



*HIV Infected
Health Care Workers:*
Guidance on Management and
Patient Notification

*HIV Infected
Health Care Workers:*

**Guidance on Management and
Patient Notification**

READER INFORMATION BOX

Policy HR/Workforce Management Planning Clinical	Estates Performance IM&T Finance Partnership Working
Document Purpose Best Practice Guidance	
ROCR Ref:	Gateway Ref: 4557
Title	HIV Infected Health Care Workers: Guidance on Management and Patient Notification
Author	DH//HP/GHP3
Publication Date	July 2005
Target Audience	PCT CEs, NHS Trusts CEs, SHA CEs, Care Trusts CEs, Medical Directors, Directors of PH, Directors of Nursing, Directors of HR, Allied Health Professionals, GPs, occupational physicians and nurses, consultants in communicable disease control. For information only for Foundation Trust CEs
Circulation List	
Description	This document replaces guidance published in 1998. It provides updated advice on patient notification exercises.
Cross Ref	N/A
Superseded Docs	Guidance on the Management of AIDS/HIV Infected Health Care Workers and Patient Notification (HSC 1998/226)
Action required	N/A
Timing	N/A
Contact Details	Gerry Robb DH/HP/GHP3 Room 631B Skipton House 80 London Road London SE1 6LH 020 7972 5732 www.dh.gov.uk/publications
For recipient use	

Contents

Summary	3
Key points and recommendations	4
1. Introduction	10
2. Current estimates of the risk of HIV transmission	12
3. General principles of blood-borne virus infection control and exposure prone procedures	14
4. The duties and obligations of health care workers who are, or may be, infected with HIV	18
5. The responsibilities of employers and commissioning bodies	22
6. The role and responsibilities of the occupational health service and HIV physicians	26
7. The role of the UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP)	28
8. When a patient notification exercise should be conducted	29
9. Care of the health care worker	36
10. Confidentiality concerning the infected health care worker	37
11. Guidance on notifying patients	39
Abbreviations	50
References	51

Annexes

A	Examples of UKAP advice on exposure prone procedures	52
B	Regulatory bodies' statements on professional responsibilities	63
C	UK Advisory Panel for Health Care Workers Infected with Blood-borne viruses: background information	67
D	Sources of advice and support	69

Summary

This guidance replaces the previous version published in 1998 and includes updated advice on patient notification exercises.

The document reflects the new policy on patient notification exercises when a health care worker is found to be infected with HIV, which was announced in November 2001. It follows expert advice from the Expert Advisory Group on AIDS (EAGA) and UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP). They advise that it is no longer necessary to notify every patient who has undergone an exposure prone procedure by an HIV infected health care worker because of the low risk of transmission and the anxiety caused to patients and the wider public. However, the long-standing restriction on HIV infected health care workers carrying out exposure prone procedures remains.

It is recommended that the decision on whether a patient notification exercise should be undertaken should be assessed on a case-by-case basis using a criteria based framework, as set out in this document. In line with *Shifting the Balance of Power*, Directors of Public Health of Primary Care Trusts will be responsible for deciding whether patient notification is necessary, although UKAP will be available to provide advice.

Key points and recommendations

Management of infected health care workers

1. These guidelines apply to all health care workers in the NHS and independent sectors, including visiting health care workers and students. **(Paragraph 1.1)**
2. All health care workers are under ethical and legal duties to protect the health and safety of their patients. They also have a right to expect that their confidentiality will be respected and protected. **(Paragraph 1.5)**
3. Provided appropriate infection control precautions are adhered to scrupulously, the majority of procedures in the health care setting pose no risk of transmission of the human immunodeficiency virus (HIV) from an infected health care worker to a patient. **(Paragraph 1.6)**
4. The circumstances in which HIV could be transmitted from a health care worker to a patient are limited to exposure prone procedures in which injury to the health care worker could result in the worker's blood contaminating the patient's open tissues ("bleed-back"). HIV infected health care workers must not perform any exposure prone procedures. **(Paragraphs 1.7 and 3.5)**
5. It is recommended that, as far as is practicable, patients should only be notified if they have been at distinct risk of bleed-back from the particular exposure prone procedures performed on them by an HIV infected health care worker. Such patients should be contacted and encouraged to have pre-test discussion and HIV antibody testing. **(Paragraph 1.8)**
6. The decision on whether a patient notification exercise is undertaken should be made on a case-by-case basis using risk assessment. It is anticipated that in most cases this decision will be made locally by Directors of Public Health (DsPH) of Primary Care Trusts (PCTs), supported as necessary by Regional Epidemiologists or Regional Directors of Public

Health. Where there is still uncertainty, the United Kingdom Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP) may also be approached for advice. **(Paragraph 1.9)**

6. HIV infected health care workers must not rely on their own assessment of the risk they pose to patients. **(Paragraph 4.6)**
7. A health care worker who has any reason to believe they may have been exposed to infection with HIV, in whatever circumstances, must promptly seek and follow confidential professional advice on whether they should be tested for HIV. Failure to do so may breach the duty of care to patients. **(Paragraph 4.7)**
8. Examples of how a health care worker may have been exposed to HIV infection include if they have:
 - engaged in unprotected sexual intercourse between men;
 - had unprotected intercourse in, or with a person who had been exposed in, a country where HIV transmission through sexual intercourse between men and women is common;
 - shared injecting equipment whilst using drugs;
 - had a significant occupational exposure to HIV infected material in any circumstances;
 - engaged in invasive medical, surgical, dental or midwifery procedures, either as a practitioner or patient, in parts of the world where infection control precautions may have been inadequate, or with populations with a high prevalence of HIV infection.
10. Additionally, a person who has had unprotected sexual intercourse with someone in any of the above categories may also have been exposed to HIV infection. **(Paragraph 4.8)**
11. Health care workers who are infected with HIV must promptly seek appropriate expert medical and occupational health advice. If no occupational health physician is available locally, all possible effort must be made to contact one elsewhere. Those who perform or may be expected

to perform exposure prone procedures must obtain further expert advice about modification or limitation of their work practices to avoid exposure prone procedures. Procedures which are thought to be exposure prone must not be performed whilst expert advice is sought. **(Paragraph 4.9)**

12. If there is uncertainty whether an HIV infected worker has performed exposure prone procedures, a detailed occupational health assessment should be arranged. UKAP can be consulted by the occupational health physician, the health care worker or a physician on their behalf if there is doubt. The health care worker's identity should not be disclosed to UKAP. **(Paragraph 4.10)**
13. If it is believed that any exposure prone procedures have been performed and that a patient notification exercise needs to be considered, the infected health care worker or their chosen representative (e.g. the occupational or HIV physician) should inform the Director of Public Health (DPH) of the relevant Primary Care Trust on a strictly confidential basis. The DPH will, in turn, make an appraisal of the situation to decide whether a patient notification exercise is necessary, consulting the Consultant in Communicable Disease Control (CCDC), Regional Epidemiologists, Regional Directors of Public Health, and UKAP, as necessary. The medical director of the employing trust should also be informed in confidence at this stage. **(Paragraphs 1.9, 4.11 and 4.12)**
14. HIV infected health care workers who do not perform exposure prone procedures but who continue to provide clinical care to patients must remain under regular medical and occupational health supervision. They should follow appropriate occupational health advice, especially if their circumstances change. **(Paragraph 4.13)**
15. Health care workers who know or have good reason to believe (having taken steps to confirm the facts as far as practicable) that an HIV infected worker is practising in a way which places patients at risk, or has done so in the past, must inform an appropriate person in the infected worker's employing authority (e.g. a consultant occupational health physician) or, where appropriate, the relevant regulatory body. The DPH should also be informed in confidence. UKAP can be asked to advise when the need for

such notification is unclear. Such cases are likely to arise very rarely. Wherever possible the health care worker should be informed before information is passed to an employer or regulatory body. **(Paragraph 4.16)**

16. All employers in the health care setting should ensure that new and existing staff (including agency and locum staff and visiting health care workers) are aware of this guidance and of the professional regulatory bodies' statements of ethical responsibilities, and occupational health guidance for HIV/AIDS infected health care workers. **(Paragraph 5.1)**
17. Medical, dental, nursing and midwifery schools, colleges and universities should draw students' attention to this guidance and the relevant professional statements. **(Paragraph 5.4)**
18. Where an employer or member of staff is aware of the health status of an infected health care worker, there is a duty to keep such information confidential. **(Paragraph 5.5)**
19. Employers should assure infected health care workers that their status and rights as employees will be safeguarded so far as is practicable. Where necessary, employers should make every effort to arrange suitable alternative work and retraining opportunities, or, where appropriate, early retirement, for HIV infected health care workers, in accordance with good general principles of occupational health practice. **(Paragraph 5.6)**
20. All matters arising from and relating to the employment of HIV infected health care workers should be co-ordinated through a specialist occupational health physician. **(Paragraph 6.1)**
21. Patient safety and public confidence are paramount and dependent on the HIV infected, or potentially infected, health care worker observing their duty of self-declaration to an occupational physician. Employers should promote a climate which encourages such confidential disclosure. It is extremely important that HIV infected health care workers receive the same rights of confidentiality as any patient seeking or receiving medical care. **(Paragraph 6.7)**

Patient notification exercises

22. Notification of patients identified as having been exposed to a risk of HIV infection by an infected health care worker is considered necessary:
 - To provide the patients with information about the nature of the risk to which they have been exposed;
 - To detect HIV infection and provide care and advice on measures to prevent onward HIV transmission;
 - To collect valid data to augment existing estimates of the risk of HIV transmission from an infected health care worker to patients during exposure prone procedures. **(Paragraph 8.1)**
23. The need for patient notification should be decided on a case-by-case basis using three risk assessment criteria: evidence of possible HIV transmission; nature and history of the infected health care worker's clinical practice; and other relevant considerations (e.g. evidence of poor clinical practice in relation to infection control or physical/mental impairment as a result of symptomatic HIV disease). **(Paragraph 8.4)**
24. Exposure prone procedures have been classified into three levels of risk of bleed-back (categories 1-3 of increasing risk). Where there is evidence of HIV transmission from infected health care worker to patient, notification of all patients who have undergone exposure prone procedures by that health care worker should take place. In the absence of evidence of HIV transmission, all patients who have undergone category 3 procedures by an HIV infected health care worker should be notified. When only category 1 or 2 procedures have been carried out, patient notification will not be necessary, unless the other relevant considerations suggest that it is. **(Paragraphs 8.5-8.8 and 8.13)**
25. The decision about the need for a patient notification exercise should rest with the DPH, supported as necessary by the Regional Epidemiologist and the Regional Director of Public Health. When a patient notification exercise is to be undertaken the DPH or delegated colleague (e.g. CCDC) should inform UKAP. If more than one Primary Care Trust is involved, it will be appropriate for the Regional Epidemiologist(s) to become involved

at this stage. If there is doubt about the need for patient notification, UKAP should be consulted. UKAP should also be informed in writing of incidents where it is concluded that a patient notification is not warranted. **(Paragraphs 8.15)**

