Policy

Staff immunisation and infection screening

Key messages

- All staff in patient contact/ in contact with clinical specimens must have immunisation and infection screening performed prior to commencing appointment in accordance with the Trust's immunisation and screening matrix.
- Staff whose role includes performing exposure prone procedures (EPP) must not commence work until health clearance is provided by OH. This includes staff transferring to EPP dependent roles or if a role changes to include activities which require EPP clearance.
- Occupational health provides immunisation and infection screening for Trust staff and contractors who have a contract with the OH service to provide such services.
- Managers are responsible for ensuring that their staff have the correct level of health screening and immunisation for the role.
- It is the employee's responsibility to ensure they are appropriately protected at work and to contact OH for further screening if they believe themselves to have been at risk of infection eg exposure to blood borne virus, respiratory diseases.

Summary

Staff immunisation and infection screening is an important control measure for preventing the spread of infectious diseases. Immunisation and infection screening is performed when staff are appointed to post. Staff should be seen in OH on commencement if advised by the fitness certificate issued by OH. Managers are responsible for ensuring appointments are arranged for their staff if required. Immunisation and infection screening requirements can be found in the immunisation and screening matrix.

1 Scope

Trust-wide including all honorary contract, agency/ locum staff and students affiliated to educational establishments working on the Trust campus.

2 Purpose

To ensure that workers are adequately screened and appropriately immunised against infectious diseases to reduce the risks of infection transmission to staff and patients.

3 Abbreviations used

AHP	allied health professional
AIDS	acquired immune deficiency syndrome
ANHOPS	Association of National Health Occupational Physicians
BBV	blood borne virus
BCG	bacillus Calmette-Guérin (vaccine)
cART	combination antiretroviral therapy
CCDC	consultant in communicable disease control
CHW	Cambridge Health at Work – Trust occupational health department
CMO	chief medical officer
CoIC	control of infection committee
COSHH	Control of Substances Hazardous to Health
CXR	chest x-ray
DH	Department of Health
EAU	emergency assessment unit
ED	emergency department
EPP	exposure prone procedure
ESR	electronic staff record
HBeAg	hepatitis B e antigen
HBsAg	hepatitis B surface antigen
HCA	health care assistant
HCW	health care worker
HIV	human immunodeficiency virus
HSC	health service circular
HSG	health service guidance
IGRA	interferon gamma release assay
ISQ	immunisation/ infection screening questionnaire
IVS	identified validated sample
MMR	measles, mumps and rubella (vaccine)
NCCU	neurosciences critical care unit
NICE	National Institute for Health and Care Excellence
OH	occupational health (department)
OHNA	
OHP	occupational health physician
OT	occupational therapist
PHE	Public Health England
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RNA	ribonucleic acid
TB	tuberculosis
Td/IPV	combined tetanus, diphtheria and polio vaccine
UKAP	United Kingdom Advisory Panel
UKAP-OHR	UKAP Occupational Health Monitoring Register
VZV	varicella zoster virus
WHO	World Health Organization

4 Definitions

4.1 Health care worker (HCW)

'Health care worker' is the term used for staff involved in direct patient care. This includes:

- doctors
- dentists
- nurses
- midwives
- AHPs including:
    - OTs
    - physiotherapists
    - radiographers
    - HCAs
    - physicians' assistants

Students and volunteers working with patients in these disciplines should be included; for example observers, clinical placement. This group of staff can be subdivided into those who are exposure prone procedure staff (EPP) and those who are not (non-EPP).

4.1.1 New health care worker

A 'new' HCW is one starting work or training in the NHS for the first time from August 2007.

4.1.2 Health care workers performing EPPs for the first time

This term refers to those HCWs moving into training posts involving EPPs for the first time, for example Foundation Year 1 or 2 doctors if screening has not previously been performed. If full screening has been performed in training, for example medical school and there is no break in NHS service, screening does not need to be repeated.

4.2 Exposure prone procedures (EPPs)

EPPs are:

> "those (procedures) where there is a risk that injury to the worker will result in the worker's blood contaminating a patient's open tissues… including those where a worker's gloved hand may come into contact with sharp instruments, needle tips and sharp tissues (spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hand or fingertips may not be completely visible at all times."

4.3 Support staff

This staff group includes staff who can have regular face-to-face patient contact and/or contact with specimens and/or clinical waste, for example:

- porters
- cleaners
- ward assistants
- housekeeping staff
- incinerator technicians

4.4 Non-HCW staff with patient contact

This staff group includes staff who are not involved with clinical care but have regular face-to-face patient contact, for example:

- ward clerks
- receptionists in clinical areas

4.5 Staff with no regular patient contact or contact with specimens

This staff group includes staff who work in administrative or support roles who do not have regular face-to-face contact with patients, for example:

- non-clinical managers
- secretarial staff
- administration and clerical staff
- support staff working in non-clinical areas

4.6 Laboratory staff

This staff group includes:

- staff who work with clinical specimens in the laboratory setting, for example:
  - haematology
  - biochemistry
  - microbiology
- staff who work in this area if they are involved in the handling of specimens or clinical waste, for example:
  - cleaners
  - porters
  - receptionists
  - secretaries

4.7 Staff working in special occupational risk areas

Certain work areas have been identified as posing increased risk of vaccine-preventable occupationally acquired infections. These areas include:

- infectious diseases wards (ward D10)
- mortuary
- incinerator

- microbiology laboratories

All staff working in these areas in contact with patients, specimens and/or clinical waste are included in the special risk group.

4.8 Staff working in special patient risk areas

Areas of high risk to patients involve patients who are:

- immunocompromised
- in an intensive care setting or
- pregnant
- children (as they may remain susceptible to infections to which they may not have been previously exposed)

All staff working in these areas in contact with patients, specimens and/or clinical waste are included in the special risk group.

4.9 New entrant (UK)

This term refers to those staff starting in employment (including returnees to the NHS) who have lived in a country with a high prevalence of tuberculosis for a period of **three months or more** within the last five years.

4.10 Observers

This term refers to those individuals hosted by the Trust to observe clinical work practices. They should not be involved in direct clinical contact with patients but may have social contact.

4.11 Returnee to the NHS

A returnee to the NHS is a new member of staff starting in employment following a period of **three months or more** out of NHS service. This includes returnees who have been working for private or locum agencies in the UK and those who have spent time outside the UK, for example:

- voluntary service with medical charities
- extended electives
- sabbaticals (including tours of duty with the armed services)
- periods of unemployment

Staff are only considered returnees **if they have had a period of three months or more out of service in the NHS**.

4.12 High prevalence countries for tuberculosis (TB)

High prevalence countries for TB are those where the prevalence is greater than 40 cases per 100,000 population. Up-to-date lists can be found at PHE tuberculosis information.

