Integrated Guidance on Health Clearance of Healthcare Workers and the Management of Healthcare Workers Living with Bloodborne Viruses (Hepatitis B, Hepatitis C and HIV)

Version 1.0

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Please note that this document should be used in tandem with other related guidance on the HPSC website.

Readers should not rely solely on the information contained with these guidance outputs. Guidance information is not intended to be a substitute for advice from other relevant sources including and not limited to, the advice from a health professional. Clinical judgement and discretion will be required in the interpretation and application of this guidance document. This guidance document is under constant review based upon emerging evidence at national and international levels and national policy decisions.

ADAPTATION STATEMENT

This document is adapted from guidance produced by the UK Advisory Panel for Healthcare Workers Living with Bloodborne Viruses (UKAP), available online here.

Table of Contents

Glossary of abbreviations and terms

Terms used in this guidance

Accredited specialist in occupational medicine: A person listed on the **Medical Council Specialist Register** for Occupational Medicine in Ireland.

EPP-Clearance: A certification granted to a worker who has been medically cleared by Occupational Health to perform Exposure Prone Procedures.

Expert OH advice: Guidance provided by a registered medical practitioner listed on the Specialist Register for Occupational Medicine in the Republic of Ireland (Specialist in Occupational Medicine), possessing specific experience in the health clearance of healthcare workers.

Indefinite EPP Certificate: A certificate of *indefinite duration* issued by Occupational Health, authorising a healthcare worker to perform Exposure Prone Procedures (EPP) without the need for periodic re-certification in the context of EPP. An indefinite EPP certificate may need to be re-evaluated subject to possible exposures for example as set out in **HSE HR Circular 012/2009**: 'Professional codes of practice from regulatory bodies require healthcare workers who may have been exposed to infection with serious communicable disease, in whatever circumstance, promptly to seek and follow confidential advice about whether to undergo testing. Failure to do so may breach the duty of care to patients.'

Health Clearance: A formal assessment conducted by Occupational Health to evaluate and determine a worker's medical fitness to undertake assigned work duties.

Healthcare worker (HCW) refers to all who have direct patient contact, both clinical and non-clinical staff. It applies to those who have roles in which:

- Their work requires face to face contact with patients, or
- Their normal work location is in a clinical area such as a ward, emergency Department or outpatient clinic, or
- Their work frequently requires them to attend clinical areas. (1)

Such staff include:

- Medical, nursing, and allied health professionals
- Medical, nursing and allied health students
- Dentists, dental hygienists and dental assistants
- Hospital porters and cleaners
- Pre-hospital emergency care providers
- Other at-risk healthcare personnel including laboratory workers, students, trainees and volunteers

Incident: An event or circumstance which could have or did lead to unintended and/or unnecessary harm (as per HSE Incident Management Framework). (2)

IU (International Unit): An internationally agreed unit to allow comparison of biological measurements worldwide.

Look-back review: A Look-back Review is defined in the (HSE) Incident Management Framework as a review where a number of people may have been exposed to a specific hazard in order to identify if any of those exposed have been harmed and how to take care of them.

Local risk assessment: A local risk assessment is an assessment of the risk posed to patients by a HCW who undertakes EPPs, who has been diagnosed with a BBV. The risk assessment identifies any factors that may impact on the HCW's ability to practise safely and/or increase the risk of transmission of a BBV from the HCW to patients.

Ongoing monitoring: The continuous evaluation process involving *identified validated sampling* (blood tests), such as viral load testing and occupational health reviews, aimed at determining a worker's continued medical fitness to perform Exposure Prone Procedures (EPP).

Pre-placement health testing: BBV testing completed in line with this guidance prior to a HCW commencing employment to facilitate EPP clearance.

Abbreviations

ALT: Alanine aminotransferase
ART: Anti-retroviral therapy
BBV: Bloodborne virus
CPHM: Consultant in Public Health Medicine
DCI: Dental Council of Ireland
EPP: Exposure-prone procedure
GDG: Guideline Development Group
GUM: Genitourinary Medicine
HBcAb: Hepatitis B Core Antibody
HBsAg: Hepatitis B Surface Antigen
HBV: Hepatitis B Virus
HCV: Hepatitis C Virus
HCW: Healthcare worker
HEI: Higher Education Institute
HIV: Human Immunodeficiency Virus
HSE: Health Service Executive
IMC: Irish Medical Council
IPC: Infection Prevention and Control
IVS: Identified Validated Sample
MOH: Medical Officer of Health
NCHD: Non-consultant hospital doctor
NIAC: National Immunisation Advisory Committee
NMBI: Nursing and Midwifery Board of Ireland
OH: Occupational Health
PHECC: Pre-Hospital Emergency Care Council
PLHIV: People/person living with HIV
PNE: Patient Notification Exercise
PPE: Personal Protective Equipment
PPHA: Pre-placement Health Assessment
rHBV: Reactivation of Hepatitis B Virus
RTC: Road Traffic Collision
TAT: Turnaround time
UKAP: UK Advisory Panel for Healthcare Workers Living with Bloodborne Viruses
VISR: Vaccine Induced Sero-Reactivity
WHO: World Health Organization

How to use this document

The document should be used in electronic format to ensure the most recent guidance is being followed.

