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## **HSE HR Circular 19/2008**

**2<sup>nd</sup> July 2008**

**To:** National Director, National Hospitals Office  
National Director, Primary, Community and Continuing Care  
National Director, Population Health  
Each Assistant National Director, National Hospitals Office  
Each Assistant National Director, Primary, Community and Continuing Care  
Each Assistant National Director, Population Health  
Each Assistant National Director of Human Resources  
Each Hospital Network Manager  
Each Chief Executive Officer, Voluntary Hospitals  
Each Chief Executive Officer, Intellectual Disability Services  
Each Chief Executive Officer, Specialist Agencies  
Each Medical Manpower Manager

**Re:** Implementation of Recommendations of Report on The Prevention of Transmission of Blood Borne Diseases in the Health Care Setting

The Standing Advisory Committee on the Prevention of Blood Borne Diseases in the health care setting reported in 2006. The HSE has engaged with relevant staff associations on the implementation of the employment related measures contained in the report and following agreement on progression of same, the following measures are to be put in operation by employers:

### **New Employees**

- 1 With effect from 7<sup>th</sup> July 2008, all new staff starting a post in the public health services, where they might be required to be involved in an exposure prone procedure (EPPs) will have to provide evidence via the occupational health service that they are immune to, and not infectious for Hepatitis B. In the absence of such evidence, a potential member of staff will not be employed in a post whose duties involves EPPs. No appointment should be made until the individual's immune status is established.
- 2 As of 7<sup>th</sup> July 2008, all new staff commencing in a post which involves EPPs should be tested for Hepatitis C.  
New staff are defined as those staff entering the Irish public health system for the first time or those staff currently in the system but now transferring to or taking up employment in an area that involves EPPs e.g. a nurse undertaking midwifery or a medical intern taking up a post of Surgical Senior House Officer. (Appendix 2 refers).  
A definition of exposure prone procedures (EPPs) is outlined in Appendix 3.

## **Existing Employees**

- 3 With effect from 1<sup>st</sup> May 2009, all existing staff involved in EPPs must have a statement from the occupational health service confirming that they are non-infectious for and immune to Hepatitis B. If such a statement cannot be provided, any such individual will not be allowed to perform EPPs.
- 4 In circumstances where an employee is identified as being infectious with a blood borne virus, the process set out in Appendix 1 will be initiated. The purpose of this arrangement is to support and accommodate an employee who has been diagnosed as being infectious by seeking to offer redeployment, retraining or other support, as appropriate, in agreement with the individual.

## **5 Risk Management and Infection Control**

The development of risk management and infection control strategies is essential for the prevention of blood borne pathogens in the health care setting. A separate letter in respect of this matter will issue shortly.

## **6 Helpline**

A confidential helpline for health care staff will be developed to provide basic information and contact details in the event of exposure through contact with risk material. Details will be posted on the HSE website.

## **7 Staff Obligations**

Professional codes of practice from regulatory bodies require health care workers who may have been infected with a serious communicable disease, in whatever circumstances, to promptly seek and follow confidential professional advice about the need to undergo testing. This requirement means that health care workers are under an ongoing obligation to seek professional advice about the need to be tested if they have been exposed to a serious communicable disease, obligating the need for repeat testing. This obligation equally applies to health care workers already in post.

## **8 Implementation**

At this stage, the necessary internal consultative process to advance the implementation of the contents of this circular should commence. This will necessitate the involvement of personnel from human resources, recruitment, occupational health and medical manpower and should include the identification of the numbers and categories of staff who will be encompassed by these provisions and who will require to be tested in advance of the 1<sup>st</sup> May 2009 deadline, together with the putting in place of the appropriate mechanisms to ensure that this deadline is met.

Any enquiries with regard to the contents of this circular as it pertains to EPPs should be directed to the Occupational Health Department. Any other queries should be directed to the Human Resources Department.

Yours sincerely,



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**Sean McGrath**  
**National Director of Human Resources**



# Appendix 1

## Proposals for addressing employment related issues for staff diagnosed as carrying Hep B, Hep C or HIV, acquired in the workplace

### CONTEXT

The proposals outlined are made in the context of, and in full compliance with, the recommendations of the Standing Advisory Committee on the Prevention of Transmission of Blood Borne Diseases in the health care setting, as outlined in the DOHC's Report of the same title...

These provisions seek to ensure that there is a co-ordinated and comprehensive approach to the prevention, identification and treatment of blood borne diseases and are designed to support those members of the health care team at risk of exposure to blood borne pathogens, including medical doctors, nurses / midwives and dentists.