4.13 Identified validated sample (IVS)

An IVS is defined according to the following criteria:

- The employee should show proof of identity with a photograph when the sample is taken. Acceptable ID include the following:
  - NHS trust identity badge
  - photo driver's licence
  - passport
  - national identity card
- The sample of blood should be taken in the OH department.
- Samples should be delivered to the laboratory in the usual manner, not transported by the employee.
- When results are received from the laboratory, the clinical notes should be checked for a record that the sample was sent by the OH department at the relevant time.

4.14 Temperate regions

Temperate regions are defined as:

- United Kingdom
- rest of Europe
- North America
- antipodes
- Middle East
- Indian sub-continent

4.15 Tropical regions

Tropical regions are defined as:

- sub-Saharan Africa
- southeast Asia
- the Caribbean
- Central America

4.16 Volunteers

Volunteers are individuals engaged through the voluntary services department to help support services in the Trust. This may involve patient contact and in these circumstances should be screened to the same level as non-HCW with patient contact.

4.17 Food handlers

Food handlers are individuals who directly touch open food as part of their work. Staff groups who are recognised as food handlers include HCAs, nutrition assistants, occupational therapists, occupational therapy assistants, etc.

5 Introduction

Employers are required to reduce the risks in the workplace, as far as reasonably practicable, to comply with the Health and Safety at Work Act 1974. The Control of Substances Hazardous to Health (COSHH) Regulations 2002 is the specific legislation that requires employers to:

- assess the risks of exposure to hazardous substances, including pathogens, and
- implement necessary control measures to reduce the risk of infection transmission to employees and patients

Immunisation is one of the possible control measures available to protect employees from the occupational risk of contracting communicable disease; however, it should not be considered as a substitute to compliance with good infection control practice.

Immunisation is to:

- protect the employee and the employee's family from an occupationally acquired infection
- protect patients and service users from acquiring infections from staff
- allow for efficient running of services with minimal disruption due to work restrictions following staff exposure to infectious diseases

National guidance lays down certain screening requirements for patient safety. Certain blood borne virus screening is mandatory for staff who perform invasive EPPs. If infected with a blood borne virus, confidential advice must be sought from an occupational physician. In certain cases work practices will be restricted if potentially infectious to patients.

National guidance detailing infection screening for patient protection includes:

- hepatitis B infection (HSC 93)
- protecting HCWs and patients from hepatitis B [HSG (93) 40]
- hepatitis B infection (HSC 2000/020 Hepatitis B Infected HCWs)
- hepatitis C infection (HSC 2002/010 Hepatitis C Infected HCWs)
- AIDS/ HIV infected health care workers guidance on the management of infected health care workers and patient notification 2005
- health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: new health care workers 2007
- DH, Measles Letter from Professor David Salisbury, May 2008. Gateway reference no: 9949
- Hepatitis B infected healthcare workers and antiviral therapy 2007
- The Management of HIV infected Healthcare Workers who perform exposure prone procedures: updated guidance, January 2014

National guidelines on immunisation for staff protection are detailed in:

- Guidance for clinical health care workers: protection against infection with blood borne viruses. London: DH, 1998
- DH 2006 Immunisation of healthcare and laboratory staff in: Immunisation against infectious disease (the 'Green Book'), Chapter 12
- CMO letter chickenpox (varicella) immunisation in health care workers 2003
- NICE Clinical Guideline 33: Tuberculosis – Clinical diagnosis and management of tuberculosis and measures for its prevention and control 2006 updated March 2011
- ANHOPS: Immunisation of the health care worker guidelines (ANHOPS 2005/6)
- NHS Plus Varicella zoster virus. Occupational aspects of management – a national guideline, 2010

The importance of appropriate immunisation of staff is also highlighted in:

- Effective Management of Occupational Health & Safety Services in the NHS 2001
- Winning Ways – Working together to reduce Healthcare Associated Infection in England 2003
- Blood borne viruses in the workplace, guidance for employers and employees HSE. Infection at work: Controlling the risks 2006
- A guide for employers and the self employed on identifying, assessing and controlling the risks of infection in the workplace 2003
- Biological agents: Managing the risks in laboratories and healthcare premises. HSE Advisory Committee on Dangerous Pathogens 2005

6 Responsibilities

6.1 Control of infection committee (CoIC)

The CoIC reports to the quality committee on issues related to infection control. In the production of this policy the CoIC is responsible for receiving information from and advising on:

- reports of infections and infection control problems including national reports and initiatives that may affect patient or staff health
- specific requirements for the management of infection outbreaks that require staff screening and vaccination
- infection control programmes undertaken by the CHW (Trust occupational health department)

6.2 Health and safety committee

The health and safety committee is the forum for consulting with elected representatives of employee safety and staff side safety representatives on matters of health, safety and welfare as required under the Safety Representatives & Safety Committee Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996. The committee meets on a quarterly basis. Any unresolved health and safety issues are escalated to the workforce committee.

6.3 Managers

Section 9 of the Health and Safety at Work Act 1974 requires that employers provide a healthy and safe working environment for their employees.

Generic risk assessments indicate that staff in a health care setting are more at risk of infection and transmission of infectious disease. **It is the responsibility of line managers to ensure that their staff comply with the Trust's staff immunisation and infection screening policy**.

Managers must:

- ensure that Trust employment processes are followed correctly
- ensure that staff do not start work until they have received appropriate health clearance
- not allow their staff to undertake EPPs until EPP clearance is issued (this information is provided on the OH health clearance certificate)
- ensure that risk assessments have been undertaken for all tasks involving exposure to infectious diseases
- ensure that all new staff attend OH for immunisation review in a nurse clinic within the first four weeks of commencing in post if recommended following health screening and act upon OH advice received
- ensure that staff undertaking exposure prone procedures maintain EPP health clearance
- ensure that staff re-attend OH for appropriate re-screening when an expiry date is issued on EPP clearance
- ensure that staff do not undertake EPPs if their EPP clearance has expired
- keep records of staff who are not immune and therefore should not work in high risk clinical areas, and ensure that individual risk assessments are performed in these cases with advice from OH and/or infection control
- contact infection control and/or OH for further advice if specific disease outbreaks occur in their work area

- ensure that all staff handling food and anyone working in a food handling area knows to report the symptoms of infection and if they have close contact with someone with these symptoms

6.4 Employees

Section 7 of the Health and Safety at Work Act 1974 requires that employees follow all health and safety policies designed to protect their health whilst at work.

Health care professionals have a responsibility under their professional codes of conduct to ensure that they are not at risk of infection or transmission of a disease that may affect patient safety.