Acknowledgements

The National Health Protection Office is grateful for the contributions of the Subject Matter Expert Topic Group (SME-TG), the Guideline Development Group (GDG) and the individuals and organisations that contributed to the development of this guidance. A full list of SME-TG and GDG members is available at **Appendix 5.**

Future updates

A review of this guidance will be undertaken no more than three years after publication by the Research and Guideline Development Unit (RGDU) as part of the routine cycle of guideline review. The RGDU may undertake a more rapid update of specific chapters within this guidance if new and relevant evidence is published according to need.

Disclosure statement and funding

The subject matter expert group members were asked to declare potential conflicts of interest at the time of appointment. A policy for the management of conflict of interest was put in place.

No funding was received for the development of this guidance.

Chapter 1: Introduction

1.1 Purpose and background

The purpose of this new guidance *Integrated Guidance on Health Clearance of Healthcare Workers and the Management of Healthcare Workers Living with Bloodborne Viruses (Hepatitis B, Hepatitis C and HIV)* is to provide a national framework for developing policies and procedures to prevent the transmission of bloodborne viruses (BBVs), specifically human immunodeficiency virus (HIV), hepatitis C virus (HCV) and hepatitis B virus (HBV), from healthcare workers (HCWs) living with BBVs, to patients in the Irish healthcare setting. This guidance is also intended to provide a framework for HCWs living with a BBV to safely and confidently contribute to healthcare in Ireland. Whilst it is never possible to achieve a zero risk of transmission, the availability of a vaccine that prevents HBV infection, effective treatment to eliminate and cure HCV, effective treatment that results in sustained virological suppression of HBV and HIV in the setting of adherence to treatment, and good Infection Prevention and Control (IPC) practices (3, 4) and procedures, make transmission risks from these BBVs very low when managed appropriately.

The report of the Department of Health's Standing Advisory Committee on *the Prevention of Transmission of Blood-Borne Diseases in the Health-Care Setting, 2005* was historically the national guidance used within the HSE and the wider health system in Ireland to prevent transmission of BBVs. However, since then, the evidence and knowledge base regarding BBV transmission has expanded and additional effective treatment options for BBVs are now available. The 2005 guidance therefore required updating or replacement as some of its recommendations did not align with current international best practice, particularly the absence of mandatory screening of HCWs undertaking Exposure Prone Procedures (EPPs) for HIV, and advice on the fitness for work and ongoing monitoring for HCWs living with BBVs.

1.2 Methods

The work of the UK Advisory Panel for Healthcare Workers Living with Bloodborne Viruses (UKAP), is well respected internationally, and a decision was taken to adopt and adapt, where appropriate, its evidence-based document ***Integrated guidance on health clearance of healthcare workers and the management of healthcare workers living with bloodborne***

viruses (hepatitis B, hepatitis C and Human Immunodeficiency Virus (HIV)) by the November 2022 (updated April 2024) for use in Ireland (5). A multidisciplinary Guideline Development Group (GDG) was established for this purpose and has overseen the development of this guidance. (Please see **Appendix 5** for membership).

This guidance was developed using Research and Guideline Development Unit good-practice guidance methodology and the GRADE-ADOLOPMENT framework for guideline adaptation (6). Decisions on contextualising key content and recommendations were made via informal consensus-based process. This involved a group discussion process designed to allow all members of the group to voice their opinions and contribute equally to the decision-making, as outlined in the WHO handbook for guideline development. (7) Decisions were recorded in a detailed and transparent manner and were not attributed to any one individual.

This guidance underwent targeted consultation with external and internal stakeholders. The consultation draft of this guidance was prepared by the SME-TG and RGDU through a rigorous process and multiple rounds of iterative review with the GDG. The consultation draft was made available to stakeholders for review over a four-week period in early 2025, during which time selected groups and individuals were invited to provide feedback on each chapter of the guidance. Following closure of the consultation period, all responses were collated and analysed by the RGDU and the SME-TG and incorporated via iterative review with oversight by the GDG and GDG Chairs. All decisions made on incorporating this feedback were recorded in a transparent manner, and rationale made available to the GDG, and where applicable, the individual or group submitting the feedback. A list of organisations and groups that were invited to review is provided in **Appendix 9.**

Following sign-off by the GDG, this guidance was externally reviewed by core stakeholders, including the Chief Medical Officer and Chief Dental Officer at the Department of Health, and by the Health Protection Advisory Committee for Infectious Disease (HPAC-ID) and approved by the Director of National Health Protection (DNHP). This guidance should be considered in conjunction with other relevant documents issued by the HSE Public Health: National Health Protection Office, including those referenced in **Chapter 8**. Importantly, **any new additions or modifications introduced in this version that were not present in previous iterations have been reviewed during stakeholder consultation by relevant Irish professional groups as**

listed in Appendix 9. These changes reflect the evolving context of public health practice in Ireland and ensure continued alignment with international best practice, particularly that of the UK.

1.3 Scope

What is included in the scope of this guidance?

The principles and recommendations outlined in this new guidance document apply to all health care and dental health care settings across the Irish healthcare system where EPPs or haemodialysis are performed, private health care settings, and Higher Education Institutions. The guidance is further intended to provide advice on key operational and service delivery issues that need to be addressed to ensure HCWs living with BBVs who perform EPPs or clinical duties in haemodialysis units or other settings involving haemodialysis are managed in a manner that safeguards their confidentiality and employment rights.

