



BLOOD BORNE VIRUSES

KEY POINTS

Patients with blood-borne viruses are generally not infectious to others, however, health care staff are at risk because of **Sharps** injuries.

All staff must be immunised against hepatitis B virus and know their immune status

Staff who are infectious carriers of Hepatitis B virus, hepatitis C virus and immunodeficiency virus are not allowed to perform exposure-prone procedures (EPP). An exposure-prone procedure is defined as an invasive procedure involving sharp instruments where the operators hands are hidden from sight.

The hospital management has a responsibility to make sure that staff are immunised against hepatitis B virus but it is the staff members' responsibility to alert the hospital if they think they might have HIV or HCV and intend to perform EPP's.

Consultants have a responsibility to inform staff when they know a patient has a BBV

INTRODUCTION

The care of patients who are known to be, or likely to be, infected by HBV, HIV and HCV presents a potential hazard of infection to health care workers through inoculation accidents with used "sharps" and contamination of skin and mucous membranes with blood or other body fluids.

It is essential that when such patients are admitted to hospital, the clinician in charge ensures that all staff who have direct dealings with them (or materials arising from them) are informed of the risk of infection. Staff must take care to avoid inoculation accidents and contaminating themselves with blood or body fluids from ALL patients in their care, irrespective of the perceived risk of infection, thus reducing the risk of acquiring blood-borne infection.

HEPATITIS B VIRUS (HBV)

HBV can be transmitted from patients with acute hepatitis B infection and from long-term carriers. There are several serological markers for hepatitis B infection. Hepatitis B surface antigen (HBsAg) in blood denotes ongoing hepatitis B infection. Hepatitis B 'e' antigen (HBeAg) indicates that large amounts of infectious virus are present in the blood. All patients who are HBsAg positive and have detectable HBeAg or who lack HBe antibody (anti-HBe) are regarded as having blood of high infectivity. Inoculation accidents with blood from these patients are very likely to result in HBV infection in a non-immune recipient. Where there is doubt as to the infectivity of a subject (particularly a staff carrier who performs exposure-prone (invasive) procedures), viral load can be measured. This will be done in independent laboratories.

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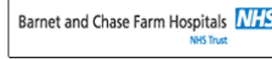
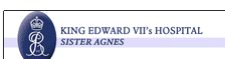
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HBsAg-positive patients who have anti-HBe have little or no circulating virus and are considered to be of low infectivity. Inoculation accidents with blood from such patients are much less likely to cause hepatitis B infection. Since the results of the HBe antigen/antibody testing are rarely available at the time of an accident, all HBsAg positive patients should be treated as of high infectivity until the HBeAg status is known.


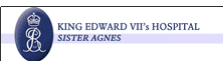


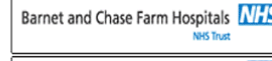





HBV HIGH RISK PATIENT GROUPS

- Known carriers
- Patients with acute hepatitis where the cause has not been identified
- Homosexual and bisexual men
- Intravenous drug users
- Patients from areas where the disease is endemic (eg countries other than Western Europe and North America)
- Sexual partners and children of the above
- Institutionalized patients (especially mentally handicapped children)

HBV PATIENT MANAGEMENT

Hepatitis B virus is transmitted by sexual intercourse or direct inoculation of blood or other body fluids contaminated by blood. It is therefore not necessary to Source Isolate infected patients routinely. However it is considered prudent to Source Isolate the following:

- Patients with acute hepatitis B infection.
- Patients with acute hepatitis where the cause is not known.
- Patients who have HBsAg and are of high infectivity and are likely to bleed, or have open wounds or lesions.

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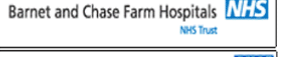



HBV STAFF MANAGEMENT

All staff are offered immunisation. Those who do not respond to vaccine are at higher risk of severe hepatitis should they catch the virus. They should take extra care and report sharps injuries promptly.

