnel provided with instruction, training etc?		
Can exposure occur in normal use?		
If YES, what is its nature? Please tick the appropriate box. Inhalation ☐ Contact ☐ Ingestion ☐ Eyes ☐ Other (Please specify) ☐		

USE/EXPOSURE	LOW		MEDIUM		HIGH	
LOCATION:	ISOLATED		RESTRICTED		WIDESPREAD	
USERS:	SINGLE		RESTRICTED		UNLIMITED	

RISK ASSESSMENT	
Insignificant risks - unlikely to change	
Medium risk - unsatisfactorily managed- require remedial measures	
High risk - unsatisfactorily managed – Remedial measures ASAP.	

FURTHER CONTROL MEASURES

	Actual Controls in Place	Additional Controls Required
Ventilation:		
Respiratory Protection		
Personal Protection		
Other Control Measures		

FIRST AID
Comments/Further Control measures
FIRE FIGHTING
Comments/Further measures Control
ACCIDENTAL RELEASE
Comments/Further Control measures
HANDLING AND STORAGE
Comments/Further Control measures
STABILITY OR REACTIVITY OF THE SUBSTANCES
Comments/Further measures Control
TOXICITY
Comments/Further measures Control
DISPOSAL CONSIDERATIONS – (effect of the substance on the environment)
Comments/Further measures Control