Confidentiality

26. Every effort should be made to avoid disclosure of the infected worker's identity, or information that would allow deductive disclosure. This may include the use of a media injunction to prevent publication or other disclosure of a worker's identity. **(Paragraph 10.2)**
27. The duties of confidentiality still apply even if the infected health care worker has died, or has already been identified publicly. **(Paragraph 10.5)**

1. Introduction

- 1.1 These guidelines apply to all health care workers in the NHS and independent sectors, including visiting health care workers in any health care setting and students in training for whom there may be implications for future career options.
- 1.2 The recommendations in this guidance reflect the need to protect patients, to retain public confidence and to safeguard the confidentiality and employment rights of HIV infected health care workers.
- 1.3 The guidelines replace the version issued in December 1998, *AIDS/HIV Infected Health Care Workers: Guidance on the Management of Infected Health Care Workers and Patient Notification* (Health Service Circular (HSC) 1998/226). The new edition of the guidelines reflects changes in NHS structures, experience of patient notification exercises and the recommendations of a joint working group of the Expert Advisory Group on AIDS (EAGA) and the United Kingdom Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP), which has reviewed the policy for notifying patients exposed to HIV infected health care workers.
- 1.4 This guidance continues to endorse the ethical guidance in the statements from the professional regulatory bodies, clarifies the duties of HIV infected health care workers, their medical advisers and employers, and outlines the procedures which should be followed if a patient notification exercise is being considered.
- 1.5 All health care workers are under ethical and legal duties to protect the health and safety of their patients. They also have a right to expect that their confidentiality will be respected and protected.
- 1.6 Provided appropriate infection control precautions are adhered to scrupulously, the majority of procedures in the health care setting pose no

risk of transmission of the human immunodeficiency virus (HIV) from an infected health care worker to a patient. Employees with HIV could have a compromised immune status and hence be more susceptible to other infections. Employers should take this into account when assessing the possible risks of infection.

- 1.7 The circumstances in which HIV could be transmitted from an infected health care worker to a patient are limited to exposure prone procedures in which injury to the health care worker could result in the worker's blood contaminating the patient's open tissues. This is described as "bleed-back" in this guidance. HIV infected health care workers must not perform any exposure prone procedures. The majority of health care workers do not perform exposure prone procedures.
- 1.8 It is recommended that, as far as is practicable, patients should only be notified if they have been at distinct risk of bleed-back from the particular exposure prone procedures performed on them by an HIV infected worker. Such patients should be contacted and encouraged to have pre-test discussion and HIV antibody testing.
- 1.9 The decision on whether a patient notification exercise is undertaken should be made on a case-by-case basis using the risk assessment criteria developed by the EAGA/UKAP Working Group. It is anticipated that, in most cases, this decision will be made locally by Directors of Public Health (DsPH) of Primary Care Trusts (PCTs), supported as necessary by Regional Epidemiologists or Regional Directors of Public Health. Where there is still uncertainty, UKAP may also be approached for advice

2. Current estimates of the risk of HIV transmission

- 2.1 Documented cases of hepatitis B and hepatitis C infections have occurred in patients operated on by hepatitis B or C infected health care workers in this country. It is plausible that HIV could be transmitted under similar circumstances, although the risk of HIV transmission has been shown to be considerably less than for hepatitis B or hepatitis C following needlestick injuries.
- 2.2 Worldwide, there have been three reports of possible transmissions of HIV from infected health care workers performing exposure prone procedures: a Florida dentist¹, a French orthopaedic surgeon², and a Spanish gynaecologist³. Genetic relatedness of virus in the health care worker and patient(s) was demonstrated in all three cases; in the case of the French orthopaedic surgeon the route of transmission was clear, and it has been reported that a caesarean section was the route of transmission in the case of the Spanish gynaecologist.
- 2.3 All other retrospective studies worldwide of patients exposed to the potential risk of transmission of HIV during exposure prone procedures have failed to identify any patients who have become infected by this route.
- 2.4 The data available from patient notification exercises support the conclusion that the overall risk of transmission of HIV from infected health care workers to patients is very low. Between 1988 and 2003 in the UK, there were 28 patient notification exercises. However, there was no detectable transmission of HIV from an infected health care worker to a patient despite over 7,000 patients having been tested.
- 2.5 The Health Protection Agency's (HPA) Centre for Infections, receives reports of newly diagnosed HIV infections to establish the likely route of transmission. There have been no inexplicable infections that might otherwise have been potentially linked to exposure prone procedures.

However, if there had been a health care worker to patient transmission, this might be masked by the case having other HIV exposure risks.

- 2.6 The evidence indicates that there is a far greater risk of transmission of HIV from infected patients to health care workers than from infected workers to patients. Up to December 2002, there had been 106 cases worldwide of health care workers in whom seroconversion was documented after occupational exposure to HIV from patients. Five of these were cases in which transmission occurred in the UK.⁴
- 2.7 The Department of Health, EAGA and UKAP will continue to evaluate the epidemiological evidence on the risks of transmission, informed by results from properly documented patient notification exercises when these are considered necessary.

3. General principles of blood-borne virus infection control and exposure prone procedures

- 3.1 The Health Departments' published guidance for clinical health care workers on protection against infection with blood-borne viruses in 1998 (see box).⁵ This guidance should be followed to minimise the risk of blood-borne virus transmission to health care workers from patients. The measures recommended will also minimise the risk of transmission from infected workers to patients, and from patient-to-patient.

General measures to prevent occupational transmission of blood-borne viruses

1. Apply good basic hygiene practices with regular hand washing, before and after contact with each patient, and before putting on and after removing gloves. Change gloves between patients.
2. For all clinical procedures, cover existing wounds, skin lesions and all breaks in exposed skin with waterproof dressings, or with gloves if hands extensively affected.
3. Health care workers with chronic skin disease such as eczema should avoid those invasive procedures which involve sharp instruments or needles when their skin lesions are active, or if there are extensive breaks in the skin surface. A non-intact skin surface provides a potential route for blood-borne virus transmission, and blood-skin contact is common through glove puncture that may go unnoticed.
4. Use protective clothing as appropriate, including protection of mucous membranes of eyes, mouth and nose from blood and body fluid splashes. Open footwear should not be worn in situations where blood may be spilt, or where sharp instruments or needles are handled.

5. Prevent puncture wounds, cuts and abrasions and, if present, ensure that they are not exposed (see 2).
 6. Avoid sharps usage wherever possible and consider the use of alternative instruments, cutting diathermy and laser.
 7. Where sharps usage is essential, exercise particular care in handling and disposal, following approved procedures and using approved sharps disposal containers.
 8. Clear up spillages of blood and other body fluids promptly and disinfect surfaces.
 9. Follow approved procedures for sterilization and disinfection of instruments and equipment.
 10. Follow approved procedures for safe disposal of contaminated waste.
- 3.2. In the event of a health care worker or patient sustaining an injury where there is the possibility of HIV transmission (e.g. a sharps injury with an instrument that has been in contact with blood or other body fluids), guidance on HIV post-exposure prophylaxis from EAGA should be followed. This guidance can be found at <http://www.advisorybodies.doh.gov.uk/eaga/PDFS/prophylaxisguidancefeb04.pdf>
- 3.3 All breaches of the skin or epithelia by sharp instruments are by definition invasive. Most clinical procedures, including many which are invasive, do not provide an opportunity for the blood of the health care worker to come into contact with the patient's open tissues. Provided the general measures to prevent occupational transmission of blood-borne viruses are adhered to scrupulously at all times, most clinical procedures pose no risk of transmission of HIV from an infected health care worker to a patient, and can safely be performed.
- 3.4 Those procedures where an opportunity for health care worker-to-patient transmission of HIV **does** exist are described as exposure prone and must not be performed by a health care worker who is HIV infected.

3.5 Exposure prone procedures are those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker (bleed-back). These include procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. However, other situations, such as pre-hospital trauma care should be avoided by health care workers restricted from performing exposure prone procedures, as they could also result in the exposure of the patient's open tissues to the blood of the worker.

3.6 Procedures where the hands and fingertips of the worker are visible and outside the patient's body at all times, and internal examinations or procedures that do not involve possible injury to the worker's gloved hands from sharp instruments and/or tissues, are considered not to be exposure prone provided routine infection control procedures are adhered to at all times. Examples of such procedures include:

- taking blood (venepuncture);
- setting up and maintaining intravenous lines or central lines (provided any skin tunnelling procedure used for the latter is performed in a non-exposure prone manner);
- minor surface suturing;
- the incision of external abscesses;
- routine vaginal or rectal examinations;
- simple endoscopic procedures.

Examples of UKAP's advice on which procedures are, and are not, exposure prone are attached at **Annex A**.

3.7 The final decision about the type of work that may be undertaken by an HIV infected health care worker should be made on an individual basis, in conjunction with a specialist occupational physician, taking into account

the specific circumstances including working practices of the worker concerned. The occupational physician may wish to consult UKAP.

- 3.8 The decision whether an HIV infected worker should continue to perform a procedure which itself is **not** exposure prone should take into account the risk of complications arising which might necessitate the performance of an exposure prone procedure. Only reasonably predictable complications need to be considered in this context.
- 3.9 The likelihood of injury to the health care worker and consequent possible risk to the patient depends on a number of factors which include not only the type and circumstances of the procedure, but also the skill and fitness to practice of the health care worker and patient circumstances (e.g. if the patient is restless or agitated).

4. The duties and obligations of health care workers who are, or may be, infected with HIV

- 4.1 The current statements of the General Medical Council, General Dental Council and the Nursing and Midwifery Council about the ethical responsibilities of health care workers towards their patients are set out at **Annex B**. These responsibilities are equally applicable to all other professional groups not covered by these regulatory bodies.
- 4.2 All doctors, dentists, nurses, midwives, health visitors and other health care professionals who have direct clinical care of patients, have a duty to keep themselves informed and updated on the codes of professional conduct and guidelines on HIV infection laid down by their regulatory bodies and any relevant guidance issued by the Department of Health.
- 4.3 In addition, students should be made aware of the implications of these statements and of the contents of this guidance (**see also Paragraphs 1.1 and 5.5**).
- 4.4 All health care workers are under ethical and legal duties to protect the health and safety of their patients. Under the Health and Safety at Work etc. Act 1974, and associated regulations, such as the Control of Substances Hazardous to Health (COSHH) Regulations 2002, health care workers who are employees have a legal duty to take reasonable care for the health and safety of themselves and of others, such as colleagues and patients, and to co-operate with their employer in health and safety matters.
- 4.5 Self-employed health care workers have general duties to conduct their work so that they and others are not exposed to health and safety risks. The Employment Medical Advisory Service of the Health and Safety Executive (HSE) is able to act as a liaison point between health care employers and their employees, and HSE. It may also be approached by infected health care workers wishing to seek advice on health and safety issues.

4.6 HIV infected health care workers must not rely on their own assessment of the risk they pose to patients.

4.7 A health care worker who has any reason to believe they may have been exposed to infection with HIV, in whatever circumstances, must promptly seek and follow confidential professional advice on whether they should be tested for HIV. Failure to do so may breach the duty of care to patients.