Infectious staff carriers of hepatitis B virus (eg HBeAg+) and those HbsAg+ carriers without detectable anti-HBe who have a significant viral load and will not be allowed to perform invasive (exposure-prone) procedures. This is a matter for Occupational Health, Microbiologists/Virologists, Infection Control Team and Managers.

(See HSC2000/020: Hepatitis B virus infected health care workers, NHS Executive)

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SUMMARY OF DISTRICT HEPATITIS B IMMUNISATION POLICY

All staff dealing directly with patients and body fluids should be immunised against hepatitis B virus. Each staff member who has been immunised should know their hepatitis B antibody status after completion of the course. The titre of antibody falls over a period of years and staff members should be revaccinated every 5 years and the titre of antibody rechecked after immunisation. (It has been suggested that re-immunisation is not necessary for those who have made a satisfactory immune response once. The policy in these hospitals remains that reimmunisation is offered). Staff will be offered a booster immunisation if they have a needlestick injury more than one year since the last immunisation. All persons who perform invasive ("Exposure-prone") procedures will provide evidence of immunity to or absence of infection with HBV to Occupational Health. Failure to provide this evidence will result in withdrawal of the right to operate in the Trust/Hospital.

HEPATITIS B IMMUNISATION PROTOCOL

- There is no pre-immunisation screening except for those who wish to perform exposure-prone procedures and cannot provide proof of immunity
- A full course of three doses of recombinant vaccine (20mcg/1 ml Engerix B or equivalent intramuscularly to the deltoid at 0, 1 and 6 months) is followed by a serum test for antibody two months after the last dose
- The response to vaccine will be reported as "nil", "poor" or "good" on the basis of the titre or a value given. Good responders are protected against hepatitis B infection but should receive a booster dose of vaccine at 5 years
- If they have a needlestick accident, a booster dose is recommended if more than 1 year has elapsed since the last dose
- Non-responders are tested for HbsAg and, if positive, for other markers of hepatitis B virus
- "Poor-" and "non-" responders are given a booster dose 6 months after completing the full course
- Serum should be checked for antibody titre 1-2 months after any booster
- "Non-" responders are particularly susceptible to hepatitis B infection and should take great care to avoid needlestick accidents
- Advice on risks in the work place will be given on an individual basis by Occupational Health Staff.

Infectious carriers of hepatitis B virus, hepatitis C virus and human immunodeficiency virus are not allowed to perform exposure-prone (invasive) procedures.

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HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

Infection with the HIV has a wide spectrum of clinical expression. Acute infection leads to a self-limiting glandular fever-like syndrome in about 5% of patients, after an incubation period of about six weeks. After a very long latent interval (median 10y), most patients develop severe impairment of the cell-mediated immune system, which may ultimately result in infections by organisms of low virulence (opportunists), and/or the development of unusual malignant tumours (e.g. Kaposi's sarcoma or certain lymphomas). Patients who are diagnosed as suffering from either or both conditions are classified as having developed the Acquired Immune Deficiency Syndrome (AIDS). Others may be infected but can remain completely asymptomatic.

Evidence of infection is usually demonstrated by the detection of antibodies to HIV in the patient's blood. Tests for the presence of HIV RNA or antigen may also be performed when it is necessary to diagnose a suspected acute or primary infection. Seroconversion (when HIV antibodies can be detected) usually occurs 6-8 weeks of infection, although studies have shown that rare infected individuals may not produce antibodies until a year after exposure. However, patients who have been infected by the virus are potentially infectious to others whether or not they have clinical symptoms or antibodies.

The epidemiology of HIV infection is similar to that of Hepatitis B. In hospital, the principal risk of transmission to health staff is by inoculation accident. Contamination of skin and mucous membranes by blood or body fluids is a theoretical risk.

HIV HIGH RISK PATIENT GROUPS

- Known HIV infected patients
- Homosexual and bisexual men, those with many sexual partners, sex industry workers.
- Injecting drug abusers who share equipment.
- Haemophiliacs.
- Patients from areas of the world where the disease is prevalent (particularly tropical Africa).
- Sexual partners of any of the above.
- Children of high risk and HIV-infected individuals.