Employees must:

- provide accurate vaccination history when requested and allow for their immunisation data to be held by their manager including on an electronic record
- attend OH for screening tests when requested by their manager, OH or infection control
- attend OH for screening tests or immunisation review if requested to do so by their manager or OH
- inform OH if they know themselves to be infected with a blood borne virus and attend for OH appointments when requested
- keep personal records of vaccinations and immunisation status for future reference
- attend OH in good time for repeat EPP screening if required; if there is a delay in three monthly/ annual EPP testing and EPP clearance has expired the individual should not perform EPPs until repeat test results are available
- advise their manager if they are not immune and at risk of infection or transmission of infectious disease in the workplace
- attend review appointments with an OH practitioner, for advice and guidance if they decline any recommended vaccination (managers will be informed if not immune and employee work practices may be restricted)
- contact OH if they have any queries regarding immunisation requirements

6.5 Occupational health (OH)

The *Effective Management of OH and Safety Services in the NHS* requires all OH services to provide a comprehensive occupational immunisation programme including:

- tuberculosis
- rubella

- measles
- varicella (chickenpox)
- hepatitis B
- other conditions where occupationally relevant

OH will:

- undertake health screening on employment in line with current employment processes
- perform appropriate screening if individuals provide inadequate evidence of immunity/ non-infectivity
- issue health clearance for EPP roles only when appropriate screening results have been obtained
- advise managers if EPP clearance has an expiry date
- advise on immunisations required for specific work areas
- offer appropriate immunisation to all staff
- offer appointments at the request of line managers
- provide screening to determine immunisation status
- document immunisation status of staff in their OH clinical record and provide copies of immunisation/ infection screening records for the individuals to collect from OH
- provide individuals with an updated immunisation report following each immunisation/ infection screening activity
- recall staff for further vaccination/ screening when required
- provide confidential advice and support to staff that have, or develop, an infectious disease

6.6 Domestic service contractor

The domestic service contractor site manager will be responsible for ensuring that all staff are compliant with the Trust's staff immunisation and infection screening policy.

6.7 Agency staff/ students/ honorary contract holders/ work placements

Workers from agencies, educational establishments, honorary contract holders (including observers) or individuals on work placement within the Trust who are in patient contact or contact with clinical materials must be screened and immunised to the same standard as Trust staff.
The organisation responsible for the individual must ensure that workers are appropriately screened and vaccinated in line with this policy.

If the individual is to perform EPPs, full EPP screening is required. This includes clinical students, agency/ locum staff and contract ancillary

workers. If these staff access OH services from another provider they should be advised of the screening and immunisation standards required by the Trust if working or due to work within the Trust.

Vaccination will only be performed in the Trust's OH department for staff employed by organisations who have an agreement with the CHW to provide such services. Access to appropriate OH advice is mandatory for all staff who work with patient contact.

7 Immunisation and infection screening

All new staff will undergo health screening prior to commencement in post. Those staff who are in clinical roles/ work in a clinical environment or with clinical specimens are required to complete an immunisation and infection screening questionnaire (ISQ) which is assessed by CHW. This questionnaire is designed to determine if restrictions or further screening/ immunisation is required. This screening is performed by questionnaire and in certain situations face-to-face assessment in OH. If outstanding assessment is required, staff are requested to attend a nurse clinic/ occupational health duty nurse.

Health clearance will **not** be issued in the following circumstances:

- workers recruited to EPP posts with insufficient evidence of hepatitis B, hepatitis C and HIV status
- new staff with symptoms consistent with tuberculosis without recent chest x-ray (CXR) and medical review
- food handlers who report infection with typhoid/ paratyphoid or contact with infected individuals within the last 21 days without receiving further advice from the local Health Protection Agency

In certain circumstances health clearance will be issued if outstanding screening tests and vaccination are required with advice to the manager that further action is required.

In the following circumstances individuals are required to attend OH **on their first day of post**; managers are responsible for ensuring staff attend for a further health check if advised on the health clearance certificate:

- new entrants to the NHS are required to attend for BCG scar check and/or IGRA on first day HCWs in special patient risk areas with no history of rubella immunity/ vaccination

In the following circumstances individuals are required to attend OH **within the first month of employment**; managers are responsible for ensuring staff attend a nurse clinic, Mantoux clinic or vaccine specific clinic for hepatitis B and MMR vaccination, for further vaccination if advised on the fitness certificate:

- uncertain or no chickenpox/ varicella zoster (VZV) immunity

- uncertain or no measles immunity
- uncertain or no rubella immunity – if not performed on first day of employment
- Mantoux test where:
  - no previous reliable BCG vaccination evidence
- IGRA where
  - new entrant (UK) to NHS
  - history of previous BCG but no scar and no documentary evidence
  - positive Mantoux test inconsistent with BCG history
- special occupational risk areas for diphtheria and/or hepatitis A and/or typhoid vaccine

The staff groups and screening requirements can be located in the staff immunisation and screening matrix.

7.1 EPP screening

All staff performing EPPs must be screened for hepatitis B. Whether hepatitis C or HIV screening is required will depend on when EPP workers commenced in an EPP post.

All EPP screening should be performed with an IVS.

Please see list of current EPP dependent post within the Trust – a list can be found in appendix 1.

7.1.1 Hepatitis B screening

New HCWs who perform EPPs are required to provide documented evidence of hepatitis immunity/ non-infectivity from a confirmed IVS from UK laboratory/ OH department including hepatitis B surface antigen (HBsAg) and antibody (anti HBs) results. If unavailable the HCW is required to attend OH for further screening with an IVS to confirm their status.

Existing staff who have already undergone screening for hepatitis B for EPP clearance and have a level of antibodies of greater than 10IU/l will not be re-screened unless they present to OH due to concern following blood exposure incident, eg needlestick injury.

If a HCW is known to be a chronic carrier of the hepatitis B virus (ie HBsAg positive) further tests are required to determine if the individual is fit to perform EPPs. All HCWs who have been identified by screening to be HBsAg positive should be seen by an occupational physician. All HBsAg positive individuals will be referred to a hepatologist.

In the following cases EPP clearance will not be authorised:

- 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 three months if on antiviral treatment – assuming viral load has never exceeded 10^5

The following table indicates OH monitoring dependent on the outcome of screening:

Status	**EPP clearance expiry**
HBsAg negative, anti HBs unknown as vaccination course incomplete/ not provided.	One year from date of last HBsAg test.
HBsAg negative, anti HBs >100 .	None
HBsAg negative, anti HBs 10-100 and anti HBc negative.	None
HBsAg negative, anti HBs 10-100 and anti HBc positive – natural immunity.	None
HbsAg negative, anti HBs <10 and anti HBc positive – natural immunity.	None
HBsAg negative anti HBs <10 anti HBc negative – true non-responder.	One year from date of last HBsAg test.
HBsAg positive – e antigen negative, viral load test less than 10^3 units/ml within the last twelve months.	One year from date of last viral load test.
HBsAg positive – e antigen negative, viral load test previously less than 10^5 but greater than 10^3. Viral load test less than 10^3 units/ml within the last three months and on anti viral treatment.	Three months from date of last viral load test.

Vaccination against hepatitis B is mandatory for non-immune HCWs who perform EPPs.