4.8 Examples of how a health care worker may have been exposed to HIV infection include if they have:

- engaged in unprotected sexual intercourse between men;
- had unprotected intercourse in, or with a person who had been exposed in, a country where transmission of HIV through sexual intercourse between men and women is common;
- shared injecting equipment whilst misusing drugs;
- had a significant occupational exposure to HIV infected material in any circumstances;
- engaged in invasive medical, surgical, dental or midwifery procedures, either as a practitioner or patient, in parts of the world where infection control precautions may have been inadequate, or with populations with a high prevalence of HIV infection.

Additionally, a person who has had unprotected sexual intercourse with someone in any of the above categories may also have been exposed to HIV infection.

4.9 HIV infected health care workers must promptly seek and follow appropriate expert medical and occupational health advice. If there is no occupational health physician available locally, all possible effort must be made to contact one elsewhere. Those who perform, or who may perform, exposure prone procedures must obtain further expert advice about modification or limitation of their working practices to avoid exposure prone procedures. Procedures which are thought to be exposure prone must not be performed whilst expert advice is sought (**see Section 6**).

- 4.10** If there is uncertainty whether an HIV infected worker has performed exposure prone procedures, a detailed occupational health assessment should be arranged. UKAP can be consulted by the occupational health physician, the health care worker or a physician on their behalf. The health care worker's identity should not be disclosed to UKAP (any correspondence must be anonymised or pseudonyms used).
- 4.11** If it is believed that any exposure prone procedures have been performed by an infected health care worker, then the infected health care worker or their chosen representative (e.g. the occupational health physician or the HIV physician) should, without delay inform the Director of Public Health (DPH) of the relevant PCT on a strictly confidential basis.
- 4.12** The DPH will in turn make an appraisal of the situation to decide whether a patient notification exercise is warranted, consulting the Consultant in Communicable Disease Control (CCDC), Regional Epidemiologists, Regional Directors of Public Health, and UKAP, as necessary. The medical director of an employing trust should also be informed in confidence at this stage (**see Section 8**). The health care worker, the occupational health physician or the HIV physician should not make the decision about whether a patient notification exercise needs to be considered.
- 4.13** HIV infected health care workers who do not perform exposure prone procedures, but who continue to provide clinical care to patients, must remain under regular medical and occupational health supervision. They should follow appropriate occupational health advice, especially if their circumstances change (**see Section 6**).
- 4.14** Once any health care worker has symptomatic HIV disease, closer and more frequent occupational health supervision is necessary. As well as providing support to the worker, the aim of this is to detect at the earliest opportunity any physical or psychological impairment which may render a worker unfit to practise, or may place their health at risk.
- 4.15** HIV infected health care workers applying for new posts should complete health questionnaires honestly. HIV infection is a medical condition about which an occupational health physician should be informed, verbally if

preferred. Details will remain confidential to the occupational health department, as for other medical conditions disclosed in confidence to occupational health practitioners **(see Paragraphs 6.7-6.9)**.

- 4.16** Health care workers who know or have good reason to believe (having taken steps to confirm the facts as far as practicable) that an HIV infected worker is performing exposure prone procedures or has done so in the past, must inform an appropriate person in the health care worker's employing authority (e.g. an occupational health physician) or, where appropriate, the relevant regulatory body. The DPH should also be informed in confidence. UKAP can be asked to advise when the need for such notification is unclear. Such cases are likely to arise very rarely. Wherever possible, the health care worker should be informed before information is passed to an employer or regulatory body.

5. The responsibilities of employers and commissioning bodies

- 5.1** All employers in the health care setting should ensure that new and existing staff (including agency and locum staff and visiting health care workers) are aware of this guidance and of the professional regulatory bodies' statements of ethical responsibilities, and occupational health guidance for HIV/AIDS infected health care workers. This may include issuing regular reminders. Commissioners may wish to stipulate this when placing service agreements with NHS Trusts. *Independent Health Care: National Minimum Standards Regulations* require all health care workers in the independent health care sector to comply with professional codes of practice and Department of Health guidelines on health care workers infected with blood-borne viruses.
- 5.2** The Control of Substances Hazardous to Health (COSHH) Regulations 2002 provide the legal framework for assessing the risk to employees in the workplace. Employers have a duty to identify the hazards in the workplace, assess the risks posed and put measures in place to control these risks. Employers are required to produce a risk assessment which should include all of the activities which may result in workers being exposed to blood-borne viruses. This will help employers decide what control measures should be put in place to protect health care workers. This includes the requirement for employees to receive suitable and sufficient information, instruction and training on the risks posed by blood-borne viruses and precautions to take when exposed to biological agents. More information on the duties and responsibilities under the COSHH Regulations can be found in the COSHH Approved Code of Practice (L5), which is available from HSE books⁶.
- 5.3** There is a legal requirement under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) to report all occupationally acquired needlestick injuries involving significant exposure

to HIV positive material, to the Health and Safety Executive (see www.riddor.gov.uk for further information).

- 5.4 Medical, dental, nursing and midwifery schools, colleges and universities should draw students' attention to this guidance and the relevant professional statements. Each training establishment should identify a nominated officer with whom students may discuss their concerns in confidence. In addition, all students should be appropriately trained in procedures and precautions to minimise the risk of occupational blood-borne virus transmission. All these issues should be addressed before there is clinical contact with patients.
- 5.5 Where an employer or member of staff is aware of the health status of an infected health care worker, there is a duty to keep any such information confidential. They are not legally entitled to disclose the information unless that individual consents, or in exceptional circumstances (**see Section 10**). A decision to disclose without consent should be carefully weighed as authorities or persons taking such action may be required to justify their decision.
- 5.6 Employers should assure infected health care workers that their status and rights as employees will be safeguarded so far as practicable. Where necessary, employers should make every effort to arrange suitable alternative work and retraining opportunities, or where appropriate, early retirement for HIV infected workers, in accordance with good general principles of occupational health practice.
- 5.7 The Disability Discrimination Act 1995 protects people with progressive conditions against disability discrimination from the point at which symptoms have begun to have some adverse effect on a person's ability to carry out normal day-to-day activities. It is unlawful to discriminate against disabled persons including those with symptomatic AIDS or HIV infection in any area of employment, unless the employer has justification because of a material and substantial reason. The restriction of such a worker for the purpose of protecting patients from risk of infection, such as the requirement to refrain from performing exposure prone procedures, would justify such discrimination. However, the employer who knows that

the worker is disabled has a duty to make reasonable adjustment, e.g. by moving the worker to a post, if available, where exposure prone procedures could be avoided.

- 5.8** The Disability Discrimination Act 2005 extends the definition of disability in the Disability Discrimination Act 1995 to cover more people with HIV infection, effectively from diagnosis, and so before the point at which symptoms have begun to have any adverse effect on normal day-to-day activities. The Government has proposed that this change should take effect in December 2005.
- 5.9** The NHS Injury Benefits Scheme and the DWP Industrial Injuries Disablement Benefit Scheme may, in certain circumstances, provide benefits where HIV has been occupationally acquired.
- 5.10** The NHS Injury Benefits (IB) Scheme provides temporary or permanent benefits for all NHS employees who suffer a temporary loss of earnings (Temporary Injury Allowance) or suffer a permanent reduction in their earning ability (Permanent Injury Benefit) because of an injury or disease wholly or mainly attributable to their NHS duties. The IB Scheme is also available to general medical and dental practitioners working in the NHS. Under the terms of the Scheme, it must be established whether, on the balance of probabilities, the injury or disease was acquired during the course of NHS work.
- 5.11** The Industrial Injuries Disablement Benefit Scheme provides benefits where HIV has been acquired as a result of an accident arising out of and in the course of employment (e.g. a needlestick injury) and a level of disablement has been established.
- 5.12** Details of the NHS IB Scheme can be obtained from the Injury Benefits Section, NHS Pensions Agency, Hesketh House, 200-220 Broadway, Fleetwood, Lancashire, FY7 8LG or by logging onto (http://www.nhspa.gov.uk/scheme_booklets.cfm). Leaflets and advice on the Industrial Injuries Disablement Scheme can be obtained from local social security offices. (http://www.dwp.gov.uk/lifeevent/benefits/industrial_injuries_dis.htm).

5.13 Ill-health retirement benefits under the NHS Pension Scheme may be payable when health care workers are permanently incapable of performing their duties because of their HIV infection. Information on ill-health retirement is available from the NHS Pensions Agency (see address and website address above).

6. The role and responsibilities of the occupational health service and HIV physicians

- 6.1 All matters arising from and relating to the employment of HIV infected health care workers should be co-ordinated through a specialist occupational health physician
- 6.2 The HIV physician providing the necessary regular care to an infected worker, with their consent, should liaise with the occupational health physician and preferably they should jointly manage the case.
- 6.3 Occupational health services which do not employ a specialist occupational health physician should refer individuals to such a physician in another unit. The Association of National Health Service Occupational Physicians (ANHOPS) has issued guidance to its members and has given a list of specialist occupational physicians who can be contacted by those working in occupational medicine in the field (**see Annex D**). The close involvement of occupational health departments in developing local procedures for managing and supporting HIV infected health care workers is strongly recommended.
- 6.4 If such arrangements do not exist, the Faculty of Occupational Medicine or ANHOPS will also put independent contractors and other non-NHS staff in touch with a specialist occupational health physician. Alternatively, the physician looking after the worker may contact UKAP for advice.
- 6.5 While the occupational health physician has responsibility for occupational medical management and assessment, if a physician is not immediately available, some infected health care workers may initially seek advice from an occupational health nurse. The nurse should make every effort to arrange for the health care worker to see the occupational health physician as soon as possible. If necessary the occupational health nurse should seek confidential advice directly from the UKAP. As for any other referral to the UKAP, identification of the worker should be avoided.

- 6.6 HIV infected health care workers should remain under regular medical and occupational health supervision in accordance with good practice. Occupational health physicians should consider the impact of HIV positivity on the individual's resistance to infection when advising on suitability for particular posts, especially if the duties involve exposure to known or undiagnosed TB.
- 6.7 Patient safety and public confidence are paramount and dependent on the HIV infected, or potentially infected, health care worker observing their duty of self-declaration to an occupational health physician. Employers should promote a climate that encourages such confidential disclosure. It is extremely important that HIV infected health care workers receive the same rights of confidentiality as any patient seeking or receiving medical care. Occupational health practitioners, who work within strict guidelines on confidentiality, have a key role in this process, since they are able to act as an advocate for the health care worker and adviser to the employing authority. They should adopt a proactive role in helping health care workers to assess if they have been at risk of HIV infection and encourage them to be tested for HIV, if appropriate (**see Paragraphs 4.6-4.9**).
- 6.8 Occupational health records are held separately from other hospital notes and can be accessed only by occupational health practitioners, who are obliged ethically and professionally not to release records or information without the consent of the individual. Conversely, occupational health practitioners do not have access to hospital notes. There are occasions when an employer may need to be advised that a change in duties should take place, but HIV status itself normally would not be disclosed without the health care worker's consent. However, it may be necessary in the public interest for the employer and the DPH to have access to confidential information where patients are, or may have been, at risk.
- 6.9 Occupational physicians are well placed to act as advocates for the worker on issues of retraining and redeployment, or, if indicated, medical retirement. Occupational health departments have a key role to play in developing local policies for the management of infected health care workers' future employment.