This guidance *Integrated Guidance on Health Clearance of Healthcare Workers and the Management of Healthcare Workers Living with Bloodborne Viruses (Hepatitis B, Hepatitis C and HIV)* **focuses solely on prevention of transmission of BBV from HCWs to patients**, to support HCWs living with a BBV to work safely and confidently in healthcare in Ireland. **It does not address the prevention of transmission of BBV to HCWs from patients living with BBVs.**

What is NOT included in the scope of this guidance:

The 2005 document *The Prevention of Transmission of Blood-Borne Diseases in the Healthcare Setting* (8) had a wider scope than the current adoption and adaptation of the UKAP advice and included a chapter on blood-borne viruses in haemodialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD) and renal transplant settings, which was subsequently updated by a subgroup of the then National Standing Advisory Committee for Blood-Borne Diseases in 2013 as a standalone document ***Blood-Borne Viruses in the Haemodialysis, CAPD and Renal Transplantation Setting 2013.*** It includes guidance on infection prevention and control and recommendations regarding vaccination, BBV testing and management of dialysis and renal

transplant patients who have a BBV. Guidance on this topic is **not included** in the *Integrated Guidance on Health Clearance of Healthcare Workers and the Management of Healthcare Workers Living with Bloodborne Viruses (Hepatitis B, Hepatitis C and HIV)* guidance.

The **NIAC guidance Chapter 9** provides up to date information for hepatitis B testing and vaccination for high-risk groups, including patients with chronic kidney disease and patients on haemodialysis, CAPD and prior to renal transplantation.

1.4 Objectives

This integrated guidance provides updated, evidence-informed recommendations that are intended to:

1. Reduce the risk of HCW-to-patient transmission of BBVs
2. Ensure that the needs of HCW living with BBVs are met in a fair and non-stigmatising way, recognising that people living with HIV (PLHIV) in particular experience stigma including in healthcare settings
3. Ensure that the adoption and adaptation of the UKHSA guidance provides recommendations that have been appropriately considered and are appropriate for implementation in the Irish context
4. Ensure that look-back reviews are initiated only when required, based on evidence of transmission of a BBV from a HCW to a patient(s) or of non-compliance with good clinical practice.

1.5 Target audience

The guidance is intended for use by Occupational Health (OH) services who have the responsibility for dealing with all matters arising from and relating to employment of HCWs living with BBVs in Ireland. It is also relevant for clinicians who are treating HCWs who are living with a BBV. In addition, it provides information for HCWs who are living with a BBV around how they can safely work within the healthcare system.

The guidance should be brought to the attention of all HCWs (including laboratory workers) working in Ireland in the Heath Service Executive (HSE) and other settings, including independent contractors such as general dental and medical practitioners and relevant staff

(including those in private practice); independent midwives; healthcare students; locums and agency staff and visiting HCWs. Employers, managers, clinical directors, education establishments and HEI representatives should ensure that staff and students are aware of this guidance. This guidance may be incorporated into relevant education programmes for HCWs, OH professionals, and clinical managers.

Chapter 2: Exposure prone procedures (EPPs)

The majority of clinical procedures (including many of which are invasive) in the healthcare setting pose no risk of transmission of BBVs from a HCW to a patient provided appropriate IPC precautions are adhered to at all times and so can be performed safely. Those procedures where an opportunity for HCW-to-patient transmission of BBV does exist, are described as Exposure Prone Procedures (EPPs).

The Irish National Clinical Effectiveness Committee Guideline 30 on IPC defines EPPs and non-EPPs as follows (3):

Exposure prone procedures (EPPs) are invasive procedures where there is potential for direct contact between the skin, usually finger or thumb of the healthcare worker and sharp objects or surgical instruments – such as needles, sharp body parts (for example fractured bones) spicules of bone or teeth – in body cavities or in poorly visualised or confined body sites, including the mouth of the patient.

Non exposure prone procedures (NPP) are procedures where the hands and fingers of the healthcare worker are visible and outside of the body at all times and procedures or internal examinations that do not involve possible injury to the healthcare workers hands by sharp instruments and/or tissues, provided routine IPC procedures are adhered to at all times. Examples include routine oral examination with appropriate personal protective equipment, insertion and maintenance of intravenous or central lines

Additionally, some procedures that are generally considered not to be EPPs may have the potential to escalate to EPPs. These procedures include:

- Minimally invasive procedures including laparoscopy, endovascular procedures, thoracoscopic procedures, Natural Orifice Transluminal Endoscopic Surgery, cystoscopic procedures, arthroscopic procedures and robotic surgery
- Trauma/emergency procedures where a previously non-EPP may escalate into an EPP.

- Table 31 on page 178 of National Clinical Guideline 30 on Infection Prevention and Control provides advice on EPPs in specific areas of clinical care as well as general procedures that are not considered to be EPPs.

In Ireland, all prehospital practitioners are **EPP cleared** (please see **Glossary of abbreviations and terms**)

Categorisation of procedures undertaken in a clinical service as EPP or non-EPP is the responsibility of the clinical manager/director.* The clinical manager/director of the service is best placed to review the range of procedures undertaken in their service and to identify the staff roles that will require EPP clearance. In the event of ambiguity of task/role EPP classification, a job function analysis of the role should be conducted and/or advice sought from relevant educational and professional bodies. Infection Prevention and Control may assist, in the case of uncertainty.