It is now recognised that many patients will present with AIDS associated opportunistic infection without giving a history suggestive of any particular risk.

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HIV PATIENT MANAGEMENT

Most patients with known or suspected HIV infection may be safely nursed in a general ward. However, it is considered prudent to Source Isolate the following in a single room:

- Patients who are likely to bleed or have open wounds or lesions.
- Patients with diarrhoea.
- Patients who are mentally disturbed or unconscious.
- Patients who may have an added infection risk. Most of the opportunistic organisms that cause infection in AIDS are not considered a risk to others. An exception would be *Mycobacterium tuberculosis*. Patients with tuberculosis must be kept separate from HIV infected individuals.

HIV STAFF MANAGEMENT

- There is no vaccination to protect staff. Antivirals are available to protect staff if they have a sharps injury with HIV infected blood.
- Staff found to have HIV will, in general, not be allowed to perform invasive (exposure-prone) procedures.

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HEPATITIS C VIRUS (HCV)

HCV is a single-stranded RNA virus which used to be the most common cause of post-transfusion hepatitis, until blood units were screened. Transmission may occur through “Sharps” injuries in health care workers, through shared needles in injecting drug users and (less efficiently) through sexual intercourse. The incubation period is 6-8 weeks. Most infections are subclinical though chronic infection may cause chronic hepatitis and cirrhosis.

The diagnosis is made by detecting HCV-specific antibodies (anti-HCV). However, it may be several months before antibodies can be detected. Therefore serology is useful for diagnosing chronic but not acute infection. Acute infection can be diagnosed by detecting HCV-RNA in the serum and is only done under very special circumstances (eg on the recipient of a needlestick injury from HCV+ blood).

HCV HIGH RISK PATIENT GROUPS

- Known HCV-infected persons
- Injecting drug users
- Recipients of multiple blood transfusion, (especially before 1993)
- Surgeons

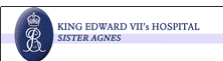

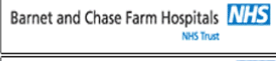

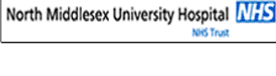

HCV STAFF MANAGEMENT

Most patients with known or suspected HCV infection may be safely nursed in a general ward. However, it is considered prudent to Source Isolate the following in a single room:

- Patients who are likely to bleed or have open wounds or lesions.
- Patients with diarrhoea.

Health care workers who perform EPP and who believe they may have been exposed to HCV must inform Occupational Health. Those with antibodies to HCV will be tested for viral RNA before being allowed to perform EPP.

Antiviral therapy is available and will be administered by a specialist hepatitis physician.

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NURSING MANAGEMENT OF HBV, HCV AND HIV-INFECTED PATIENTS

Because you cannot tell who has these infections, **UNIVERSAL PRECAUTIONS** are used. Assume everyone is an infectious risk.

CROSS INFECTION

Cross infection is likely to occur in chronic care units such as renal dialysis units where there is frequent contact with blood. Separate facilities may be provided for known HCV, HIV and HBV infected individuals to reduce the risk of cross infection.


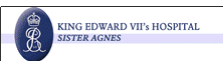



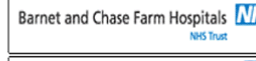




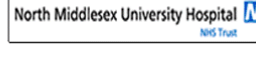
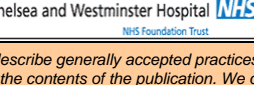
There should be no distinction in the precautions taken with those patients in these high risk groups, the asymptomatic carriers of HBsAg or HIV, and those with clinical AIDS or HBV. The following precautions represent good clinical practice and should be followed in the care of all patients in whom blood borne virus infection is suspected.

PROTECTIVE CLOTHING

A plastic apron and procedure gloves should be worn for the following direct patient procedures:

- Invasive procedures such as urethral catheterisation, intravenous infusion care and wound dressing.
- Attending to the patient's sanitary needs, and when disposing of faeces and urine.
- Handling contaminated instruments, laundry, soiled dressings or disposable clinical waste.
- Administering injections or performing venepuncture and finger prick blood tests.
- Collecting specimens for ward or laboratory analysis.
- Dealing with spillages of blood or body fluids.