This proposal applies to HCWs who do not have clearance to undertake exposure prone procedures (EPPs) due to being infective carriers of hepatitis B, hepatitis C or HIV. However, it should be understood that while there are in excess of 100,000 people employed in the public health services, only a fraction of this number will be engaged in exposure prone procedures. In addition, all available evidence suggests that the numbers of such staff who may be diagnosed are likely to be very minimal.

It is recognised that HCWs who become infected may need retraining, redeployment and/or a support package, whichever is most appropriate for and agreed with the individual. (In the event of a dispute the matter will be referred to the National Advisory Panel) In most jobs in the health service, restriction from performing EPPs can be facilitated allowing the health care worker to continue in post observing standard precautions etc. The extent of the facilitation and support of staff will depend on their job description/clinical practice.

### DEFINITIONS

#### **Exposure Prone Procedures**

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. They have been more precisely defined as procedures which involve surgical entry into tissues, cavities or organs or repair of major traumatic injuries, vaginal or Caesarean deliveries or other obstetric procedures during which sharp instruments are used; the manipulation, cutting or removal of any oral or perioral tissues including tooth structure, during which bleeding may occur. These include procedures where the worker's 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. EPPs would not usually include giving injections, taking blood, setting up IV lines, minor surface suturing, and the incision of abscesses, routine vaginal or rectal examinations or uncomplicated endoscopies.

**Work Categories:** It is helpful to divide positions in three different categories:

*Category 1:* Staff performs exposure prone procedures.

*Category 1(A)* Staff may be excluded from practice if infected with a BBV because EPPs form an integral part of their work

*Category 1 (B)* staff will be asked to restrict certain aspects of their work that involve EPP but can continue in their profession.

*Category 2:* staff would be at risk of inoculation injuries but do not undertake exposure prone procedures.

*Category 3:* staff work in administration and are not exposed to blood or body fluids.

### **Reasonable Accommodation**

All staff who have a disability are entitled to reasonable accommodation in the workplace in accordance with statutory legislation. Category 2 and 3 staff should not require reasonable accommodation. Category 1 staff may require either retraining or redeployment if they cannot be accommodated in their present post.

### **Co-Operation.**

The operation of this agreement is dependent on the full co-operation of the individual staff member with any treatment programme, modification of working procedures, or retraining as deemed necessary by their treatment team and or co-operation with any look back exercise. The principal focus of employers will be, in the first instance, to maintain the individual in employment in their own post, albeit with certain restrictions to their normal range of duties in particular situations. Where this is not possible, the emphasis will be on the redeployment and retraining in a related field of expertise, where necessary, of affected staff.

### **Redeployment**

The employing authority should make every effort to redeploy an infected health care worker within the same organisation where this is the most appropriate course of action for the employee. Where redeployment of an infected health care worker within a hospital or health care setting alters their job description/clinical practice, this must be agreed with the HCW. If a dispute exists, this will be discussed by the National Advisory Panel.

### **Retraining**

For a health care worker at the beginning of his/her career, retraining is generally feasible. Because of the difficulties of accessing training programmes, the National Advisory Panel in liaison with the Training Bodies will ensure a place is available on an appropriate training scheme for the infected health care worker for the duration of the training. These positions would be ring fenced and would cease and return to the normal number of training posts once the infected health care worker has completed training. The health care worker will maintain his/her previous salary level and Terms and Conditions of Employment while undertaking retraining.

### **Vocational Rehabilitation**

The restriction on performing exposure prone procedures is a medical restriction and not a functional limitation. Therefore, the emphasis is on vocational rehabilitation as opposed to sick leave, with a focus on retraining and re-employment to optimise the use of the skills and experience of the individual. It is recognised that some paid administrative leave may be required while such arrangements are being put in place, but it is not envisaged that the terms of the sick leave schemes should be invoked.



**Treatment Costs**

The cost of treatment arising from this infection and which is obtained in the public health service will be borne by the individual employer. GP, casualty and consultant visits and prescription charges, where relevant, will be reimbursed by the employer on presentation of invoice.

**National Advisory Panel**

It is agreed to establish a National Advisory Panel which will have not less than two meetings per annum. The panel will consist of three nominees from the employers' side and three nominees from relevant staff representative organisations. The panel will have an independent chairperson to be agreed between the parties.