Page 178 Table 31 of the NCEC **National Clinical Guideline No 30** on IPC provides advice on EPPs in specific areas of clinical care as well as general procedures that are not considered to be EPPs. However, it does not encompass all possible EPPs, and healthcare workers must consider the risks in each situation. It is not possible to provide an exhaustive list of what procedures are EPPs or non-EPPs.

*This responsibility applies to dentists who work single-handed and who do not have a clinical manager.

Chapter 3: Duties and obligations of HCWs, including those who are, or who may be living with a BBV

The following duties and obligations apply to all HCWs, including those who are or may be living with a BBV (this includes students participating in EPPs as part of their training and education):

- **Ethical and Legal Duties**: All HCWs, including those who are self-employed, independent contractors, or employed in the private sector, are under ethical and legal duties to protect the health and safety of themselves and others, such as colleagues and patients. This includes understanding BBV prevention and cooperating in all health and safety matters.

- **Adhering to Protocols**: HCWs must follow established protocols for infection control, such as using personal protective equipment (PPE) and adhering to hand hygiene practices.

- **Professional Conduct and Ethics**: The current codes of professional conduct and ethics, such as those of the Irish Medical Council (IMC), Dental Council of Ireland (DCI), Nursing and Midwifery Board of Ireland (NMBI), Regulating Health and Social Care Professionals (CORU), and the Pre-Hospital Emergency Care Council (PHECC), set out responsibilities and expectations regarding safeguarding patient health which should minimise BBV exposure risks to patients.

- **Health Clearance Requirements**: All HCWs, including students, must meet health clearance requirements (screening for BBVs) at appropriate career stages, including during training and education and when undertaking new roles involving exposure-prone procedures (EPPs). See **Chapter 6** for more information. Students may need to discuss course requirements with the HEI course personnel based on the outcome of their EPP clearance to ensure that they are guided through their training and education appropriately.

- **Health Declarations**: HCWs applying for new posts must complete health questionnaires honestly.

- **Ongoing Responsibility for BBV Testing**: HCWs who may perform EPPs or work in haemodialysis units have an ongoing responsibility to seek advice and/or a BBV test if they believe they may have been exposed to a BBV infection or are at risk of reactivation of HBV infection, regardless of whether this was in an occupational or personal setting. For example, where a HCW becomes aware of a BBV diagnosis in a sexual partner or household contact or following a needlestick or mucosal splash injury in the workplace. This testing is typically obtained through clinical services, such as their GP or a sexual health clinic, or from an OH service, or an emergency department.

- **Seeking Expert OH Advice**: HCWs diagnosed with a BBV infection must seek expert OH advice regarding fitness for work and the implementation of any necessary work practice restrictions. Self-employed HCWs or locums must independently arrange advice from an accredited specialist in occupational medicine if not provided by their agency or employer.

- **Continuity of Care for HCWs Moving to Ireland**: HCWs moving from abroad to work in Ireland who are already known to have a BBV infection and have this confirmed again (for the first time in Ireland) should access specialist treatment services upon arrival in order to provide continuity with management of their BBV infection. HCWs who are newly diagnosed in Ireland should access clinical services, e.g. GP, immediately upon diagnosis.

- **Restrictions on EPPs**: HCWs living with BBVs must not undertake EPPs while seeking expert advice and/or until they meet the criteria to recommence EPPs. See **Chapter 7** for information on OH monitoring of HCWs living with BBVs.

- **Reporting Concerns**: HCWs with concerns about another HCW's practice related to BBV infection should follow local patient safety policies. For example, if working in the HSE follow the HSE **Enterprise Risk Management Policy and Procedures.**

Chapter 4: Roles and responsibilities of organisations

4.1 Occupational Health (OH) Service

Assessment of fitness for work of HCWs who are living with BBVs should be co-ordinated through an accredited specialist in occupational medicine.† Where a healthcare establishment's OH service does not have its own accredited specialist in occupational medicine, arrangements should be put in place for this advice to be sought from an accredited specialist in occupational medicine outside the establishment with relevant experience.‡ Suitable arrangements must be in place for agency or locum staff, including dental staff, to ensure that they have access to a designated accredited specialist in occupational medicine.

While the accredited specialist in occupational medicine has responsibility for occupational medical management and assessment, if an accredited specialist in occupational medicine is not immediately available, HCWs may initially seek advice from OH nurses under the supervision of an accredited specialist in occupational medicine. Every effort should be made to arrange for the HCW to see the accredited specialist in occupational medicine as soon as possible. Fitness to perform EPPs or clinical duties involving haemodialysis will be communicated to the HCW and, where relevant, to the employer (or self-employed HCW) in writing by the OH service or private OH provider.

It is the responsibility of the employer, working with the clinical manager/director of the service, to ensure that new HCWs who intend to perform EPPs, or clinical duties involving haemodialysis, and existing HCWs whose roles have changed to include these duties, have the necessary clearance to do so. All HCWs that have been identified as EPP workers must have pre-placement health testing carried out by the OH service in this jurisdiction, carried out by an OH provider. HCWs in private practice must ensure they have the necessary EPP screening and clearance.

† See glossary of terms for definition of this role.

‡ To check if a doctor is on the specialist register of the medical council in Ireland , visit the following link : **https://www.medicalcouncil.ie/public-information/check-the-register/**

HCWs moving from abroad to work in Ireland who are diagnosed with a BBV in Ireland for the first time, or have a known BBV infection confirmed in Ireland, should be notified of this guidance and referred to specialist services. Every effort should be made for HCWs to register with a GP. The OH services should provide information regarding the testing arrangements for health clearance and how BBV infection might affect continued performance of EPPs. All HCWs starting in an EPP role must meet the requirements for **EPP clearance** (see **glossary of terms**) before performing EPPs.