7. The role of the UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP)

- 7.1 Details of UKAP's remit and contact details are provided in **Annex C**.
- 7.2 UKAP advises as a committee and may be consulted through its Secretariat:
- when the general guidelines in this document cannot be applied to individual cases;
 - when assistance is required to help decide if a patient notification exercise is warranted;
 - when health care workers or their professional advocates dispute local advice;
 - if advice is needed about modification of working practices to avoid exposure prone procedures prospectively;
 - where special circumstances exist.
- 7.3 UKAP can also advise individual health care workers or their professional advocates on how to obtain local guidance on working practices.
- 7.4 Those seeking the advice of UKAP should ensure the anonymity of the referred health care worker and should avoid the use of personal identifiers.

8. When a patient notification exercise should be conducted

Purpose of patient notification

- 8.1 Notification of patients identified as having been exposed to a risk of HIV infection by an infected health care worker is considered necessary:
- to provide patients with information about the nature of the risk to which they have been exposed;
 - to detect any HIV infection, provide care to the infected person and advice on measures to prevent onward HIV transmission;
 - to collect valid data to augment existing estimates of the risk of HIV transmission from an infected worker to patients during exposure prone procedures.
- 8.2 The overall objective of patient notification is to identify the patient population at a distinct risk of exposure to the infected health care worker's blood during exposure prone procedures (**see Paragraph 3.4-3.6**). These patients should be contacted, offered a pre-test discussion and encouraged to have an HIV antibody test. The decision on whether a patient notification exercise should be carried out at all, and if so on how far the look back should go, should be taken by the DPH on a case-by-case basis after a criteria based risk assessment has been conducted.

Risk assessment of need for patient notification

- 8.3 It is recommended that it is no longer necessary to notify automatically every patient who has undergone **any** exposure prone procedure by an HIV infected health care worker because the overall risk of transmission is very low.
- 8.4 Instead, EAGA and UKAP have recommended that the decision on whether a patient notification exercise should be undertaken should be made on a case-by-case basis using three risk assessment criteria. These are:

- if evidence of HIV transmission is found, a patient notification exercise should always be carried out and **all** patients who have undergone exposure prone procedures contacted;
- the nature and history of the clinical practice of the health care worker; this would take into account the clinical speciality and the level of risk of various exposure prone procedures performed (**see Paragraph 8.6**);
- other relevant considerations, for example
 - evidence of poor clinical practice (e.g. poor infection control and frequent needlestick injuries);
 - evidence of physical or mental impairment as a result of symptomatic HIV disease (or any other disease) which could affect the HIV infected health care worker's standard of practice. Examples include visual impairment, neurological deficit and dementia.
 - other relevant medical conditions, e.g. skin diseases such as weeping eczema.

8.5 The definition of exposure prone procedures given in **Paragraph 3.5** embraces a wide range of procedures, in which there may be very different levels of risk of bleed-back (injury to the health care worker resulting in the worker's blood contaminating the patient's open tissues – **see Paragraph 1.7**). A risk-based categorisation of clinical procedures has been developed including procedures where there is negligible risk of bleed-back (non-exposure prone procedures) and three categories of exposure prone procedures with increasing risk of bleed-back.

8.6 The definitions and examples of categories 1, 2 and 3 are:

Category 1

Procedures where the hands and fingertips of the worker are usually visible and outside the body most of the time and the possibility of injury to the worker's gloved hands from sharp instruments and/or tissues is slight. This means that the risk of the health care worker bleeding into a patient's open tissues should be remote.

Examples: *local anaesthetic injection in dentistry, removal of haemorrhoids.*

Category 2

Procedures where the fingertips may not be visible at all times but injury to the worker's gloved hands from sharp instruments and/or tissues is unlikely. If injury occurs it is likely to be noticed and acted upon quickly to avoid the health care worker's blood contaminating a patient's open tissues.

Examples: *routine tooth extraction, appendicectomy.*

Category 3

Procedures where the fingertips are out of sight for a significant part of the procedure, or during certain critical stages, and in which there is a distinct risk of injury to the worker's gloved hands from sharp instruments and/or tissues. In such circumstances it is possible that exposure of the patient's open tissues to the health care worker's blood may go unnoticed or would not be noticed immediately.

Examples: *hysterectomy, caesarean section, open cardiac surgical procedures.*

- 8.7 A categorisation of the most common clinical procedures depending upon the relative risk of bleed-back is being developed by UKAP. Preliminary work on the categorisation of procedures has been completed.
- 8.8 In assessing the "other relevant considerations" criterion, the following information will be helpful:
- the health care worker's current or past health;
 - any information to suggest that the infection could have affected his or her working practices e.g. visual impairment, neurological deficit or dementia;
 - whether the health care worker has a skin condition (e.g. weeping eczema);
 - the employment history of the health care worker;

- any evidence of the health care worker not following recommended infection control practises;
- any direct evidence available that might suggest that the health care worker was at higher risk of transmitting HIV e.g. reported episodes of needlestick injuries.

Additional information for risk assessment and deciding length of patient notification

8.9 In carrying out a risk assessment and deciding on how far back patient notification should go, the following information will also be needed. The co-operation of the health care worker will be necessary, and should be sought in as sensitive a manner as possible, preferably by his or her own physician:

- confirmation of the date of diagnosis. Steps should be taken to ensure that there is no doubt that the worker is HIV infected, including repeat testing in a UK laboratory if appropriate;
- any information to suggest when the health care worker was infected. For example:
 - evidence of a possible seroconversion illness;
 - previous documented negative HIV tests;
 - presence of symptomatic HIV disease;
 - having worked in a country with a high prevalence of HIV infection;
 - other risk factors e.g. injuries, blood transfusion etc.
- whether there are any stored sera that could be tested (with informed consent) to obtain further information;
- a carefully documented clinical history (including dates, places and results of tests for HIV antibody, HIV viral load, and CD4 cell counts) to assemble a record of the course of HIV infection;
- the interval between the health care worker being diagnosed as HIV positive and reporting this to an occupational health physician or to

public health officials; what recommendations were made during any of this time, and were they documented; did the health care worker continue to practise during this time;

- the nature of the duties performed by the health care worker while likely to have been HIV infected;
- whether the health care worker is willing for his or her medical adviser(s) to provide information on all/any of the above;
- after first seeking specialist virological advice on specimen collection and processing, specimens suitable for HIV isolation and gene sequencing should be obtained from the worker and securely stored, in anticipation of a possible need for investigation at a later date.

- 8.10** Ideally, the bulk of the health care worker's medical history should be obtained from the health care worker. If for any reason this is not possible or appropriate, the history may require reconstruction or supplementation from other data sources after appropriate consent has been obtained. These may include hospital in-patient or out-patient notes, general practice records and the health care worker's partner and family.
- 8.11** Although it is unlikely that the date of the **onset** of the worker's infection with HIV will be known, in some cases the clinical history may indicate when this was likely to have occurred.
- 8.12** Where the duration of infection is unknown, where a clinical history cannot be obtained or if the health care worker has AIDS or has died, it is currently recommended that in the first instance patients who have undergone relevant exposure prone procedures during the preceding **10** years be notified, where records are still available. (Ten years is the median incubation period from infection to symptomatic disease in untreated individuals). If there is evidence of transmission of HIV from the health care worker to a patient during this time, then patient notification should be extended for as long as is possible.

Deciding whether patient notification should take place

- 8.13** Where there is evidence of HIV transmission from an infected health care worker to a patient, all patients who have undergone exposure prone procedures by that health care worker should be notified, counselled and offered an HIV test. In the absence of evidence of HIV transmission, all patients who have undergone category 3 procedures by an HIV infected health care worker should be notified and offered an HIV test. Notification of patients who have undergone procedures placed in categories 1 or 2 is **not** necessary unless information gathered under the 'other relevant considerations' criterion suggests that it is (**see Paragraph 8.4**).
- 8.14** If a DPH is informed by an HIV infected health care worker or their advocate that exposure prone procedures may have been performed, they should make a careful appraisal of the facts, seeking relevant specialist advice (e.g. occupational health, epidemiological and virological advice). It may be helpful to review some records of those treated by the infected health care worker to assess the range of procedures performed. As mentioned already, the need for patient notification will depend on the specific circumstances of each case and the perceived risk of bleed-back. This process should involve as few other people as possible, on a strictly confidential need-to-know basis.
- 8.15** The decision about the need for a patient notification exercise should rest with the DPH, supported as necessary by the Consultant in Communicable Disease Control, (CCDC), Regional Epidemiologists, Regional Directors of Public Health, and UKAP. The DPH is best placed to assess all the contributing factors and to guide PCTs, NHS Trusts and others as to appropriate action. **When a patient notification exercise is to be undertaken, the DPH or delegated person (e.g. CCDC) should inform UKAP.** If more than one PCT is involved, it will be appropriate for the Regional Epidemiologist(s) to become involved at this stage. UKAP should be consulted if there is doubt about the need for a patient notification exercise. This may arise if there is difficulty in reaching a conclusion locally about the categories of procedures performed by the health care worker or the application of the other criteria. **UKAP should also be informed in**

writing of incidents where it is concluded that a patient notification is not warranted.

- 8.16** When it has been decided that a patient notification exercise is necessary, a small incident team should be set up locally. The DPH or delegated person (e.g. CCDC) should promptly notify in confidence the DPH covering any other employing authority involved in the exercise. They should also inform the Regional Epidemiologist, who can assist in facilitating liaison and co-ordinating activities across boundaries, the HPA Centre for Infections (for cases in England, Wales and N.Ireland) or Health Protection Scotland (see **Annex D**). Consideration should be given also to the need for a multi PCT incident team. The lead PCT should be identified, and the roles of members of local as well as multi-PCT teams should be clarified at the outset.
- 8.17** The number of individuals who know the identity of the infected worker should be kept to a minimum at all stages. It may not be necessary for all members of the team(s) to be aware of the identity of the infected worker. The consent of the infected worker to disclosure should be obtained where possible.

9. Care of the health care worker

- 9.1 The interests of the health care worker and their family are very important. Where possible, the health care worker should be kept informed of decisions about the patient notification exercise. With their family, they may need immediate practical or psychological support including measures to protect privacy. If the health care worker has been only recently diagnosed as HIV infected, access to counselling and specialist medical advice will be needed, including a consideration of antiretroviral drug therapy.
- 9.2 It is important to make every effort to keep the health care worker's confidence during the assessment period and afterwards. Assurances should be given about measures to protect their identity, and that an injunction to prevent publication of their name, or other details which could lead to disclosure of their identity, will be sought on their behalf as necessary (**see Paragraphs 8.17, 10.2 and 11.40**).
- 9.3 The worker or their family may wish to seek their own independent legal advice. If they do seek legal advice it will be helpful for the Trust's legal advisers to keep in regular contact with those representing the health care worker.
- 9.4 Infected health care workers who normally perform exposure prone procedures as part of their duties will need to modify their practice or seek retraining or redeployment. Advice on the former can be obtained in the first instance from a specialist occupational health physician who may wish to take advice from UKAP. The Trust's director of human resources and/or the regional post-graduate dean should be approached for advice on retraining and redeployment issues or alternative careers (**see Section 5**).
- 9.5 It is important that staff who are involved in managing the incident, particularly the DPH, do not act as personal advisers or advocates for the health care worker. A specialist occupational health physician may be the most appropriate person to represent the worker's interests (**see Section 6**).