The panel will proactively address the training and education requirements of infected individuals through liaison with employers and other appropriate bodies eg. medical colleges, training bodies, Dental Council, An Bord Altranais etc. It shall usually operate in circumstances where local efforts have been unsuccessful in facilitating the location or relocation of individuals for training and employment purposes. Its business shall be conducted with due regard for the need for confidentiality at all times.

The Terms of Reference of this Panel are as follows:

- To assist medical, nursing / midwifery, dentists and other staff, as required in the sourcing of and provision of appropriate training.
- To facilitate, by agreement, the retraining and where necessary, the redeployment of HCWs,.
- To liaise with individual and other relevant bodies which may assist in the process set out above.
- To address and recommend in circumstances where there are divergent views on how best to address individual cases.

**Payment to Affected Staff**

On confirmation that a staff member, following initial screening and diagnosis of Hep B, Hep C or HIV, and medical evidence being produced that this staff member needs to curtail clinical practice and is consequently unable to work, the following pay arrangements would apply for such staff.

- a) Full payment, inclusive of payments accruing for premiums and allowances for a period of six months.
- b) Salary paid in this circumstance will not affect an individual's normal entitlement under the sick pay scheme.
- c) During this six month period the staff member must comply with the co-operation procedures set out above.

**First Special Extension**

If it transpires before the end of the six month period outlined above, that the staff member is unlikely to be able to return to work at the end of this six month period or immediately thereafter, but there remains a reasonable expectation that the individual may return to work, a first special extension of pay under this scheme may be granted. The arrangements to apply during this period will be the same as those outlined above and will be approved by the Assistant National Director of

Human Resources or their equivalent in non HSE settings following recommendation from the Occupational Health Department and will not exceed a period of three months.

### **Second Special Extension of Pay**

Notwithstanding the above, if it transpires, after medical evidence that a return to work is unlikely during this three month period or immediately thereafter, but there still remains a reasonable expectation that the individual will return to work, a further final extension may be granted. This special extension will provide for payment of basic pay only and this second extension will not exceed a period of three months.

### **Application of article 109 for a period**

In exceptional circumstances, at the expiry of the special pay arrangements outlined, article 109 may be invoked for such period as the employer and occupational health department may consider reasonable. Any decision to apply Article 109 for such period will be dependent on the employee agreeing to undergo regular medical assessment as may be deemed appropriate.

### **Other Points**

The proposals set out apply to staff that are liable for mandatory registration for superannuation purposes.

The proposals are independent of an individual's right to legal redress if they so desire.

The operation of these proposals may be reviewed at the request of either party within a period of not less than one year following operation of agreement.



## Appendix 2

### Categories of HCW re BBV

For the purposes of this guidance, a new healthcare worker includes healthcare workers new to the Irish Health Care System, healthcare workers moving to a post or training that involves EPPs and returning healthcare workers, depending on what activities they have engaged in while away from the health service. This guidance is intended not to prevent those infected with blood-borne viruses from working in the HSE, but rather to restrict them from working in those clinical areas where their infection may pose a risk to patients in their care.

For the purposes of this guidance, a new healthcare worker is defined as an individual who has direct clinical contact with HSE patients. Existing healthcare workers who are moving to a post or training that involves exposure-prone procedures (EPPs) are also considered as 'new'. Returning healthcare workers may also be regarded as 'new', depending on what activities they have engaged in while away from the health service (see below).

Professional codes of practice from regulatory bodies require healthcare workers who may have been exposed to infection with a serious communicable disease, in whatever circumstances, promptly to seek and follow confidential professional advice about whether to undergo testing. Failure to do so may breach the duty of care to patients. This means healthcare workers are under an ongoing obligation to seek professional advice about the need to be tested if they have been exposed to a serious communicable disease, obviating the need for repeat testing. This obligation applies equally to healthcare workers already in post.

Additional health clearance is recommended for healthcare workers who will perform EPPs. It is not possible to provide a definitive list of types or specialties of healthcare workers who perform EPPs, because individual working practices may vary between clinical settings and between workers. (Annex A provides examples of EPPs).

#### **Healthcare workers who are performing EPPs for the first time**

Healthcare workers moving into training or posts involving EPPs for the first time should also be treated as 'new', and additional health clearance is recommended. This will include, for instance, senior house officers entering surgical or other specialties involving EPPs, qualified nurses wishing to train as midwives and post-registration nurses moving into work in operating theatres and accident and emergency for the first time.