After testing, OH services should inform HCWs of the results of their tests and the implications for their working practice, including, where appropriate, any requirements for further follow up and monitoring. It is recommended that referral of HCWs living with BBVs to the appropriate physician for specialist clinical assessment (if this has not already taken place) should be made by the OH service, and not by self-referral.

Fitness to perform EPPs will be communicated to the employer in writing by the OH service.

Responsibility for the ongoing monitoring of HCWs living with HBV or HIV cleared to perform EPPs, in accordance with this guidance, rests with their accredited specialist in occupational medicine. The HCW's treating physician is responsible for providing the necessary regular care for the HCW with respect to managing their BBV infection.

As part of the process of ongoing monitoring, responsibility for maintaining accurate and contemporaneous local records relating to HCW monitoring lies with the accredited specialist in occupational medicine. Delegated authority may also be given to specific named individuals within a given OH service to undertake these roles on behalf of the accredited specialist in occupational medicine.

4.2 Employers and commissioning bodies

All employers should ensure that new and existing staff (including agency and locum staff and visiting HCWs) are aware of this guidance and of the professional regulatory bodies' statements of ethical responsibilities and/or codes of practice. This may include issuing regular reminders. Commissioners should stipulate this when placing service agreements with HSE and other healthcare organisations.

All employers, including providers using locums and agency staff, are ultimately responsible for making sure that HCWs have the necessary health clearance to undertake EPP work. Employers should provide information to prospective employees before they move to Ireland. Self-employed HCWs should ensure they are familiar with this guidance. See **Chapter 3** for more information on duties and obligations for self-employed HCWs.

Employers should provide adequate resourcing for all services including occupational health, public health, laboratory services so that they can comply with this guidance.

4.3 Educational establishments

Higher Education Institutions (HEIs) for medical, dental, nursing and midwifery schools, and educational establishments for other allied health professionals, should draw students' attention to this guidance and the relevant professional statements. Each educational establishment should identify a nominated officer with whom students may discuss their concerns regarding BBV in confidence. In addition, all students should be appropriately trained in procedures and precautions to minimise the risk of BBV acquisition and occupational BBV transmission. All these issues should be addressed before performing any potential EPPs, if a student is living with a BBV. Students should refer to local HEI policies.

Chapter 5: Confidentiality concerning the healthcare worker living with a BBV

There is a general ethical and professional duty on medical, nursing and allied health professionals to maintain the confidentiality of patients under their care. Furthermore, there is a legal duty under the **Data Protection Act (2018)** to preserve the confidentiality of medical information and records. Breach of these duties are potentially very damaging for the individuals concerned and would undermine the confidence of the public and of HCWs in assurances about confidentiality that are given to those who come forward for examination or treatment.

The OH records are held separately from other hospital clinical notes and can be accessed only by OH practitioners, who are obliged ethically and professionally not to release records or information without the consent of the individual.

Every reasonable effort should be made to avoid disclosure of the HCW's identity or information which would allow deductive disclosure. Any unauthorised disclosure about the BBV status of an employee constitutes a breach of confidence and may lead to disciplinary action. The duty of confidentiality, however, is not absolute. There are specific conditions whereby the restrictions set out under the Data Protection Act (2018) may not apply.[§] Legally, the identity of individuals living with BBVs may be disclosed with their consent, or without consent in exceptional circumstances, where it is considered necessary for the purpose of treatment, the prevention of spread of infection or in the public interest where patients are, or may have been, at risk.

The Irish Medical Council Guide to Professional conduct and ethics sets out the circumstances where doctors can disclose information without consent, and this includes disclosure of notifiable BBVs (Hepatitis B, Hepatitis C and HIV) to the Medical Officer of health as required by law under the **Infectious Diseases Regulations 1981** as amended. When information is disclosed, the HCW should be informed of the disclosure.

The duties of confidentiality still apply even if the HCW has died or has already been identified publicly.

[§] As per Section 53 of the Data Protection Act (2018): Processing of special categories of personal data for purposes of public interest in the area of public health.

Chapter 6: Health clearance for hepatitis B, hepatitis C and HIV: New HCWs

Health clearance measures **for new HCWs** provide protection for patients from exposure in the clinical care setting to HBV, HCV and HIV. These measures are also intended to facilitate those living with a BBV to work safely in healthcare facilities and should also support HCWs living with a BBV in identifying clinical areas where there is a greater risk of transmission to the patients in their care. In such situations, in order to mitigate this risk, there may be some restrictions placed on the working practices of the HCW living with a BBV.

The HCW also benefits from the health clearance arrangements personally (for example, earlier diagnosis may lead to curative or life-prolonging treatment and prevention of onward transmission), and professionally (for example, avoiding work activities that may pose a risk to their own health and making career choices appropriate to their circumstances).

All employers should have established mechanisms, in conjunction with their human resources, clinical directors/service managers and OH services, to identify new HCWs and ensure that the necessary health checks are carried out. HCWs who are self-employed and commencing a new role are under obligation to ensure that necessary health checks are carried out prior to commencement. Under the previous guidance *Prevention of Transmission of Blood-Borne Diseases in the Health-care Setting 2005,* HCWs who perform EPPs were screened for Hepatitis B and Hepatitis C. In addition, in this current guidance, EPP screening will now also include HIV testing.