10. Confidentiality concerning the infected health care worker

- 10.1** There is a general duty to preserve the confidentiality of medical information and records. Breach of this duty is very damaging for the individuals concerned, and it undermines the confidence of the public and of health care workers in the assurances about confidentiality which are given to those who come forward for examination or treatment. In dealing with the media, and in preparing press releases where necessary, it should be stressed that individuals who have been examined or treated in confidence are entitled to have their confidence respected.
- 10.2** Every effort should be made to avoid disclosure of the infected worker's identity, or information which would allow deductive disclosure. This should include the use of a media injunction as necessary to prevent disclosure of a health care worker's identity (**see Paragraph 11.40**). The use of personal identifiers in correspondence and requests for laboratory tests should be avoided and care taken to ensure that the number of people who know the worker's identity is kept to a minimum (**see Paragraph 8.18**). Any unauthorised disclosure about the HIV status of an employee or patient constitutes a breach of confidence and may lead to disciplinary action or legal proceedings. Employers should make this known to staff to deter open speculation about the identity of an infected health care worker.
- 10.3** The duty of confidentiality, however, is not absolute. Legally, the identity of infected individuals may be disclosed with their consent, or without consent in exceptional circumstances, where it is considered necessary for the purpose of treatment, or prevention of spread of infection. Any such disclosure may need to be justified.

- 10.4** In balancing duty to the infected health care worker and the wider duty to the public, complex ethical issues may arise. As in other areas of medical practice, a health care worker disclosing information about another health care worker may be required to justify their decision to do this. The need for disclosure must be carefully weighed and where there is any doubt the health care worker considering such disclosure may wish to seek advice from his or her professional body.
- 10.5** The duties of confidentiality still apply even if the infected health care worker has died, or has already been identified publicly.

11. Guidance on notifying patients

Identification of exposed patients

- 11.1 Patient identification should be conducted as swiftly as practicable. However, there may be circumstances where it is considered advantageous to adopt a more measured approach to patient identification, and involve fewer personnel. This approach may help to reduce the risk of attracting the attention of staff who are not involved, and possibly of the media, to unusual activity. A balance should be sought between conducting a patient notification exercise quickly and risking unnecessary public anxiety.
- 11.2 The patient identification process will require the assistance of the medical records officer and setting up a small team who, in some circumstances, may need to work out of hours and over weekends. There may be practical difficulties in tracking medical records, whether manual or computer based, as well as inaccuracies or omissions within the records themselves. If at all possible, patient identification should be complete before any public announcement is made to reduce unwarranted public anxiety. In practice, particularly when large numbers of patients are concerned and if the media have become aware, this may not be possible.
- 11.3 The number of people who need to know the identity of the worker should be kept as small as possible, even though a larger number of people may need to know that there is an incident. In some cases, for example, it may be possible for staff who do not know the worker's identity to perform a preliminary search of records for particular exposure prone procedures. These records may then be searched for procedures performed by the infected worker by those who know the worker's identity.

- 11.4 Depending on the particular circumstances, patient identification may include:
- checking operating theatre, delivery room, accident and emergency department records, dental records, and hospital or departmental computer records. It will often be necessary to use several sources, and data will require amalgamation and cross-checking;
 - abstracting the following patient details: full name, date of birth, hospital number or other identifier, last known address/telephone number, date of death if known to have died, name, address and telephone/fax number of GP, date(s) and type and full name/description of procedure(s) performed by the health care worker, and the role played;
 - further examination of records of patients known to have died, including review of death entry records.
- 11.5 When more than one PCT is involved, these activities should take place according to a timescale agreed by the multi-PCT incident team. The Regional Epidemiologist(s) will play an important role in co-ordination and facilitation of liaison.
- 11.6 At the start of the patient notification exercise the procedures which the health care worker is known to have performed (or is likely to have performed) should be reviewed and categorised according to level of risk of bleed-back (categories 1 to 3). If category 1 or 2 procedures have been carried out, the need to notify these patients should be assessed taking account of the other two risk assessment criteria, evidence of possible HIV transmission and other relevant considerations, e.g. evidence of poor infection control or physical or mental impairment (**see Paragraph 8.4-8.8**).
- 11.7 It is important that procedures are described in sufficient detail to allow their categorisation by risk of bleed-back. Any abbreviations should be used with care to avoid misinterpretation.
- 11.8 Once patient identification is complete, a list of patients' names and procedures should be given in confidence to the incident team.

Contacting patients

- 11.9** In deciding how best to contact patients and the information to be given, the following factors should be borne in mind:
- the numbers likely to be involved;
 - the profile of the patients who may require notification;
 - the type of operation or procedures undertaken;
 - whether children are involved.
- 11.10** As a general principle, it is preferable for patients to be personally contacted by a counsellor, health adviser or other relevant health professional before any press announcement is made and every effort should be made to do so.
- 11.11** However, in large-scale patient notification exercises it may be judged neither reasonable nor practicable to contact exposed patients personally, in which case they should be contacted by other means such as by letter.
- 11.12** For elderly or other more vulnerable patients, for example, those receiving psychiatric care (who may be disproportionately worried by receiving a letter), it may be preferable to write to the GP first, asking them to decide whether it is appropriate to inform the patient. However, not all such cases are likely to be recognisable during the patient identification process.

Writing to patients

- 11.13** If possible, letters to patients should be sent so that they arrive before or on the day of any planned press statement. The addresses should be checked and letters sent by first class post marked strictly private and confidential. If letters are sent directly to patients, it is suggested that local GPs are written to at the same time to inform them that a patient notification exercise is underway, and to advise them which of their patients, if any, are involved.

- 11.14 It is helpful to enclose a pre-paid envelope and reply slip for the patient/GP to return, to confirm they have received the letter. This assists with the documentation and further handling of the incident.
- 11.15 The letters should give details of a dedicated confidential helpline number. Patients receiving a letter may be very anxious to discuss the situation or arrange to have an HIV test at the earliest opportunity. Details of the local general helpline number and the Sexual Health Line number should also be included (**see Paragraphs 11.21-11.22**).
- 11.16 Most patients' addresses should be available from the case notes, but more up to date addresses may be obtained from the PCT, health board or health and social services board, although identifying a new address when the patient has moved out of the area can take some time. Where the PCT or board has no record of a particular patient they may possibly be traced through the NHS Central Registry at Southport or Edinburgh, or the Central Services Agency in Northern Ireland.

Staff in the hospital(s) involved in the patient notification exercise

- 11.17 Staff in the hospital(s) involved may also be worried and concerned about the issues surrounding HIV/AIDS, the effect of the exercise on their relationships with patients, or because they know or worked with the health care worker. They may also be contacted by worried patients. It is recommended that appropriate staff are briefed by the incident team about the exercise, initially on a strict need to know basis, or more widely if details have entered the public domain or are likely to do so. The identity of the infected worker should not be revealed or discussed.

General security and confidentiality of records

- 11.18 The general conditions applying to confidential information about patients are equally valid in patient notification exercises. This includes not only the names of patients being contacted, but also the names of those who have telephoned the help-lines. It is therefore important to restrict access to the local incident room or to any other place where

confidential records may be held. In addition, general heightened security measures will be necessary as there may be unauthorised attempts to gain access to this information.

- 11.19** Documents which include details that can directly identify the health care worker or patients ideally should not be left on the hard disk of an unattended computer. If they are, they should be protected by passwords which should be changed regularly. All hard copy files, compact discs and diskettes must be properly locked away in a secure place when not in use, and access to these should be limited to as few people as practicably possible.
- 11.20** If there is any doubt about security during electronic transmission, this route should not be used.

Telephone help-lines

- 11.21** If details about an infected health care worker incident have entered or are likely to enter the public domain, PCTs/NHS Trusts should consider setting up a general helpline in addition to the specific helpline offered to patients contacted in the notification exercise. This will help avoid the hospital switchboard becoming jammed. It may be appropriate to contract existing local HIV help-lines or NHS Direct to help provide such a service. The Sexual Health Line can also provide more general help and advice. Any local helpline should also take account of the particular needs of people whose first language is not English.
- 11.22** If establishing a local helpline, it is useful to bear the following in mind:
- the telephone company should be contacted immediately the decision to set up a general helpline has been made;
 - large numbers of telephone lines can take 24-48 hours to establish. If necessary, start with as many lines as can be made available at the time and then introduce more later. Lines can be decommissioned as demand subsides;
 - the number of calls can be very large. At the start of larger incidents in the past, help-lines often have had to deal with 300-400 calls an

hour. This may, in part, have been due to the public alarm provoked by the widespread publicity given to their existence;

- the desirability of publicising a general helpline number should be balanced against the possibility that this may provoke needless alarm and that members of the public may feel they ought to contact it;
- lines should ideally operate from 8am to midnight in the first instance, and over the weekend. An answer phone with a reassuring message, including the Sexual Health Line number, should be in operation overnight;
- help-lines should not be routed through the main hospital switchboard, otherwise they will become jammed;
- staff working on any helpline will need briefing and discussions with the incident team, so that they are able to reassure callers that any patient who is considered to have been placed at risk of HIV infection will be notified individually and offered testing. Depending on the complexity of the case-finding process, this may not be until after an evaluation phase has been completed;
- when patient identification is not complete, callers should be told that they will be contacted, if appropriate, once their records have been checked;
- if patient identification is complete and a patient calls a helpline insisting that they have been treated by the worker whose identity is in the public domain but there is no record of this, their views must be respected and testing offered if requested;
- in the event that help-lines are continually blocked, experience has shown some people telephone or come directly to the hospital. Switchboard and reception staff may require briefing and should know where to refer them. Such patients should be seen by a well-briefed staff member on site as soon as possible.

Pre-test discussion and testing of patients

11.23 Patients who are contacted as part of a patient notification exercise should be informed that they may have been exposed to a low risk of

HIV transmission from an infected health care worker and should be offered an HIV test with a pre-test discussion.