7.1.2 Hepatitis C screening

HCWs who are infected with hepatitis C virus and are RNA positive should not perform EPPs. As there is no vaccine for hepatitis C it is not possible to ensure permanent non-infectivity.

HCWs who know they are infected with hepatitis C virus or believe they may have been exposed to hepatitis C infection should seek advice from the OH department.

Hepatitis C screening is mandatory for all EPP workers:

- who entered in training of EPP dependent specialties from January 2003

- new to the NHS or returners to the NHS in EPP dependent specialties from August 2007
- who believe they have been exposed to hepatitis C where there is a risk of transmission eg hepatitis C positive needlestick injury

Screening consists of a hepatitis C antibody test (anti-HCV) and if positive hepatitis C virus RNA test.

If screening tests identify an individual to be infected with hepatitis C [ie hepatitis C virus antibody (anti-HCV) positive] they should be seen by an occupational physician. Further RNA tests are required. All anti-HCV positive individuals will be referred to a hepatologist for further treatment and advice.

Health care workers who respond successfully to treatment with antiviral therapy will be allowed to resume EPP work or training. Successful response is defined as remaining hepatitis C virus RNA negative for six months after the cessation of treatment. There will be ongoing assessment by an occupational physician. The worker will undergo continued monitoring with further sampling in a further six months and be advised accordingly.

In the following cases EPP clearance will not be authorised:

- anti HCV positive, HCV RNA positive
- anti HCV positive, HCV RNA negative but more than six months since the last test

The following table indicates OH monitoring dependent on the outcome of screening

Status	**EPP clearance expiry**
anti HCV negative	None
anti HCV positive, HCV RNA negative	six months from date of last HCV RNA test

7.1.3 HIV screening

All new HCWs to the NHS working in a role that requires EPPs are required to have a one off test for HIV prior to commencing work in the NHS.

All other HCWs are also entitled to access the equivalent screening although it is not mandatory for non-EPP roles.

HIV screening is mandatory for all EPP workers:

- new to the NHS or returners to the NHS in EPP dependent specialties from August 2007
- who believe they have been exposed to HIV where there is a risk of transmission eg HIV positive needlestick injury

Screening consists of an HIV antibody test (anti-HIV). EPP clearance will not be authorised if a worker is identified as being HIV positive until further screening has been undertaken. This must be overseen by a consultant occupational physician in liaison with the individual's treating physician.

If screening tests identify an individual to be HIV positive the individual should be seen by an occupational physician.

All HCWs identified as infected with HIV should be under the care of a specialist physician. If they do not have current access to care they will be referred for further treatment advice via the infectious disease clinic or genitourinary medicine clinic.

In addition HIV infected HCWs not undertaking EPPs should be offered an annual review with an occupational physician to provide advice and to review their work practices.

HIV positive HCWs who wish to undertake EPPs are required to attend for regular testing every three months.

HIV infected HCW wishing to undertake EPPs

HIV infected HCWs must meet the following criteria before they can perform EPPs:

Either

- be on effective combination antiretroviral therapy (cART), **and**
- have a plasma viral load <200 copies/ml

Or

- be an elite controller (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)

And

- be subject to plasma viral load monitoring every three months **and**
- be under joint supervision of a consultant occupational physician and their treating physician, **and**
- be registered with the UKAP Occupational Health Monitoring Register (UKAP-OHR)

Initial health clearance for HIV infected HCWs who wish to perform EPPs

If a HCW wishing to perform EPPs is know/ is identified as being HIV positive they should be seen by a consultant occupational physician for assessment and have the following screening undertaken prior to EPP clearance being issued:

- two identified and validated blood sample (IVS) test results taken no less than three months apart (for the purposes of initial health clearance, 'no less than three months apart' is defined as between 12 and 16 complete calendar weeks)
- and with viral load levels below 200 copies/ml are required to ensure viral load stability (laboratory testing should be undertaken by a Clinical Pathology Accreditation (UK) Limited accredited virology laboratory)

The decision to clear individual HCWs for work involving EPPs is the responsibility of the consultant occupational physician in consultation with the treating physician. Advice can be sought from UKAP on the application of the policy, as needed.

The following table indicates OH monitoring dependent on the outcome of initial screening:

Status	**EPP clearance expiry**
HIV Ag negative	None
HIV Ag positive – viral load test three months previously <200 and further viral load test <200 within the last three months and on anti viral treatment.	Three months from date of last viral load test.

Ongoing monitoring of HIV infected HCW wishing to undertake EPPs

HIV infected HCWs who are cleared to perform EPPs are subject to viral load testing every three months while continuing to perform such procedures. (for the purposes of initial health clearance, 'no less than three months apart' is defined as between 12 and 16 complete calendar weeks).

The three month period should be taken from the date the previous IVS was drawn, and not from the date the result was received.

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. At each screening test the HCW undertaking EPPs will be given a date for their next screening test to ensure they continue to comply with the guidance and their EPP clearance expiry updated.

If a 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 OH and treating physicians with input from appropriate local experts (eg 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 <1000copies/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.

7.2 Blood borne virus screening for non-EPP staff

All HCWs are also entitled to access hepatitis B, hepatitis C and HIV screening via OH. This screening is not mandatory for non-EPP roles however if individuals consider they may be at risk they should attend for screening. In some situations further screening is recommended, for example non-response to hepatitis B vaccine or unexpected result of TB screening.

Confidential screening is available via the OH department; individuals will be referred to an occupational physician for further advice if a blood borne virus is identified. Professional codes of practice from regulatory bodies require HCWs to report exposures to serious communicable diseases. Failure to do so may breach the duty of care to patients. This obligation also applies to staff already in post.

7.3 Food handler screening

All new staff who are appointed to roles which require food handling should complete for food handler questions on the ISQ. If identified to have an infectious disease which may require further investigation they will undergo further assessment in occupational health.

7.4 Tuberculosis screening

All new staff in clinical roles/ work in a clinical environment or with clinical specimens should have some screening for TB included in the ISQ. ISQ should be completed for each new job prior to commencing in a new role. ISQ clearance should be provided by CHW prior to individuals commencing in a new role. Increased screening is recommended for new entrants (UK) to the NHS and returnees to the NHS who have potentially been exposed to TB during their absence.

Screening for TB is included in the ISQ:

- an assessment of family or personal history of TB
- signs and symptoms enquiry
- history of CXR and results
- a history of living/ working overseas to assess if new entrant (UK)

A staff member will not be health cleared to start work if the individual has symptoms consistent with TB until fully investigated with a CXR and referred to the chest clinic for further investigations.

Individuals with past history of TB are requested to provide a medical report detailing treatment and response to treatment prior to health clearance.