#### **Healthcare workers who are returning to the HSE and who may have been exposed to serious communicable diseases**

The need for additional health checks for any particular healthcare worker who is returning to work in the HSE and who may have been exposed to serious communicable diseases while away should be based on a risk assessment. This should be carried out by the occupational health department. The timing of any tests should take account of the natural history of the infections (ie the 'window period'). Some examples of healthcare workers who might be considered 'returnees' include those returning from research experience (including electives spent in countries of high prevalence for BBVs), voluntary service with medical charities, sabbaticals (including tours of active duty in the armed forces), exchanges, locum and agency work or periods of unemployment spent outside of Ireland.

**Health clearance certificates**

Following testing, health clearance certificates should be provided by occupational health to management to indicate if an individual is fit for employment, whether or not the employee is cleared for EPPs, and the time-scale for any further testing required. The certificate, which will not include clinical information, should be sent to appropriate managers or, in the case of students, to the head of course in accordance with local arrangements.

**Healthcare workers who are applying for posts or training involving EPPs and who decline to be tested**

Healthcare workers who apply for a post or training which may involve EPPs and who decline to be tested for hepatitis B and hepatitis C should not be cleared to perform EPPs.

**Exposure-prone procedures**

Exposure-prone procedures (EPPs) 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. These include procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (eg 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 healthcare workers who are restricted from performing EPPs.

When there is any doubt about whether a procedure is exposure-prone or not, expert advice should be sought from a consultant occupational health physician.

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 that routine infection-control procedures are adhered to at all times. Examples of procedures that are not exposure-prone include:

- taking blood (venepuncture);
- setting up and maintaining IV lines or central lines (provided that any skin-tunnelling procedure used for the latter is performed in a non-exposure-prone manner, ie without the operator's fingers being at any time concealed in the patient's tissues in the presence of a sharp instrument);
- minor surface suturing;
- the incision of external abscesses;
- routine vaginal or rectal examinations;
- simple endoscopic procedures.



### Exposure Prone Procedures (EPPs)

- B1. EPPs are those invasive procedures where there is a risk that injury to the HCW may result in the exposure of the patient's open tissues to the blood of the HCW. These include procedures where the HCWs 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 and care of patients where the risk of biting is regular and predictable, should be avoided by HCWs restricted from performing EPPs.
- B2. When there is any doubt about whether a procedure is an EPP or not, expert advice should be sought in the first instance from a consultant occupational health physician who may in turn wish to consult the UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP). Some examples of advice given by UKAP below may serve as a guide, but cannot be seen as necessarily generally applicable, as the working practices of individual HCWs vary.
- B3. Procedures where the hands and fingertips of the HCW are visible and outside the patient's body at all times, and internal examinations or procedures that do not involve possible injury to the HCWs gloved hands from sharp instruments and/or tissues, are considered *not* to be an EPP, provided routine infection control procedures are adhered to at all times.
- B4. Examples of procedures that are *not* an EPP include:
- taking blood (venepuncture);
  - setting up and maintaining IV lines or central lines (provided any skin tunnelling procedure used for the latter is performed in a non-EPP manner i.e. without the operator's fingers being at any time concealed in the patient's tissues in the presence of a sharp instrument);
  - minor surface suturing;
  - the incision of external abscesses;
  - routine vaginal or rectal examinations;
  - simple endoscopic procedures.
- B5. The decision whether an HIV, Hep B or Hep C infected HCW should continue to perform a procedure, which itself is not exposure-prone, should take into account the risk of complications arising which necessitate the performance of an EPP; only reasonably predictable complications need to be considered in this context.

### Examples of UKAP advice on EPPs

- B6. The UKAP has been making recommendations about the working practices of HCWs infected with HIV since the end of 1991, and those infected with other 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.

- B7. 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 criteria as stated in para B1.
- B8. Occupational physicians and others who need to make decisions about the working practices of infected HCWs may find the advice helpful. In some cases this advice may help clarify matters, and in others may direct the reader to seek further specific advice about the individual case under consideration.

### **Cautionary note**

- B9. In the past, UKAP has not favoured issuing guidance about what areas or particular procedures of medical, nursing or midwifery practice involve EPPs. This is because individual working practices may vary between hospitals and between HCWs. Advice for one HCW may not always be applicable to another. Therefore this list must be interpreted with caution, as it provides examples only and is not exhaustive. It should also be noted that UKAP keeps its advice under ongoing review.
- B10. 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 HCW 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 open procedure becomes necessary.