- 11.24** People considering whether to have an HIV test may require reassurance concerning any effect this may have on their insurance. The Association of British Insurers has recommended to its members that for life insurance proposals and proposals for other types of insurance where health or lifestyle questions are asked, they no longer ask whether the applicant has had counselling or a negative test for HIV infection. Insurers continue to be entitled to ask about any positive HIV test result in connection with a relevant life insurance application.
- 11.25** Arrangements should be in place for voluntary confidential HIV testing of notified patients. Staff responsible for pre-test discussion will need to explain that occasionally a second specimen may be needed and that this does not necessarily indicate that HIV infection is present.
- 11.26** A large number of patients may decide to be tested for HIV infection. Such testing must be undertaken by an accredited laboratory with the facilities and experience to handle a heavy demand for testing, and which participates in a quality assurance scheme for HIV testing. The laboratory director should be consulted before any local arrangements are made. The laboratory director will also arrange for confirmatory testing and HIV gene sequence investigations where these are required.
- 11.27** If the patient's exposure prone procedure occurred less than three months earlier, the HIV test should be repeated at least three months following the procedure. This is because of the "window period" between infection with HIV and appearance of HIV antibody.
- 11.28** The results of the test must be made available to the patient as soon as possible, ideally by the person who provided pre-test discussion.
- 11.29** Depending on circumstances, it may be helpful if the laboratory forms accompanying patients' specimens are marked with an agreed code. This will allow any peripheral laboratories to recognise tests which relate to a particular incident and will facilitate the rapid reporting of results. Ideally, these should all go through the same laboratory.

- 11.30** Any initially reactive test results should be discussed with a reference laboratory as a matter of urgency so that confirmatory HIV tests can be rapidly completed.
- 11.31** Laboratories should report relevant HIV test results to the incident team for incorporation into the patient notification database.

Further investigation of HIV positive results

- 11.32** In any exercise of this nature it is possible that unrelated positive test results may be obtained because of risk factors other than treatment by the infected health care worker. A repeat blood specimen should be collected from patients with a positive test result and tested in a reference laboratory (see **Annex D**).
- 11.33** If the presence of HIV infection is confirmed, the patient should promptly be referred to a specialist HIV physician for clinical management. The following investigations should also be undertaken:
- the senior investigator should personally undertake a detailed record review to document the exposure prone procedure and to confirm that the HIV infected patient was exposed to the HIV infected worker. Copies of the relevant records should be made and securely stored;
 - if the patient received any blood or blood products, the National Blood Service should be asked to investigate the donors;
 - the infected patient should be interviewed by an experienced clinician or counsellor in order to obtain a detailed history of risk factors for HIV infection;
 - specimens suitable for HIV isolation and HIV gene sequencing should be obtained from the infected patient and securely stored;
 - if the patient is concerned for their partner(s), then they should be given the offer of HIV testing their sexual partner(s);
 - specialist epidemiological and virological advice on further investigation should be sought.

Dealing with the media

- 11.34** A nominated press officer should be part of the incident team from the start of the exercise. If at all possible, they should have experience of working with the national media and should liaise with both the Strategic Health Authority press officer and the Department of Health press officer, if appropriate (see **Annex D**).
- 11.35** External pressure should be resisted and should not be permitted to prompt inappropriate action in haste, although it is accepted that public concern may influence the speed with which the case finding process is undertaken. Unnecessary or inappropriate notification (e.g. patients who have not undergone an exposure prone procedure) can cause unjustifiable distress, and detract from the value and acceptability of properly targeted patient notification exercises.
- 11.36** In the event of media interest or other external enquiries during the period of evaluation prior to a patient notification exercise, the DPH should acknowledge that a case is being investigated. If necessary the media should be told that when the evaluation is complete anyone who is considered to have been at risk will be notified individually, counselled and offered HIV testing. At the same time, an assurance should be given that the overall risk is considered very low.
- 11.37** A public announcement can give rise to unnecessary public alarm and may result in the loss of confidentiality for exposed patients and the infected health care worker. In some incidents involving small numbers of patients no such announcement has been made. An announcement may be necessary if, for instance, wide knowledge of the incident within a hospital or Trust means that it is likely to become known to the media and public. Although desirable, it is often not possible to complete patient identification or to contact patients before any public announcement is made. This needs to be decided on a case-by-case basis as local circumstances may vary.
- 11.38** A media statement should be held in readiness at all times, reviewed regularly, for use in the event of media enquiries.

11.39 An ideal scenario exists when all exposed patients have been identified and contacted, so that if necessary a press statement could be used to confirm, if the media enquire, that all patients exposed to risk have been informed and others need have no cause for concern.

11.40 If, however, a proactive public announcement is judged necessary, it will normally be made through a press release. This should be as informative as possible to avoid unnecessary public anxiety, whilst avoiding the inclusion of information which could lead to deductive disclosure of the health care worker's identity. The health care worker should not be named. It should:

- refer to "a health care worker" unless more explicit information about the worker's profession has already entered the public domain;
- include details of arrangements which are being or have been made to contact patients;
- reassure that all patients who may have been exposed to risk will be or have been contacted individually, and offered HIV testing as appropriate.

In addition, the "Notes for Editors" might state that a media injunction will be sought and invoked if necessary, to prevent any publication or other disclosure of the worker's identity. If a media injunction is sought, careful consideration should be given to how restrictive it needs be. A very restrictive media injunction may result in greater public alarm than one which allows a limited disclosure of information that would not lead to deductive disclosure of the health care worker's identity.

11.41 If details of an incident are in the public domain, NHS and other relevant authorities may consider that in order to deal effectively with the potentially large number of media enquiries, they should hold a press conference. A medically qualified person, usually the DPH or a deputy, should be present, along with senior managers and the incident team's nominated press officer. Public announcements should not be delayed if it proves difficult to assemble all relevant persons for a press conference.

Press conferences may need to be held more than once if there is further media interest.

- 11.42 If it is known that an HIV infected worker has worked for a number of different authorities, any public announcements should ideally be made by all the authorities concerned at the same time. The multi-PCT incident team should issue a statement which covers all PCTs, or if separate communications are necessary, ensure that the content and timing of these are consistent.

Reviewing the outcome

- 11.43 Once the incident is over, the head of the incident team should correlate the master list of patients, appropriately coded, and details of the procedures undergone with the HIV antibody test results. The completed dataset should be archived with the HPA, or Health Protection Scotland (see **Annex D**). This will be collated with data from all similar patient notification exercises to assist in further epidemiological assessment.
- 11.44 In all cases it is helpful, when the exercise is complete, to evaluate how it was managed, identify pressure points or problems and refine local planning accordingly.
- 11.45 The Department of Health would be grateful if the heads of incident teams would consider sending summary datasets and/or final reports to the UKAP secretariat to assist in the further development of this guidance (see **Annex C**).

Abbreviations

ANHOPS	The Association of NHS Occupational Physicians
CCDC	Consultant in Communicable Disease Control
COSHH	Control of Substances Hazardous to Health Regulations 1999
DPH	Director of Public Health
EAGA	Expert Advisory Group on AIDS
EPP	Exposure prone procedure
HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency
HSE	Health & Safety Executive
PCT	Primary Care Trust
UKAP	UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses

References

1. Ciesielski C, Marianos D, Ou C-Y, Dumbaugh R, Witte J, Berkelman R et al. Transmission of human immunodeficiency virus in a dental practice. *Ann Int Med* 1992; 116: 798-805.
2. Lot F, Séguier J-C, Fégueux S, Astagneau P, Simon P, Aggoune M et al. Probable transmission of HIV from an orthopaedic surgeon to a patient in France. *Ann Int Med* 1999; 130: 1-6.
3. Bosch X. Second case of doctor-to-patient HIV transmission. *The Lancet Infectious Diseases* 2003; 3: 261.
4. Health Protection Agency. Occupational transmission of HIV – summary of published reports. March 2005 Edition (data to end of December 2002). London: Health Protection Agency, March 2005.
http://www.hpa.org.uk/infections/topics_az/bbv/pdf/intl_HIV_tables_2005.pdf
5. UK Health Departments. Guidance for clinical health care workers: protection against blood-borne viruses. London: Department of Health, 1998. <http://www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf>
6. <http://www.hsebooks.com/Books> or contact details: HSE Books, PO BOX 1999, Sudbury, Suffolk, CO10 2WA. Tel: 01787 881165

Annex A: Examples of UKAP advice on exposure prone procedures

1. The UKAP has been making recommendations about the working practices of health care workers (HCWs) infected with HIV since the end of 1991, and HCWs infected with other blood-borne viruses (BBVs) since September 1993. Advice for occupational physicians arises from individual queries, cases or general issues which have been referred to the UKAP since its inception.

Exposure prone procedure criteria

2. Judgements are made by occupational physicians, or in conjunction with the UKAP where doubt or difficulty exists, about whether any procedure is or is not exposure prone against the following criteria:

Exposure prone procedures (EPPs) are those where there is a risk that injury to the worker may result in exposure of the patient's open tissues to the blood of the worker. These procedures include those where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.

3. Occupational physicians and others who need to make decisions about the working practices of infected health care workers may find the following examples of UKAP advice helpful. In some cases this advice may help clarify matters, and in others it may suggest the need to seek further specific advice about the individual case under consideration.

Cautionary note

4. Individual working practices may vary between hospitals and between health care workers. Advice for one health care worker may not always be

applicable to another. This list must therefore be interpreted with caution, as it provides examples only and is not exhaustive.

Examples of advice given by UKAP

5. The following advice has been given by UKAP in relation to specialities and procedures. Please note that these are only examples and do not obviate the need for a full risk assessment at local level, including the procedures likely to be undertaken by a health care worker whose practice is restricted in a particular post; the way in which they would be performed by that individual; and the context in which they would operate e.g. colleagues available to take over if an exposure prone procedure becomes necessary.

5.1 Accident and Emergency (A&E)

A&E staff who are restricted from performing exposure prone procedures (EPPs) should not provide pre-hospital trauma care.

These staff should not physically examine or otherwise handle acute trauma patients with open tissues because of the unpredictable risk of injury from sharp tissues such as fractured bones. Cover from colleagues who are allowed to perform EPPs would be needed at all times to avoid this eventuality.

Other EPPs which may arise in an A&E setting would include:

- rectal examination in presence of suspected pelvic fracture;
- deep suturing to arrest haemorrhage;
- internal cardiac massage.

(See also **Anaesthetics, Biting, Paramedics and Resuscitation**)

5.2 Anaesthetics

Procedures performed purely percutaneously are not exposure prone, nor have endotracheal intubation nor the use of a laryngeal mask been considered so.

The only procedures currently preformed by anaesthetists which would constitute EPPs are:

- the placement of portacaths (very rarely done) which involves excavating a small pouch under the skin and may sometimes require manoeuvres which are not under direct vision;
- the insertion of chest drains in accident and emergency trauma cases such as patients with multiple rib fractures.

The insertion of a chest drain may or may not be considered to be exposure prone depending on how it is performed. Procedures where, following a small initial incision, the chest drain with its internal trochar is passed directly through the chest wall (as may happen e.g. with a pneumothorax or pleural effusion) and where the lung is well clear of the chest wall, would not be considered to be exposure prone. However, where a larger incision is made, and a finger is inserted into the chest cavity, as may be necessary e.g. with a flail chest, and where the health care worker could be injured by the broken ribs, the procedure should be considered exposure prone.

Modern techniques for skin tunnelling involve wire guided techniques and putting steel or plastic trochars from the entry site to the exit site where they are retrieved in full vision. Therefore skin tunnelling is no longer considered to be exposure prone (see also **Arterial cutdown**).