An EPP certificate of **indefinite duration** can be issued by OH, authorising a healthcare worker to perform EPPs without the need for periodic re-certification. This indefinite EPP certificate may need to be re-evaluated if there has been possible exposure to a BBV infection or a risk of reactivation of HBV infection.

6.1 Introduction of HIV screening

In line with international best practice, by adopting and adapting the UKAP guidance, HIV screening is now part of the EPP clearance process. The introduction of HIV screening as part

of EPP clearance does not apply to HCWs who are already in employment (including self-employed) in healthcare facilities, with the exception of those:

- Starting an EPP post for the first time in career
- Moving to a new post (including a new self-employment post) which requires **EPP Clearance**, with no previous HIV testing as part of their EPP screening.

Healthcare workers with a previous valid and indefinite EPP certificate provided by an OH department in the Republic of Ireland, should complete HIV testing on their first move to a new post. A new EPP certificate should then be issued, specifying that the new guidance requirements have been fulfilled. The new EPP certificate should contain information of the previous EPP certificate's issuance date. (An example certificate is available in **Appendix 7**).

In line with this guidance, repeat Hepatitis B and Hepatitis C screening should be offered, where the healthcare worker considers that he/she may have been at risk of contracting these infections since the last EPP clearance.

HCWs who may have been infected with a serious communicable disease, including BBVs, in whatever circumstances, should seek and follow confidential professional advice about the need to undergo testing. This requirement means that HCWs should seek appropriate professional advice about the need to be tested if they have been exposed to a serious communicable disease, obligating the need for repeat testing.

6.1.1 Identified Validated Sample Process

Initial clearance to perform EPPs or carry out haemodialysis requires an Identified and Validated Sample (IVS). An IVS is defined as meeting the following criteria:

- The healthcare worker should show a proof of identity with a photograph (either a current driver's licence, or current passport) when the sample is taken.
- The sample of blood should be taken in the OH department or relevant student medical service that provides an OH service.
- The sample should be clearly and correctly labelled

- Samples should be delivered to the laboratory in the usual manner, not transported by the healthcare worker.

When results are received from the laboratory, the clinical notes should be checked for a record that the sample was sent by the Occupational Health department or relevant student medical service, at the relevant time or another appropriate service contracted by the organisation.

6.1.2 Immunisation of HCWs

Guidance on the immunisation of HCWs is not reproduced in this document, as recommendations are continually under review by the **National Immunisation Advisory Committee (NIAC).** Current recommendations on immunisation for HCWs can be found in **Chapter 4** of The NIAC guidelines.

6.2 Categories of new HCWs

For the purpose of this guidance, a new HCW is defined as an individual who has direct clinical contact with patients in a healthcare facility for the first time, whether as an employee, self-employed, or with the employer's agreement (for example, student placements, visiting fellows).

Existing HCWs who are moving to a post or training that involves EPPs for the first time in their career, are also considered as 'new'.

Returning HCWs may also be regarded as 'new', based on OH assessment and will depend on what activities they have engaged in while away from the health service.

6.3 Students

HEIs should provide an assurance in writing to healthcare facilities that take student placements, that they have written processes in place to ensure implementation of and ongoing adherence to this guidance. This assurance should be confirmed in writing every 2 years.

HEIs should ensure that their students do not perform EPPs as part of their training until completion of EPP screening has been confirmed. Services screening students should ensure that their processes are in line with standards outlined in **Section 6.11**. Identified Validated

Samples should only be carried out in settings with clear policies/procedures. Local pathways to access relevant specialists for management and treatment of BBVs and accredited specialists in Occupational Medicine should be in place.

Students found to be infectious carriers of BBVs will need to comply with advice from OH, from their treating specialist and from their student health service. Clearance to carry out EPP duties must be communicated by OH to the responsible designated course contact. Fitness for duty or study, including being able to achieve the required learning outcomes will be a matter for the HEI.

6.3.1 Medical students

The practical skills required of medical students to obtain provisional IMC registration, or of interns to obtain full IMC registration, generally do not include EPPs, however new medical student entrants to the healthcare system will have EPP screening provided. It is not an IMC requirement to have practical skills mandating EPP clearance. Having a BBV does not prevent people from having a career in medicine. Many career paths are available to doctors which do not require the performance of EPPs. It may also be possible for HCWs living with a BBV to pursue a career path that will require the performance/carrying out of EPPs, in line with this guidance (see **Chapter 7**).

However, some components of the undergraduate medical curriculum may provide an opportunity for students to perform EPPs, (for example, obstetrics and gynaecology, trauma or surgical attachments). EPP clearance is therefore required for those students who may find themselves in a position where the opportunity to perform an EPP may arise.

6.3.2 Nursing students

EPP clearance is not necessary for nursing students, as performance of EPPs is not a requirement of the curriculum for pre-registration student nurse education.

6.3.3 Dental, midwifery, and podiatric surgery students

EPP clearance is required for all oral healthcare students whose scope of practice during education or after qualification involves performing EPPs (including dentists, dental hygienists,

dental nurses taking radiographs, clinical dental technicians and orthodontic therapists), and midwifery.