Enhanced screening is performed for staff working with **direct patient contact either providing clinical care or support staff**. They should provide evidence of:

- previous BCG and documented scar check from OH department or
- Mantoux test
- IGRA test result

If no documentary evidence is available the staff member must:

- attend OH on the first day of work for BCG scar check
- attend OH within the first month of employment for a Mantoux test/ IGRA test

It is expected that staff with direct patient contact who do not perform direct clinical care or have exposures to clinical waste/ specimens should have a Mantoux test as an initial screen but may not routinely receive a BCG vaccine.

New entrants (UK) should have had an IGRA test +/- CXR (unless possibly pregnant) within the first month of the post. Returnees to the NHS who are new entrants (UK) require an equivalent level of screening.

In addition to standard screening new entrants (UK) are required to:

- attend OH on the first day of work for BCG scar check
- attend OH for an IGRA test within the first month of employment

Screening is performed in line with the algorithm in appendix 2.

7.4.1 Referral to for medical assessment for TB

All staff who have symptoms suggestive of TB, either identified through the ISQ process or via contact to CHW (for existing staff), should be discussed with an OHP as soon as possible for further assessment. Part of this assessment may include organising a CXR, if not recently performed. They should be booked to see an OHP and IGRA completed, if not recently completed. Managers will not be routinely advised of attendance unless fitness for work issues or work restrictions necessary.

If the CXR is normal and no symptoms consistent with TB are present the staff member can continue at work but is required to attend an OHP appointment follow-up as soon as possible. If the CXR is abnormal advice will be sought from the chest clinic.

Staff with a positive IGRA test, or Mantoux test >15mm positive or not in keeping with BCG history will be referred to the chest clinic (clinic 2a) by the occupational health nurses. They are also provided with a letter advising of symptoms to report if further symptoms develop whilst waiting for an appointment.

If a staff member fails to attend the chest clinic for review following an OH referral the chest clinic will notify OH of non-attendance. OH will contact the individual to advise them that they must contact the chest clinic for an appointment. If there is persistent non-attendance, the individual's manager will be informed by OH (after informing the individual) that the individual has not complied with the policy and must attend OH for review and follow further advice.

Occasionally staff will be referred to the chest clinic via another route (eg GP referral) who may also require work restrictions/ OH advice may be necessary. In such situations the TB specialist nurse will contact OH (after requesting the staff member's consent) to ensure the individual has appropriate OH advice.

7.4.2 Symptom advice

All staff when attending CHW for routine TB screening will also be advised about symptoms of TB and the importance of the prompt reporting of symptoms and seeking treatment advice.

7.4.3 Occupational exposure – symptom reminders

If there is a TB incident on the ward, OH should be advised of the staff in contact with the patient and re-issue further information on symptoms. This should be co-ordinated by the manager responsible for the work area where the incident occurred.

High risk areas for exposure to TB are considered to be:

- ward D10
- microbiology
- mortuary

7.5 Vaccination requirements

7.5.1 BCG

Although vaccination with BCG does not preclude TB, it has been shown to be 70-80% effective against the more severe forms of the disease eg TB meningitis, but less effective at preventing the respiratory disease. Protection will reduce over time and is expected to last 10-15 years.

In 2005 the national vaccination campaign for vaccinating all school age children was discontinued and vaccination is now only provided for certain risk groups. Healthcare workers and other staff with potential occupational exposure to TB eg microbiology laboratory and pathology staff should be receiving BCG vaccination.

Health care workers, laboratory workers and support staff potentially exposed to patients, clinical specimens and/or waste should be vaccinated with BCG when there is:

- no past history of vaccination or
- no past history of positive skin test for TB
- no past history of a positive IGRA test for TB
- Mantoux test within last three months less than 6mm
- no evidence of HIV infection or other contraindication

There is no data on the protection afforded by BCG vaccine when it is given to adults aged 35 years or over, however NICE guidelines on tuberculosis recommend BCG in all unvaccinated HCW, regardless of age. Where HCW are over 35 an individual assessment of risk should be made prior to vaccinating with BCG.

Non-HCW staff in regular patient contact, for example ward clerks, volunteers and receptionists, should not be routinely vaccinated.

Vaccination is mandatory for high risk work areas, for example ward D10, mortuary, and microbiology.

If an employee declines BCG when it is recommended the employee should be seen by an OHP and have the risks explained. The individual's manager

will be informed and they should assess workplace risks. Advice can be sought by OH. The individual should not work where there is a higher risk of exposure to TB eg mortuary, ward D10, microbiology laboratories.

7.5.2 Hepatitis B

All staff who may come into contact with blood in the line of their work should be vaccinated against hepatitis B. Vaccination is available through OH for all staff groups within this category.

Vaccination involves a primary course of three doses of vaccine followed by a blood test to ensure immunity. If immunity is confirmed (ie anti-HBs >100 IU/l) one five-year booster only is recommended. Further boosters may be recommended following occupational exposures to blood in line with the Trust's sharps injury and other exposures to blood policy.

If an individual has a poor (ie anti-HBs >10 but <100IU/l) they will be advised to have one further vaccine booster followed by their five-year booster.

If an individual has no response to the vaccine when tested (ie anti-HBs <10IU/l) a repeat vaccination course is performed. If the antibody response remains below 10 IU/l a full hepatitis B screen is undertaken to look for natural infection if the immune response to the vaccine remains poor.

Vaccination against hepatitis B is mandatory for non-immune HCW who perform EPPs. Vaccination is available from CHW (occupational health); details on clinics can be found at http://connect/index.cfm?articleid=5890 or telephone extension 2767.

7.5.3 Rubella

Rubella vaccine is a single vaccination encompassed in the MMR vaccine. Prior to MMR it was administered as a single vaccine.

All HCW, non HCW with regular patient contact, and support staff should provide evidence of immunity to rubella. Sufficient evidence would be either:

- evidence of vaccination against rubella with a single dose of vaccine or
- evidence of immunity by blood test rubella IgG or
- evidence of two doses of MMR vaccination

If insufficient evidence of immunity is provided at initial assessment on employment, the individual will be required to attend OH in the first month of employment for vaccination. Staff working in special patient risk areas are required to attend on the first day of employment.

7.5.4 Measles

Measles vaccine is encompassed in the MMR vaccine. Two doses of the vaccine administered one month apart are considered sufficient to assume immunity. Immunity is presumed if born prior to 1958 and a definite history of disease; however in high risk areas documentary evidence is required.

All HCW and non-HCW staff in regular patient contact should provide evidence of immunity to measles. Sufficient evidence would be one of:

- evidence of immunity by blood test measles IgG positive
- written evidence of having received two doses of MMR

Routine serology testing following vaccination is not required.

If insufficient evidence of immunity is provided on employment, the individual will be required to attend OH in the first month of employment for vaccination. Clinics for MMR vaccination are provided regularly at CHW.

Further details on clinics can be found at http://connect/index.cfm?articleid=5891 or telephone extension 2767.