5.3 Arterial Cutdown

Although the use of more percutaneous techniques has made arterial or venous cutdown to obtain access to blood vessels an unusual procedure, it may still be used in rare cases. However, as the operator's hands are always visible, it should no longer be considered exposure prone.

5.4 Biting

Staff working in areas posing a significant risk of biting should not be treated as performing EPPs. In October 2003, UKAP considered a review of the available literature on the risk of onward transmission from health care workers infected with blood-borne viruses to patients. The review

showed that the published literature on this subject is very scarce. In follow-up studies of incidents involving infected health care workers working with patients known to be 'regular and predictable' biters, there were no documented cases of transmission from the health care worker to the biter. However, where biters were infected, there were documented cases of seroconversion in their victims and the risk of infection was increased in the presence of:

- Blood in the oral cavity – risk proportionate to the volume of blood;
- Broken skin due to the bite;
- Bite associated with previous injury i.e. non-intact skin;
- Biter deficient in anti-HIV salivary elements (IgA deficient).

Based on the available information, it can only be tentatively concluded that even though there is a theoretical risk of transmission of a blood borne virus from an infected health care worker to a biting patient, the risk remains negligible. The lack of information may suggest that this has not been perceived to be a problem to date, rather than that there is an absence of risk.

UKAP has advised that, despite the theoretical risk, since there is no documented case of transmission from an infected health care worker to a biting patient, individuals infected with blood-borne viruses should not be prevented from working in or training for specialties where there is a risk of being bitten.

The evidence is dynamic and the area will be kept under review and updated in the light of any new evidence that subsequently emerges suggesting there is a risk. However, it is important for biting incidents to be reported and risk assessments conducted in accordance with NHS procedures. Biting poses a much greater risk to health care workers than to patients. Therefore employers should take measures to prevent injury to staff, and health care workers bitten by patients should seek advice and treatment, in the same way as after a needlestick injury.

5.5 Bone Marrow transplants

Not exposure prone.

5.6 Cardiology

Percutaneous procedures including angiography/cardiac catheterisation are not exposure prone. Implantation of permanent pacemakers (for which a skin tunnelling technique is used to site the pacemaker device subcutaneously) may or may not be exposure prone. This will depend on whether the operator's fingers are or are not concealed from view in the patient's tissues in the presence of sharp instruments during the procedure (see also **Arterial cutdown**).

5.7 Chiropodists

see **Podiatrists**

5.8 Dentistry and orthodontics (including hygienists)

The majority of procedures in dentistry are exposure prone, with the exception of:

- examination using a mouth mirror only;
- taking extra-oral radiographs;
- visual and digital examination of the head and neck;
- visual and digital examination of the edentulous mouth;
- taking impressions of edentulous patients; and
- the construction and fitting of full dentures.

However, taking impressions from dentate or partially dentate patients would be considered exposure prone, as would the fitting of partial dentures and fixed or removable orthodontic appliances, where clasps and other pieces of metal could result in injury to the dentist.

In general dental practice, procedures which are considered to be exposure prone usually fall into category 1 or 2. Hospital-based dental surgery will include category 3 procedures.

5.9 Ear, Nose and Throat Surgery (Otolaryngology)

ENT surgical procedures generally should be regarded as exposure prone with the exception of simple ear or nasal procedures, and procedures performed using endoscopes (flexible and rigid) **provided fingertips are always visible**. Non-exposure prone ear procedures include stapedectomy/stapedotomy, insertion of ventilation tubes and insertion of a titanium screw for a bone anchored hearing aid.

5.10 Endoscopy

Simple endoscopic procedures (e.g. gastroscopy, bronchoscopy) have not been considered exposure prone. In general there is a risk that surgical endoscopic procedures (e.g. cystoscopy, laparoscopy – see below) may escalate due to complications which may not have been foreseen and may necessitate an open EPP. The need for cover from a colleague who is allowed to perform EPPs should be considered as a contingency (see also **Biting**).

5.11 General Practice

See **Accident and Emergency, Biting, Minor Surgery, Midwifery/Obstetrics, Resuscitation**

5.12 Gynaecology (see also Laparoscopy)

Open surgical procedures are exposure prone. Many minor gynaecological procedures are not considered exposure prone, examples include dilatation & curettage (D& C), suction termination of pregnancy, colposcopy, surgical insertion of depot contraceptive implants/devices, fitting intrauterine contraceptive devices (coils), and vaginal egg collection **provided fingers remain visible at all times when sharp instruments are in use**.

Performing **cone biopsies** with a scalpel (and with the necessary suturing of the cervix) would be exposure prone. Cone biopsies performed with a loop or laser would not in themselves be classified as exposure prone, but if local anaesthetic was administered to the cervix other than under direct vision i.e. with fingers concealed in the vagina, then the latter would be an exposure prone procedure (category 1).

5.13 Haemodialysis/Haemofiltration

See **Renal Medicine**

5.14 Intensive Care

Intensive care does not generally involve EPPs on the part of medical or nursing staff

5.15 Laparoscopy

Mostly non-exposure prone because fingers are never concealed in the patient's tissues. Exceptions are, exposure prone if main trocar inserted using an open procedure, as for example in a patient who has had previous abdominal surgery. Also exposure prone if rectus sheath closed at port sites using J-needle, and fingers rather than needle holders and forceps are used.

In general there is a risk that a therapeutic, rather than a diagnostic, laparoscopy may escalate due to complications which may not have been foreseen necessitating an open exposure prone procedure. Cover from colleagues who are allowed to perform EPPs would be needed at all times to avoid this eventuality.

5.16 Midwifery/Obstetrics

Simple vaginal delivery, amniotomy using a plastic device, attachment of fetal scalp electrodes, infiltration of local anaesthetic prior to an episiotomy and the use of scissors to make an episiotomy cut are not exposure prone.

The only exposure prone procedures routinely undertaken by midwives are repairs following episiotomies and perineal tears: category 1 in the case of first degree lacerations; category 2 in the case of second, third and fourth degree lacerations. Repairs of third and fourth degree tears are normally undertaken by medical staff who may include general practitioners assisting at births in a community setting.

5.17 Minor Surgery

In the context of general practice, minor surgical procedures such as excision of sebaceous cysts, skin lesions, cauterization of skin warts,

aspiration of bursae, cortisone injections into joints and vasectomies do not usually constitute EPPs.

5.18 Needlestick/Occupational Exposure to HIV

Health care workers need not refrain from performing exposure prone procedures pending follow up of occupational exposure to an HIV infected source. The combined risks of contracting HIV infection from the source patient, and then transmitting this to another patient during an exposure prone procedure is so low as to be considered negligible. However in the event of the worker being diagnosed HIV positive, such procedures must cease in accordance with this guidance.

5.19 Nursing

General nursing procedures do not include EPPs. The duties of operating theatre nurses should be considered individually. Theatre scrub nurses do not generally undertake exposure prone procedures. However, it is possible that nurses acting as first assistant may perform EPPs (see also **Accident and Emergency, Renal Medicine/Nursing, and Resuscitation**).

5.20 Obstetrics/Midwifery

See **Midwifery/Obstetrics**. Obstetricians perform surgical procedures, many of which will be exposure prone according to the criteria.

5.21 Operating Department Assistant/Technician

General duties do not normally include exposure prone procedures.

5.22 Ophthalmology

With the exception of orbital surgery which is usually performed by maxillo-facial surgeons (who perform many other EPPs), routine ophthalmological surgical procedures are not exposure prone as the operator's fingers are not concealed in the patient's tissues. Exceptions may occur in some acute trauma cases, which should be avoided by EPP restricted surgeons.

5.23 Optometry

The training and practice of optometry does not require the performance of EPPs.

5.24 Orthodontics

See **Dentistry and orthodontics (including hygienists)**

5.25 Orthopaedics

Exposure prone procedures

- Open surgical procedures;
- Procedures involving the cutting or fixation of bones, including the use of K-wire fixation and osteotomies;
- Procedures involving the distant transfer of tissues from a second site (such as in a thumb reconstruction);
- Acute hand trauma;
- Nail avulsion of the toes for in-growing toenails and Zadek's procedure (this advice may not apply to other situations such as when nail avulsions are performed by podiatrists).

Non-exposure prone procedures

- Manipulation of joints with the skin intact;
- Arthroscopy, provided that if there is any possibility that an open procedure might become necessary, the procedure is undertaken by a colleague able to perform the appropriate open surgical procedure;
- Superficial surgery involving the soft tissues of the hand;
- Work on tendons using purely instrumental tunnelling techniques that do not involve fingers and sharp instruments together in the tunnel;
- Procedures for secondary reconstruction of the hand, provided that the operator's fingers are in full view;

- Carpal tunnel decompression provided fingers and sharp instruments are not together in the wound;
- Closed reductions of fractures and other percutaneous procedures.

5.26 Paediatrics

Neither general nor neonatal/special care paediatrics has been considered likely to involve any EPPs. Paediatric surgeons do perform EPPs (see also **Arterial cutdown**).

5.27 Paramedics

In contrast to other emergency workers, a paramedic's primary function is to provide care to patients. Paramedics do not normally perform EPPs. However, paramedics who would be restricted from performing EPPs should not provide pre-hospital trauma care. This advice is subject to review as the work undertaken by paramedics continues to develop (see also **Accident & Emergency, Biting and Resuscitation**).

5.28 Pathology

In the event of injury to an EPP restricted pathologist performing a post mortem examination, the risk to other workers handling the same body subsequently is so remote that no restriction is recommended.

5.29 Podiatrists

Routine procedures undertaken by podiatrists who are not trained in and do not perform surgical techniques are not exposure prone. Procedures undertaken by podiatric surgeons include surgery on nails, bones and soft tissue of the foot and lower leg, and joint replacements. In a proportion of these procedures, part of the operator's fingers will be inside the wound and out of view, making them exposure prone procedures (see also **Orthopaedics**).

5.30 Radiology

All percutaneous procedures, including imaging of the vascular tree, biliary system and renal system, drainage procedures and biopsies as appropriate, are not EPPs (see also **Arterial cutdown**).

5.31 Renal Medicine

The 2002 guidance stated, “obtaining vascular access at the femoral site in a distressed patient may constitute an exposure prone procedure as the risk of injury to the HCW may be significant.” There have since been technological advances in the way venous access is obtained, including in renal units. In procedures performed now, the operator’s fingers remain visible all the time during the procedure. Therefore these procedures are not exposure prone and neither haemofiltration nor haemodialysis constitute exposure prone procedures.

The working practices of those staff who supervise haemofiltration and haemodialysis circuits do not include EPPs. (Different guidance applies for hepatitis B infected health care workers.)

5.32 Resuscitation

Resuscitation performed wearing appropriate protective equipment does not constitute an EPP. The Resuscitation Council (UK) recommends the use of a pocket mask when delivering cardio-pulmonary resuscitation. Pocket masks incorporate a filter and are single-use.