If splashing of blood or body fluids is likely, eye protection (eg goggles or face visor) is recommended. Other precautions may be required if the patient has additional infection problems. Seek advice from the Infection Control Nurse.

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USE OF WARD EQUIPMENT AND FACILITIES

Crockery and Cutlery

- Normal ward stock may be used. It should be washed in the usual manner (preferably in a commercial dishwasher on a hot cycle).

Bath and toilet

- Patients may use the ward sanitary facilities unless diarrhoea or open skin or genital lesions are present or the patient is bleeding.
- Patients who are in single room isolation should use a commode.

Bedpans and urinals:

- Can be decontaminated by processing in a correctly functioning washer (one that achieves 80°C for a minimum of one minute).
- If soiled, the commode seat must be wiped with a disposable cloth with general purpose detergent, then a chlorine releasing agent (e.g. HAZ-TAB solution 10,000 ppm of available chlorine).

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DISPOSAL PROCEDURES

- All used disposable clinical items, except “sharps”, must be placed in a **yellow plastic bag** which is sealed before sending for incineration. Bags should be sealed with ties and marked with the ward/unit of origin.
- **Used “Sharps”**: Meticulous care in the disposal of used “sharps” is essential. They must be placed in the correct “sharps” disposal box IMMEDIATELY after use. Used needles should NOT BE RESHEATHED, as this may increase the risk of an inoculation accident. Such accidents must be avoided at all costs. The sharps container is sealed and sent for incineration when it is 3/4 full. It will be marked with the ward/unit of origin and dated and signed.
- **Soiled linen** (i.e. contaminated by blood or body fluids) must be placed in a red alginate-stitched bag, which is enclosed in a clear plastic bag, sealed and sent for laundering. Otherwise laundry may be treated as non-infectious.
- **Non-disposable Equipment**. Used instruments or equipment should be returned to CSSD for autoclaving. Place instruments in standard (eg two-ply brown paper) CSSD sack. Decontamination of non-autoclavable equipment should be carried out in accordance with infection control advice. See “Permit to Work” protocol in this manual (See website for Permit to Work Policy).

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SPECIMEN COLLECTION

Specimens from patients known to have blood borne virus infections must be labelled "High Risk" (Guidance in "HIV and the Practice of Pathology". Royal College of Pathologists, 1995). However, all specimens must be treated by portering and laboratory staff as a Danger of Infection. It is most important that specimens are transported safely in rigid boxes. Lids should be firmly tightened. Ensure that forms are properly filled in and place the specimen in the plastic wallet attached to the form. Do not use paper-clips, pins or staples or attach anything to a request card. All leaking or contaminated or broken specimens will be discarded.

TESTING FOR BLOOD BORNE VIRUSES (ESPECIALLY HIV)

A special request form may be provided for HIV antibody tests. The Consultant for the patient will take responsibility for all the tests performed on their patients. HIV testing is a special case because the GMC indicate that a special pre-test discussion should be carried out. Laboratory staff are not in a position to check whether counselling has been done so will generally test blood in good faith.

If a consultant wishes to test the blood of an ill patient to exclude the diagnosis of AIDS without asking the patient, or if the patient is not able to understand or give consent, then it is acceptable for this to be done and the consultant will take responsibility. The justification must be clearly written in the patient's notes and the consultant must inform the Microbiologist/Virologist that the test is being requested under these special circumstances.

In the case of a needlestick injury a donor's blood will be tested for BBVs **FOR THE BENEFIT OF THE RECIPIENT OF THE INJURY**. In this case limited counselling will be done by the person requesting the test as indicated in the Sharps Policy

TREATMENT OF SPILLAGES

Any spillage of blood/body fluids must be dealt with promptly using a chlorine-releasing agent. For details of the procedure see the Spillage Policy.