7.5.5 Mumps

Mumps vaccine is encompassed in the MMR vaccine. Two doses of vaccine administered three months apart are considered sufficient to assume immunity.

No routine screening is performed on any staff group for mumps infection. Many staff will be vaccinated through MMR vaccine.

If staff members are concerned about non-immunity to mumps alone, vaccination should be accessed via the staff member's GP.

Measles immunity through MMR is a marker of mumps immunity as now combined vaccination with MMR.

7.5.6 Chickenpox [varicella zoster (VZV)]

Chickenpox immunisation for HCWs and staff in direct patient contact was introduced in 2003.

All HCW and non-HCW staff in regular patient contact in high risk areas should provide evidence of immunity to chickenpox. Sufficient evidence would include:

- history of chickenpox illness and shingles infection if childhood spent in temperate region
- evidence of immunity by blood test varicella zoster (VZV) IgG
- history of vaccination against varicella – two doses of VZV vaccine three months apart

Chickenpox is a common childhood illness in the UK; a history of past infection is considered adequate evidence of immunity if raised in the UK or other temperate regions. A history of illness is less reliable to confirm immunity in tropical regions. Serological testing of individual born and raised in these areas is required and vaccination administered if appropriate.

7.5.7 Poliomyelitis (polio)

Polio vaccine is part of the UK national vaccination campaign. Usually five doses of polio containing vaccine administered at appropriate intervals are considered to give satisfactory long term protection. If the national vaccination schedule is strictly followed the course in usually complete by the age of 15.

If a course is interrupted and incomplete it is recommended it is resumed and not repeated. The previous oral vaccine has now been replaced by an injectable form of vaccine (included in Td/IPV) which can be used to continue a course.

Individuals born before 1962 may not have been immunised or have received low-potency polio vaccine. Those who have not received a full five doses should seek advice from the GP or OH.

All HCWs and support staff should provide evidence of polio immunisation by history of vaccination in childhood.

All staff working in high risk areas where they regularly handle faecal specimens who are more likely to be exposed to polio virus, evidence of a booster vaccination is required every 10 years. These staff groups include:

- ward D10 staff
- mortuary workers
- microbiology staff

New ward D10 staff, mortuary staff and microbiology staff are required to attend a nurse clinic in OH within the first month of employment to ensure immunisations are complete.

7.5.8 Tetanus

Primary vaccination against tetanus is usually completed in infancy along with polio vaccination. The first booster is provided three years after the primary course and the second booster dose of Td/IPV should be given to all individuals ideally ten years after the first booster dose.

No enhanced tetanus vaccination is required outside the standard vaccination campaign.

7.5.9 Diphtheria

Primary vaccination against diphtheria is usually completed in infancy along with polio and tetanus vaccination (Td/IPV). The first booster is provided three years after primary course and the second booster dose of Td/IPV should be given to all individuals ideally ten years after the first booster dose.

Diphtheria vaccination history is only checked for ward D10 workers and microbiology staff although it is recommended that all staff are vaccinated in line with the national vaccination programme.

Ward D10 and microbiology staff are required to attend a nurse clinic in OH within the first month of employment to have their diphtheria immune status confirmed and booster vaccination if necessary. Staff who have not received a primary vaccination course will be required to have a full vaccination course. If a booster vaccine is given the individual should attend three months later for repeat blood test to confirm immunity and repeat boosters at ten year intervals thereafter. In the case of repeat primary course this should be at three months after the third dose.

The cut off level for diphtheria immunity is 0.01 IU/ml for microbiology laboratory, and ward D10 workers – not 0.1IU/ml which is recommended if they have exposure to more toxigenic strains. Testing of immunity and 10 year boosters are mandatory in these work areas.

7.5.10 Typhoid

Typhoid fever is rare in the UK as standards of sanitation are high. Usually cases of typhoid or paratyphoid are imported associated with foreign travel or contact with someone who has travelled to an area where typhoid is endemic. Typhoid vaccination is most often provided as a travel vaccination.

The only work area identified as having increased occupational risk of contractive typhoid is the microbiology laboratories; staff potentially at risk in these work areas should be vaccinated and receive booster vaccination every three years.

Vaccination is provided in OH for microbiology workers with injectable Vi polysaccharide vaccine. An oral vaccine is available but not usually given via OH. It is acknowledged that the oral vaccine may be more acceptable to some staff groups and will be considered (subject to availability) if injectable vaccine is considered unacceptable. In the absence of vaccination work practices need to be restricted.

Typhoid vaccination is mandatory in laboratory staff who may handle S. Typhi in the course of their work.

7.5.11 Hepatitis A

Hepatitis A is not included in the national vaccination programme. Improvements in living standards and hygiene have led to a marked fall in the incidence of the disease. Certain risk groups that are vaccinated against hepatitis A include:

- those with chronic liver disease
- men who have sex with men
- haemophiliacs
- IV drug users and
- those travelling to countries where it is recommended

These individuals should access vaccination via their GP.

Most HCWs are not at increased risk of occupationally acquired hepatitis A; routine vaccination is not indicated for all health care staff.

Increased risk of exposure to hepatitis A has been highlighted in the infectious disease unit setting and accordingly HCW staff on ward D10 should be vaccinated. In addition, mortuary staff who have increased risk of exposure to contaminated faeces should be vaccinated.

Hepatitis A vaccination is mandatory in ward D10 and mortuary staff.

7.5.12 Influenza (flu)

Influenza is a highly infectious disease and spreads rapidly, especially in closed communities. Because of their changing nature, the WHO monitors influenza viruses throughout the world and each year makes recommendations about the strains to be included in vaccines for the forthcoming winter. Annual vaccination is therefore required to ensure optimum protection.

Influenza vaccine is offered annually between October and early December to all staff groups. HCWs and staff in patient contact are strongly encouraged to attend for vaccination.

Vaccination is made accessible through the OH department and if sufficient demand visits to the workplace to provide vaccination can be organised.

Employees of external agencies who work on the Trust campus will only be able to receive flu vaccination if they have a contract with CHW to deliver this service.

7.5.13 Other vaccine-preventable infections

Currently vaccination against the following is not routinely performed for occupational reasons:

- meningitis C
- anthrax
- smallpox

If certain staff groups are identified to be at increased risk of these infections a risk assessment should be performed and the need for vaccination discussed with a consultant occupational physician.

8 Infected HCWs

8.1 Blood borne virus (BBV) infections

If a staff member is identified as having hepatitis B, hepatitis C or HIV whilst in employment an assessment of the individual's work activity will be required. If the individual has worked in a role that may have involved EPPs the occupational physician should notify the medical director and director for public health who will review the situation and decide whether a patient notification exercise is warranted, consulting, as necessary:

- the consultant in communicable disease control (CCDC)
- regional epidemiologists
- regional directors of public health
- UKAP

The medical director of an employing trust should also be informed in confidence at this stage.