5.33 Surgery

Open surgical procedures are exposure prone. This applies equally to major organ retrieval because there is a very small, though remote, risk that major organs retrieved for transplant could be contaminated by a health care worker’s blood during what are long retrieval operations while the patient’s circulation remains intact. It is possible for some contaminated blood cells to remain following pre-transplantation preparatory procedures and for any virus to remain intact since organs are chilled to only 10°C (see also **Laparoscopy, Minor Surgery**).

5.34 Volunteer health care workers (including first aid)

The important issue is whether or not an infected health care worker undertakes EPPs. If this is the case, this guidance should be applied, whether or not the health care worker is paid for their work.

Annex B: Regulatory bodies' statements on professional responsibilities

1. General Medical Council

The GMC Statement, *HIV Infection and AIDS: the Ethical Considerations*, was first sent to all registered medical practitioners in August 1988, and in April 1991 was sent to those who had obtained full registration since 1988. A revised version was sent in June 1993, and this was re-circulated to doctors as part of the series of booklets *Duties of a Doctor* in 1995.

In 1997, it was superseded by the booklet *Serious Communicable Diseases*. This term applies to any disease which may be transmitted from human to human and which may result in death or serious illness. It particularly concerns, but is not limited to, infections such as HIV, tuberculosis and hepatitis B and C.

Excerpts relevant to health care workers with HIV/AIDS are as follows:

Responsibilities of doctors who have been exposed to a serious communicable disease

29. If you have any reason to believe that you have been exposed to a serious communicable disease you must seek and follow professional advice without delay on whether you should undergo testing and, if so, which tests are appropriate. Further guidance on your responsibilities if your health may put patients at risk is included in our booklet *Good Medical Practice*.
30. If you acquire a serious communicable disease you must promptly seek and follow advice from a suitably qualified colleague – such as a consultant in occupational health, infectious diseases or public health on:
 - Whether, and in what ways, you should modify your professional practice;

- Whether you should inform your current employer, your previous employers or any prospective employer, about your condition.
31. You must not rely on your own assessment of the risks you pose to patients.
 32. If you have a serious communicable disease and continue in professional practice you must have appropriate medical supervision.
 33. If you apply for a new post you must complete health questionnaires honestly and fully.

Treating colleagues with serious communicable diseases

34. If you are treating a doctor or other health care worker with a serious communicable disease you must provide the confidentiality and support to which every patient is entitled.
35. If you know, or have good reason to believe, that a medical colleague or health care worker who has, or may have, a serious communicable disease, is practising, or has practised, in a way which places patients at risk, you must inform an appropriate person in the health care worker's employing authority, for example an occupational health physician, or where appropriate the relevant regulatory body. Such cases are likely to arise very rarely. Wherever possible you should inform the health care worker concerned before passing information to an employer or regulatory body.

2. General Dental Council

Extract from *Maintaining Standards Guidance to dentists on professional and personal conduct*. November 1997.

This guidance was sent to all registered dental practitioners in December 1997 and replaces the guidance entitled Professional Conduct and Fitness to Practise.

Dealing with Cross-Infection

- 4.1 There has always existed the risk of cross-infection in dental treatment. Therefore, a dentist has a duty to take appropriate precautions to protect

patients and other members of the dental team from that risk. The publicity surrounding the spread of HIV infection has served to highlight the precautions which a dentist should already have been taking and which are now more important than ever. Detailed guidance on cross-infection control has been issued by the Health Departments and the British Dental Association, and is endorsed by the Council.

It is unethical for a dentist to refuse to treat a patient solely on the grounds that the person has a blood borne virus or any other transmissible disease or infection.

Failure to employ adequate methods of cross-infection control would almost certainly render a dentist liable to a charge of serious professional misconduct.

Dealing with Transmissible Disease

4.2 A dentist who is aware of being infected with a blood-borne virus or any other transmissible disease or infection which might jeopardise the wellbeing of patients and takes no action is behaving unethically. The Council would take the same view if a dentist took no action when having reason to believe that such infection may be present.

It is the responsibility of a dentist in either situation to obtain medical advice which may result in appropriate testing and, if a dentist is found to be infected, regular medical supervision. The medical advice may include the necessity to cease the practice of dentistry altogether, to exclude exposure prone procedures or to modify practice in some other way.

Failure to obtain such advice or to act upon it would almost certainly lead to a charge of serious professional misconduct.

3. United Kingdom Central Council for nursing, midwifery and health visiting (UKCC) – now Nursing and Midwifery Council

Extract from: Registrar's Letter 4/1994 Annex 1 *ACQUIRED IMMUNE DEFICIENCY SYNDROME AND HUMAN IMMUNO DEFICIENCY VIRUS INFECTION (AIDS AND HIV INFECTION)* The Council's Position Statement.

The Council's Code of Professional Conduct

2. The 'Code of Professional Conduct for the Nurse, Midwife and Health Visitor' is a statement to the profession of the primacy of the interests of patients and clients. Its introductory paragraph states the requirement that each registered nurse, midwife and health visitor safeguard the interest of individual patients and clients. It goes on to indicate to all persons on the register maintained by the Council that, in the exercise of their personal professional accountability, they must 'act always in such a manner as to promote and safeguard the interests and well-being of patients and clients'.

The Responsibility of Individual Practitioners with HIV Infection

13. Although the risk of transmission of HIV infection from a practitioner to a patient is remote, and, on the available evidence much less than the risk of patient to practitioner transmission, the risk must be taken seriously. The Department of Health in England have commissioned a study to evaluate this risk. It is incumbent on the person who is HIV positive to ensure that she or he is assessed regularly by her or his medical advisers and complies with the advice received.
14. Similarly, a nurse, midwife or health visitor who believes that she or he may have been exposed to infection with HIV, in whatever circumstances, should seek specialist medical advice and diagnostic testing, if applicable. She or he must then adhere to the specialist medical advice received. Each practitioner must consider very carefully their personal accountability as defined in the Code of Professional Conduct and remember that she or he has an overriding ethical duty of care to patients.

Annex C: UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses: background information

1. Remit and tasks of UKAP

The UK Advisory Panel was set up originally under the aegis of the UK Health Departments' Expert Advisory Group on AIDS in 1991, and in 1993 its remit was extended to cover health care workers infected with all blood-borne viruses.

The tasks of UKAP are:

- to establish and update as necessary, criteria on which local advice on modifying working practices may be based;
- to provide supplementary specialist occupational advice to physicians of health care workers infected with blood-borne viruses, occupational physicians and professional bodies;
- to advise individual health care workers or their advocates how to obtain guidance on working practices;
- to advise directors of public health on patient notification exercises, where these are indicated, of patients treated by health care workers with blood-borne viruses as appropriate;
- to keep under review the literature on transmission of blood-borne viruses in health care settings and advise the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis on the need for revision of guidelines as necessary.

2. Membership of the UKAP

The Panel is chaired by a lay (non-medical) person. The following specialities are represented:

Anaesthetics Dentistry
Epidemiology General Practice
HIV Disease Midwifery
Nursing
Obstetrics and Gynaecology
Occupational Health
Public Health Surgery
Virology

Lay members in addition to the Chairman are also appointed.

The Secretariat is provided by the Health Protection Agency, Centre for Infections.

3. Contact with UKAP

Directors of Public Health, Regional Epidemiologists, physicians, occupational health practitioners and others wishing to obtain the UKAP's advice should contact the Medical Secretary by letter, or by telephone if urgent. Any information which may identify the infected health care worker should be withheld. Confidentiality of all information concerning individual referrals will be maintained by the secretariat and members of the UKAP.

Cases are considered by selected members of the UKAP according to the health care worker's area of work. Experts from other specialties not represented on the UKAP are co-opted to advise as necessary.

Address of Secretariat

The UKAP Medical Secretary
Health Protection Agency
61 Colindale Avenue
London
NW9 5EQ

Telephone: 020 8327 6423 (Medical Secretary)
020 8327 6074 (Administrative Secretary)

Annex D: Sources of advice and support

- 1. The HPA Sexually-Transmitted and Bloodborne Virus Laboratory** at the HPA Specialist and Reference Microbiology Division, Centre for Infections, 61 Colindale Avenue, London NW9 5HT (020 8200 4400) can:
 - provide facilities for rapid confirmatory testing of specimens initially reactive for anti-HIV antibody;
 - advise on the collection of specimens for HIV gene sequencing and make provision for the long term storage of specimens;
 - arrange for any necessary molecular investigations to be conducted in collaboration with other experts.
- 2. The HPA Centre for Infections (formerly CDSC)**, 61 Colindale Avenue, London NW9 5EQ (020 8200 6868) and/or Regional Epidemiologists can provide:
 - background scientific information on the outcome of patient notification exercises which have been conducted;
 - field advice and support to any incident team established to manage such an incident, including help with drafting model letters and information sheets for GPs and exposed patients;
 - facilities for collating HIV test results from widely scattered laboratories and forwarding them to the incident team co-ordinating a patient notification exercise;
 - advice on the investigation of HIV infected persons in whom risk factors for infection have not been identified;
 - advice on the selection of suitable “control” HIV infected persons, should HIV gene sequencing investigations be considered necessary.
- 3. Health Protection Scotland**, Clifton House, Clifton Place, Glasgow G3 7LN (Tel: 0141 300 1100) can provide similar advice to the above in Scotland.

4. **The Sexual Health Line**, Tel: 0800 567123. This is a 24-hour national phone line offering confidential advice, information and referrals on all aspects of sexual health to anyone.
5. **Faculty of Occupational Medicine**, Royal College of Physicians, 6 St Andrews Place, Regents Park, London NW 1 4LB (Tel: 020 7317 5890).
6. **Secretary to the Association of National Health Service Occupational Physicians (ANHOPs)**, c/o Sheffield Occupational Health Services, Northern General Hospital, Sheffield S5 7AU Tel: (0114 271 4161).
7. **Department of Health Press Office**, Richmond House, 79 Whitehall, London SW1A 2NS (Tel 020 7210 5658).
8. **Association of British Insurers**, 51 Gresham Street, London EC2V 7HQ (Tel 020 7600 3333).
9. **NHS Pensions Agency**, Injury Benefits Manager, 200–220 Broadway, Fleetwood, Lancashire FY7 8LG.
10. **Employment Medical Advisory Service (EMAS)/Health and Safety Executive (HSE)** For details of your local EMAS/HSE contact Health and Safety Information, (Tel: 08701 545500).



© **Crown Copyright**

Produced by COI Communications for the Department of Health
269675 1P 4k Jul 05 (CWP)
CHLORINE FREE PAPER

If you require further copies of this title, quote 269675/*HIV Infected Health Care Workers: Guidance on Management and Patient Notification* and contact:

DH Publications Orderline
PO Box 777
London SE1 6XH
Tel: 08701 555 455
Fax: 01623 724 524
Email: dh@prolog.uk.com



Textphone: 08700 102 870 (for minicom users) for the hard of hearing, 8am to 6pm Monday to Friday.

269675/*HIV Infected Health Care Workers: Guidance on Management and Patient Notification* can also be made available on request in braille, on audio cassette tape, on disk and in large print.

www.dh.gov.uk/publications