6.3.4 Pre-hospital practitioner students

Pre-hospital practitioner students will require EPP clearance.

6.4 HCWs who are performing EPPs for the first time

HCWs moving into education or posts involving EPPs for the first time should also be treated as 'new', and EPP clearance is required. This may include, for instance, interns entering surgical or other specialties involving EPPs, qualified nurses wishing to train as midwives and post-registration nurses moving into work in operating theatres, emergency departments or other specialities where they will be performing EPPs for the first time.

6.5 HCWs moving to a new role who have previously performed EPPs

Healthcare workers (including self-employed HCWs) who are moving from an existing post, that involves EPPs, to a new post that involves EPPs should be able to provide evidence of their EPP clearance (including HIV testing) in line with this guidance. It remains the responsibility of the HCW, if previous post was as an employee, to request evidence of their health clearance from their previous employer. If evidence of clearance is not provided, then this HCW should be treated as 'new', and EPP clearance is recommended.

A suggested framework for establishing a HCW's EPP and health clearance history is outlined in **Appendix 2** for transfers to a new OH service or new EPP role, and **Appendix 3** for transfers to a non-EPP role. This process should also involve the employer who has a duty to provide the requested information to the HCW and/or new OH services.

6.6 HCWs who are returning to a healthcare facility to an EPP role and who may have been exposed to a BBV

The need for additional health checks for any HCW who is returning to work in a healthcare facility and who have identifiable potential exposure to BBVs while away should be based on a

risk assessment and will depend on what personal and professional activities they have engaged in while away from the health service. This should be carried out by the OH service.

Some examples of HCWs who might be considered 'returners' 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 defence forces), exchanges, locum and agency work.

6.7 HCWs from locum and recruitment agencies

OH checks, to the same standard as applied to healthcare employees, should form part of pre-employment checks conducted by providers of temporary staff, regardless of whether they have worked previously in the healthcare facility. Health clearance appropriate to HCWs' duties should be verified before the individual undertakes any clinical work. Whilst it is the responsibility of the agency to clear temporary staff for EPPs, the employer has the responsibility to check they have been cleared. Agencies are responsible for supplying staff that are certified as fit for the post they are being recruited into.

6.8 HCWs in the independent healthcare sector

HSE services that arrange for HSE patients to be treated by non-HSE hospitals or healthcare facilities in the independent sector in Ireland should ensure that this health clearance guidance is followed.

6.9 Standard BBV health checks for all new HCWs

OH clearance is recommended for all categories of new HCWs employed or starting education (including students) in a clinical care setting, either for the first time or returning to work in healthcare facilities. Immunisation requirements for HCWs are outlined in **Chapter 4 of the NIAC Guidelines.** Routine testing of non–EPP HCWs for BBV is not currently recommended.

HCWs diagnosed with a BBV will receive appropriate OH advice regarding fitness for work, if relevant, during the health clearance process.

6.10 Offer of Hepatitis B immunisation: non-EPP HCWs

It is recommended that all HCWs, including students, who have direct contact with blood, blood-stained body fluids or patients' tissues, are offered immunisation against hepatitis B and tests to check their response to immunisation. Guidance on immunisation against hepatitis B, which includes information about dosage, protocols and supplies, is contained in **Chapter 9 of the NIAC Guidelines.**

Declining vaccination (whether contra-indicated or not), or non-response to vaccine, will not affect the employment or education of HCWs who will not perform EPPs.

6.11 BBVs health checks (testing for HBV, HCV and HIV) for new HCWs who will perform EPPs, and for existing HCWs who are new to EPPs

EPP clearance is required for HCWs who will perform EPPs. HCWs have the right to decline to be tested for HIV, HBV and HCV, in which case, they will not be cleared for EPP work.

Practising HCWs who undertake EPPs or who perform clinical duties in haemodialysis units are under a professional duty to seek medical advice on the need to be tested if they may have been exposed to HIV, HBV or HCV, occupationally or otherwise. If found to have a BBV, the HCW should obtain and follow appropriate clinical and OH advice. Newly diagnosed HCWs should attend a specialist clinic appropriate to their diagnosis.

The optimum time for testing for new HCWs may vary depending upon the particular chosen career but should be carried out at the earliest practical opportunity to help advise career choices. Times that may be considered appropriate include:

- NCHDs entering all surgical specialties, and obstetrics and gynaecology, should be tested before their first intern post (this will include those posts in accident and emergency and trauma care where doctors may be called upon to perform EPPs),
- Prospective dental students, dentists, dental hygienists, dental nurses taking radiographs, clinical dental technicians and orthodontic therapists should be tested before entry or registration into dental school, as EPPs form an integral part of their education and in the work of dentists

- Prospective midwifery students should be tested before embarking on midwifery courses
- Nurses should be tested before they move to specialised areas of work where they may be required to perform EPPs, for example, operating theatre and accident and emergency nursing
- Pre-hospital practitioners should be tested before they embark on education.
- Podiatrists should be tested before they commence education in podiatric surgery
- Nurses should be tested for hepatitis B infection before they carry out haemodialysis.

This list covers the major specialties but is not intended to be exhaustive. It is not possible to provide a definitive list of types or specialties of HCWs who perform EPPs, because individual working practices may vary between clinical settings and between workers. It is the responsibility of the employer, including self-employed HCWs, working with the clinical manager/director of the service, to assess if the post is an EPP post or not prior to appointment and advise the OH service accordingly.