Hepatitis B and hepatitis C are notifiable diseases; the OHP should ensure the local health protection unit is informed of the diagnosis. See the notification of infectious disease or food poisoning form.

8.2 Other infections

If a staff member believes him/herself to be infected with an active infectious disease (for example chickenpox, measles, TB) the individual should restrict him/herself from work and contact infection control or OH for further advice. If an infectious disease is confirmed further contact tracing may be required.

8.3 Confidentiality

OH records are confidential and are separate from hospital notes.
OH professionals are ethically and professionally obliged not to release notes or information without the consent of the individual concerned.

All blood borne virus screening tests are sent to the laboratory on an anonymous coded sample such that the identity of the staff member is unknown to laboratory staff.

If a HCW is identified as infected, consent is sought to disclose information if there is considered to be a risk to patients or public health. Information on infected HCWs will only be disclosed without consent in exceptional circumstances (where justification made) where is it considered necessary for the purposes of prevention of the spread on infection.

Maintaining the confidence of a BBV-infected HCW in this respect is very important but it is also important that the worker is counselled at an early stage about the worker's responsibilities if a patient notification exercise is possible. It is important that HCWs do not share the information with anyone other than those who really need to know. In particular, HCWs should not discuss the problem with colleagues at work. An HCW may wish to tell her/his manager in confidence (if not already aware), although this is not mandatory.

In routine screening managers are informed of work restrictions only where relevant to the role, for example if a hepatitis C infected HCW works in a non-EPP role no additional restrictions are put in place.

Any breach of confidentiality will be considered as a serious matter and may result in disciplinary action, which may, in accordance with the Trust's disciplinary procedure, lead to dismissal.

Immunisation status will not generally be regarded as medically confidential. Such information may be made available and held by managers in each clinical area. OH notes are however confidential and are separate from other hospital notes.

If the HCW has any concerns about confidentiality the individual should seek advice from an OHP.

8.4 Reporting infections under RIDDOR

If an infection is considered occupationally acquired this should be reported the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). Contact OH for further advice.

9 Vaccination records and recalls for vaccination

Under COSHH (regulation 11) a health record should be maintained with the dates and record of immunisation status. This should address the individual's fitness for work or if any additional restrictions are required. This should be **accessible by the individual's manager** to ensure appropriate control measures are in place to protect the individual at work.

This record should:

- include personal details of the individual
- include dates and records of immunisation/ protection status and when further action is required
- address the individual's fitness for work or any specific precautions that should be taken to protect the individual against occupationally acquired infections

A health record should not include confidential clinical information but OH assessment of immune status and if a further risk assessment is required. It is not the same as a clinical record as it needs to be accessible by the employer. For example, a manager needs to know whether someone is immune or not, but not necessarily the level of immunity or any reasons for lack of immunity. This latter, more detailed information could be kept with the clinical record.

At initial screening on employment consent is taken to record vaccination records and immune status on a centralised computer system and for OH to update them on an ongoing basis throughout employment when individuals attend OH for further vaccinations.

OH maintains a clinical record on each staff member of the Trust that includes each employee's screening and vaccination results. Recalls are generated from this to remind staff for vaccination. Managers are responsible for ensuring staff attend for vaccination when recalls are generated.

9.1 Electronic storage of immunisation records (Cohort)

Cohort (OH database) has the facility to record immunisation and infection screening data and vaccination recalls. Reports can be provided to managers on their staff immune status and recalls for vaccination are sent by OH. Individuals can be provided with a copy of their records. Annual influenza vaccination is also recorded on Cohort.

Currently full electronic access to immunisation status is unavailable; managers are responsible for ensuring that a health record is maintained, including vaccination data, for their staff and ensuring that staff attend for vaccination updates. Anonymised data can be provided at divisional level and standardised departmental reports can be made available to managers upon request.

10 Information for staff

Information for staff on vaccination/ immunisation, including the immunisation matrix, is available via Connect.

Advice sheets on screening and vaccine requirements for EPP and non-EPP roles are available to staff applying for posts and can be accessed via OH, recruitment or medical staffing. See:

- information for staff applying to perform non-EPP roles and
- information for staff applying to perform EPP roles

10.1 Risk assessments for occupational exposure to infections

General risk assessments should be performed under COSHH where there is a risk of exposure to infections in the workplace. These should be completed in line with the Trust's COSHH policy and procedure.

One of the control measures against infection is vaccination. The risks and benefits of vaccination should be explained to staff to ensure they are adequately protected against infectious disease.

If staff are not protected against infectious diseases, work restrictions may be necessary. In this circumstance, an individual risk assessment is recommended and work practices may be restricted. For advice on individual risk assessment managers should contact OH.

10.2 Staff with special risks

In certain circumstances staff may be at increased risk of infection; for example, if they become immunocompromised or pregnant.

Should a staff member develop a condition where the immune system may be impaired the employee should advise her/his manager. An individual risk assessment should be performed in these circumstances. In the case of an employee pregnancy, the new and expectant mothers risk assessment checklist should be completed. In other circumstances managers should seek advice from OH.

11 Monitoring compliance with and the effectiveness of this policy

The effectiveness of this policy will be monitored through the following specific measures:

Standard	Timeframe/ Method	Whom
Vaccination statistics	Statistics report to CoIC	OH
Monitoring of staff exposed to infectious diseases	Review of case notes of staff following an exposure.	OH/ infection control
EPP audit	Annual list provided to managers on EPP status plus monthly review of health clearance of new starters – reported to CoIC.	OH/ managers

12 References

Hepatitis B infection (Health Services Circular 93)

Protecting health care workers and patients from hepatitis B [Health Service Guidance HSG (93) 40]

Hepatitis B infection (HSC 2000/020 Hepatitis B Infected HCWs)

Hepatitis C infection (HSC 2002/010 Hepatitis C Infected HCWs)

AIDS/HIV infected health care workers guidance on the management of infected health care workers and patient notification

Health Clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New health care workers

Guidance for clinical health care workers: protection against infection with blood borne viruses. London: DH, 1998

DH 2006 Immunisation of healthcare and laboratory staff in: Immunisation against infectious disease (the 'Green Book'), Chapter 12

CMO letter Chickenpox (Varicella) Immunisation in health care workers.

NICE Clinical Guideline 33: Tuberculosis – Clinical diagnosis and management of Tuberculosis and measures for its prevention and control.

ANHOPS (Association for National Health Service Occupational Physicians) – Immunisation of the Health Care worker guidelines (ANHOPS 2005/6)

Biological agents: Managing the risks in laboratories and healthcare premises HSE Advisory Committee on Dangerous Pathogens

MacMahon E et al, Identification of potential candidates for varicella vaccination by history: questionnaire and seroprevalence study. BMJ, 2004. 329(7465): p. 551-552.