### **Accident and Emergency (A&E)**

- B11. A&E staff who are restricted from performing EPPs should not provide pre-hospital trauma care.
- B12. These members of 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.
- B13. 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)

### **Anaesthetics**

- B14. Procedures performed purely percutaneously are not exposure prone, nor have endotracheal intubation nor the use of a laryngeal mask been considered so.
- B15. The only procedures currently performed by anaesthetists that 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; and
  - the insertion of chest drains in A&E trauma, cases such as patients with multiple rib fractures.



- B16. 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 HCW could be injured by the broken ribs, the procedure should be considered exposure prone.
- B17. 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).

### **Arterial Cutdown**

- B18. 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.

### **Biting**

- B19. 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 HCWs infected with BBVs to patients. The review showed that the published literature on this subject is very scarce. In follow up studies of incidents involving infected HCWs working with patients known to be 'regular and predictable' biters, there were no documented cases of transmission from the HCW 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).
- B20. Based on the available information, it can only be tentatively concluded that even though there is a theoretical risk of transmission of BBV from an infected HCW 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.
- B21. UKAP has advised that, despite the theoretical risk, since there is no documented case of transmission from an infected HCW to a biting patient, individuals infected with BBVs should not be prevented from working in or training for specialties where there is a risk of being bitten.
- B22. 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 HCWs 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.

### **Bone Marrow transplants**

B23. Not exposure prone.

### **Cardiology**

B24. 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).

### **Chiropodists**

B25. See Podiatrists

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

B26. 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
- construction and fitting of full dentures.

B27. 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.

### **Ear, Nose and Throat (ENT) Surgery (Otolaryngology)**

B28. 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.

### **Endoscopy**

B29. 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 that 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, Laparoscopy).



## **General Practice**

- B30. See Accident and Emergency, Biting, Minor Surgery, Midwifery/Obstetrics, Resuscitation

## **Gynaecology**

- B31. 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.
- B32. 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 EPP.

## **Haemodialysis/Haemofiltration**

- B33. See Renal Medicine.

## **Intensive Care**

- B34. Intensive care does not generally involve EPPs on the part of medical or nursing staff

## **Laparoscopy**

- B35. Mostly non-exposure prone because fingers are never concealed in the patient's tissues. Procedure becomes exposure prone if main trochar 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.
- B36. 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 EPP. Cover from colleagues who are allowed to perform EPPs would be needed at all times to avoid this eventuality.

## **Midwifery/Obstetrics**

- B37. 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.
- B38. The only EPPs routinely undertaken by midwives are repairs following episiotomies and perineal tears. Repairs of more serious tears are normally undertaken by medical staff who may include general practitioners assisting at births in a community setting.

## **Minor Surgery**

- B39. 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.

#### **Needlestick/Occupational Exposure to HIV**

- B40. HCWs need not refrain from performing EPPs 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 HCW being diagnosed HIV positive, such procedures must cease in accordance with this guidance.

#### **Nursing**

- B41. 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 and Resuscitation)

#### **Obstetrics/Midwifery**

- B42. See Midwifery/Obstetrics. Obstetricians perform surgical procedures, many of which will be exposure prone according to the criteria.

#### **Operating Department Assistant/Technician**

- B43. General duties do not normally include EPPs.

#### **Ophthalmology**

- B44. 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.

#### **Optometry**

- B45. The training and practice of optometry does not require the performance of EPPs.

#### **Orthodontics**

- B46. See Dentistry and orthodontics (including hygienists)

#### **Orthopaedics**

- B47. EPPs include:
- 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).

**B48 Non-EPPs:**

- 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.

**Paediatrics**

- B49. Neither general nor neonatal/special care paediatrics has been considered likely to involve any EPPs. Paediatric surgeons do perform EPPs.  
(See also Arterial cutdown)

**Paramedics**

- B50. 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)

**Pathology**

- B51. 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.

**Podiatrists**

- B52. 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 EPPs.  
(see also Orthopaedics)

## **Radiology**

- B53. 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)

## **Renal Medicine**

- B54. 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 an EPP.
- B55. The working practices of those staff who supervise haemofiltration and haemodialysis circuits do not include EPPs. (Different guidance applies for hep B infected HCWs\*)

## **Resuscitation**

- B56. 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.

## **Surgery**

- B57. 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 HCW'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).

## **Volunteer health care workers (including first aid)**

- B58. The important issue is whether or not an infected HCW undertakes EPPs. If this is the case, this guidance should be applied, whether or not the HCW is paid for their work.