LAST OFFICES

In the event of death, Last Offices should be performed observing the same precautions which were in operation when the patient was alive. For details of the laying out procedure see the policy for Last Offices on Infected Patients (See separate policy). Viewing of the deceased by family/friends should take place as soon as possible. After this, the body should be identified with a Biohazard label and then placed in a heavy-duty waterproof cadaver bag. The outside of the cadaver bag should also be discretely labelled with Biohazard tape before transfer to the

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mortuary.

CLEANING OF SINGLE CUBICLES

Nursing staff are responsible for ensuring that any spillage of blood/body fluid is dealt with before the domestic staff clean the room. As with any single room, it is essential that it is cleaned on a daily basis, and on patient discharge. Separate cleaning equipment should be available for this purpose. Liquid detergent (GPD) and hot water is adequate for the cleaning process - chemical disinfectants are not to be used routinely. For details of the daily cleaning, and the decontamination of the room on patient discharge, refer to the Domestic cleaning policies.

DETECTION OF TRANSMISSION IN SURGERY

Patients may acquire virus infection from operators if the operator has an injury during the operation. A history of surgery will be specifically sought from new cases of infection. Any suspicious incident will be investigated by the Infection Control Team together with Occupational Health. It will be necessary to test the serum of any surgeon involved in such a case. To pre-empt problems of identifying when an infection was acquired, serum should be saved for a minimum of six months, but preferably longer, from all individuals undergoing major (thoracic or abdominal) surgery.

If a needlestick accident occurs during surgery then blood is transferred from surgeon to patient and from patient to surgeon. For this reason, surgeon and patient are both donors and recipients and the surgeon's and patient's blood will be tested for blood-borne agents. Accidents in surgery must be reported.

TRANSMISSION OF BLOOD-BORNE VIRUSES IN THE RENAL DIALYSIS UNIT

Because of serious outbreaks of HBV infection in haemodialysis patients, active immunisation and surveillance are undertaken regularly: HBsAg monthly, HCV three-monthly and HIV six-monthly; and on return from travel. HBV immunisation is given as double dose of the vaccine at 0,1,2 and 12 months.

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INOCULATION ACCIDENTS (SEE SEPARATE SHARPS POLICY)

Health care workers face a potential risk of infection with HBV, HCV or HIV from used “Sharps”. It is essential that inoculation accidents are avoided by staff taking meticulous care with contaminated needles and knife blades. The risk to non-immune staff of contracting HBV from a carrier is 1-20% depending on the infectivity of the blood. HBeAg + blood is very infectious.

The risk of catching HCV from HCV positive blood is ~5%. That of contracting HIV from HIV-positive blood is 0.3%. The risks depend on the DOSE of blood inoculated and the infectivity of the blood (ie the number of infectious virus particles/ml).

The risks of catching HBV are enormously reduced by being successfully immunised. For those who are not immune (those unable to respond to vaccine or have never been immunised), passive immunisation with HBV immunoglobulin is offered after accidents with “Sharps” used on patients infected with HBV. Active immunisation can be started at the same time if appropriate.

After an accident with HIV positive blood, staff will be offered what is currently considered to be optimal antiviral treatment. This is chosen with due consideration of the availability of drugs and their toxicity against their likely benefit in reducing risks of infection. The risk of infection depends on the nature of the accident, the volume of blood injected and the status of the patient (donor). The antiviral treatment will be made freely available.

At present, there is no passive immunisation or proven active treatment for staff who have accidents with “Sharps” used on HCV infected patients. Therefore the only protection available is PREVENTION. Antiviral agents may be offered to staff who acquire HCV (RNA detection) to reduce the risk of fully established chronic infection.

Note that it is the responsibility of the injured staff member (the recipient) to make sure that the “Sharps” injury procedure is carried out.

Surgeons who have Sharps injuries in the Operating Theatre are regarded as donors and will be tested for these blood borne viruses as a protection to the patient.

***This policy updates and summarizes the detailed document entitled
District AIDS and Hepatitis B policy dated April 1986.
Details about HCV were added in 1996.***

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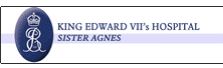







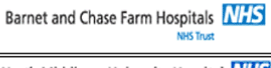

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