DH, Measles Letter from Professor David Salisbury, May 2008. Gateway reference no: 9949

NHS Plus Varicella zoster virus. Occupational aspects of management – a national guideline, 2010

Food Standards Agency Food Handlers: Fitness for work - Regulatory Guidance and Best Practice Advice For Food Business Operators 2009

Hepatitis B infected healthcare workers and antiviral therapy DH 2007

The Management of HIV infected Healthcare Workers who perform exposure prone procedures: updated guidance, January 2014

13 Associated documents

- IC12: sharps injury and other exposures to blood policy
- COSHH policy and procedure
- disciplinary procedure
- health surveillance of employees policy

See also:

- immunisation and screening matrix
- information for staff applying to perform non-EPP roles
- information for staff applying to perform EPP roles
- new and expectant mothers risk assessment checklist
- notification of infectious disease or food poisoning form

Equality and diversity statement

This document complies with the Cambridge University Hospitals NHS Foundation Trust service Equality and Diversity statement.

Disclaimer

It is **your** responsibility to check against the electronic library that this printed out copy is the most recent issue of this document.

Document management

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Appendix 1:

Exposure prone procedure (EPP) posts

Posts in the Trust considered the following roles involve EPPs

Doctors (including junior staff training in these specialties)

- orthopaedic surgeons
- urology surgeons
- general surgeons
- transplant surgeons
- vascular surgeons
- gastrointestinal surgeons
- plastic surgeons
- obstetrics & gynaecology surgeons
- ear nose and throat surgeons
- neurosurgeons
- maxillofacial surgeons
- ED specialists
- paediatric surgeons
- ophthalmologists*
- renal medicine physicians* – treat as EPP if handling dialysis machines
- dermatologists (those who perform minor surgery)*
- radiologists (those who perform interventional procedures)*
- general practitioners* (those who perform minor surgery)

Dentists

- All including orthodontics

Nursing and midwifery

- theatre scrub nurses
- ED nurses
- dental nurses
- midwives
- renal unit nurses* – treat as EPP if handling dialysis machines

Other

- HCAs in renal dialysis* – treat as EPP as may handle dialysis machines
- trainee surgical care practitioners
- operating department practitioners*
- surgical podiatrists

*Indicates posts which may be modified to be non EPP – for further advice contact a consultant occupational physician.

This list is not exhaustive; further details can be found in Annex 2 of Health Clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New health care workers.

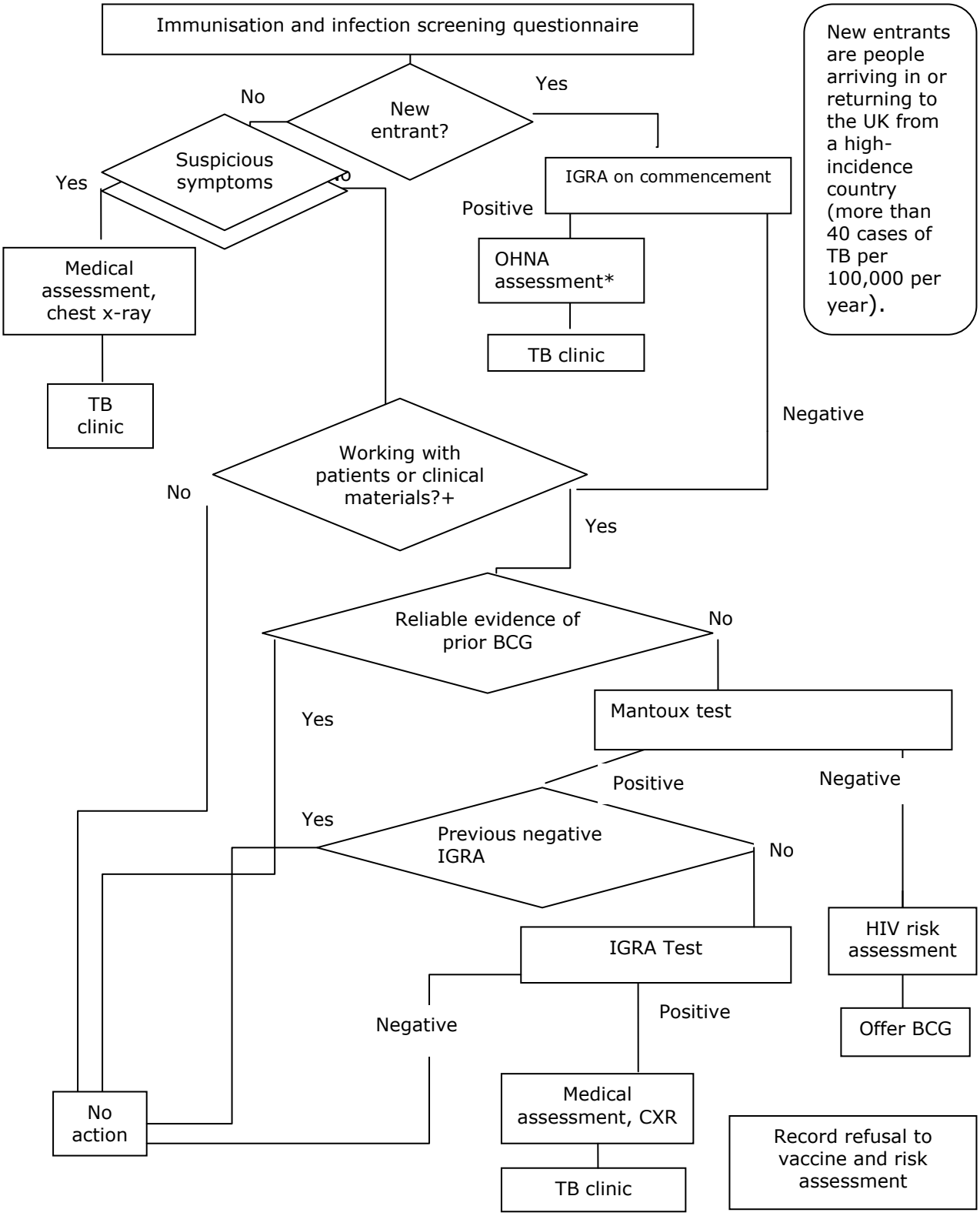
Post not currently considered EPP but may work in an area with EPP posts:

- anaesthetic nurses
- theatre support workers
- theatre support officers
- anaesthetists
- general practitioners working in EAU/ Camdoc

Medical posts not considered EPP include the following:

- oncology
- anaesthetics
- department for medicine for the elderly
- intensive care
- medicine
- specialist medicine
- haematology
- neonatology
- NCCU – unless on rotation which includes neurosurgery
- neurology
- paediatrics
- pathology

Appendix 2: TB screening algorithm



*OHNA assessment and referral to chest clinic – if suspicious symptoms refer OHP and organise medical assessment and CXR + Unless short term voluntary placement – no high risk travel and placement duration <12 weeks