6.12 Health clearance for HCWs who will perform EPPs: Hepatitis B virus.

6.12.1 Hepatitis B testing of HCWs who will perform EPPs

New HCWs who intend to perform EPPs or clinical duties in haemodialysis units or any other settings involving haemodialysis must:

- Be tested for hepatitis B to include mandatory hepatitis B surface antigen (HBsAg) before starting work with appropriate pre-test discussion.
- If HBsAg is not detected, be offered vaccination, unless they have already received a course of vaccine and have had their response checked (anti-HBs) in line with NIAC immunisation guidelines **Chapter 9**.
    - HCWs undergoing hepatitis B immunisation with HBsAg not detected should only be issued with EPP clearance of specified duration while completing their immunisation programme. EPP clearance should be reassessed when having their anti-HBs response re-checked.
    - To determine the immune status of HCWs who may have a history of either previous HBV vaccination (e.g. as part of a childhood schedule) or natural immunity, a challenge dose of Hepatitis B vaccine can be used to determine

the presence of vaccine-induced immunologic memory, as evidenced by an increase in anti-HBs levels.

- Where there is evidence that a HCW, who is known to have had a previous HBV infection that has cleared, now has natural immunity and immunisation is not necessary, the advice of a local infectious disease specialist or clinical microbiologist could be sought.
- HCWs for whom hepatitis B vaccination is contra-indicated, who decline vaccination or who are non-responders to vaccine (those with anti-HBs levels of less than 10 milli-international units per millilitre (mIU/mL), should be restricted from performing EPPs or clinical duties in haemodialysis units or any other settings involving haemodialysis, unless shown to be non-infectious, and should undergo annual EPP clearance, and be tested annually for HBsAg. Non-immune healthcare workers working in haemodialysis must adhere to relevant renal guidance.

Testing for past hepatitis B infection (Hep B Core antibody) is no longer part of routine EPP clearance. However, HCWs with a known history of past hepatitis B infection or current infection and clearance for EPPs without antiviral therapy, may reactivate hepatitis B if immunosuppressed. Such reactivation may pose a risk to patients. Therefore, where a HCW with a known history of past Hepatitis B infection is immunosuppressed or is commencing immunosuppression treatment, testing for HBcAb is advised. For further information on additional clearance considerations regarding immunosuppression see **Section 7.5.**

All testing should be carried out by any accredited laboratory that is experienced in performing such tests. Further guidance on laboratory testing for BBVs, including management of results from laboratories in other jurisdictions, is provided in **Appendix 1**.

6.12.2 Initial health clearance for HBsAg positive HCWs who intend to perform EPPs or clinical duties in haemodialysis units or any other setting involving haemodialysis

HCWs initially testing positive for HBsAg, should be tested for hepatitis B viral load (HBV DNA). On the grounds of patient safety, HCWs who perform EPPs or undertake clinical duties in haemodialysis units will not be allowed to practice if they have an HBV DNA level at or above 200 IU/mL regardless of their treatment status. The previous Irish guidance, *The Prevention of Transmission of Blood-borne Diseases in the Healthcare Setting,* used 10^4 genome equivalents

per millilitre (gEq/mL) to monitor HCWs living with HBV who have been cleared to perform EPPs. In line with the UKAP *Integrated Guidance on Health Clearance of Healthcare Workers and the Management of Healthcare Workers Living with Bloodborne Viruses (hepatitis B, hepatitis C and HIV),* this is now changing to $<10^3$, equivalent to <200 IU/ml, as determined using a CE marked assay, which is standardised to the World Health Organization (WHO) international standard for HBV nucleic acid amplification techniques.

Initial clearance to perform EPPs or carry out haemodialysis requires 2 Identified and Validated Samples (IVS) taken no less than 4 weeks apart with both showing a viral load result below 200 IU/mL.

The decision to clear individual HCWs to undertake EPPs, or clinical duties in haemodialysis units or any other settings involving haemodialysis, is the responsibility of an accredited specialist in occupational medicine.

HCWs living with HBV should continue to be periodically monitored in line with this guidance (see **Chapter 7**).

6.13 Health clearance for HCWs who will perform EPPs: Hepatitis C virus

6.13.1 HCV testing of HCWs who will perform EPPs

New HCWs who intend to perform EPPs should be tested for HCV antibody with appropriate pre-test discussion. Those who are positive should be tested for HCV RNA to detect the presence of current infection. It is essential that samples for testing for HCV RNA are collected, transported and stored according to laboratory requirements before testing as viral RNA may degrade. Testing for HCV RNA should be carried out by a laboratory that is operating to the **ISO 15189** or equivalent standard.

HCWs who have antibodies to HCV and are HCV RNA not detected in an appropriately sensitive assay should be allowed to continue performing EPPs.

HCWs who have active, or current, infection (those who are HCV RNA positive) must be restricted from performing EPPs.

HCWs living with HCV who have been successfully treated with antiviral therapy should have HCV RNA levels checked after 3 months. If they remain HCV RNA not detected at 3 months after cessation of treatment, they should be permitted to return to performing EPPs at that time. HCWs who have spontaneously cleared the virus and are HCV RNA not detected on testing at 3 months, can also return to performing EPPs.

Both should be checked again 3 months later (at 6 months). If shown still to be HCV RNA not detected after 6 months, they can continue to perform EPPs. Annual testing is no longer required unless specific clinical requirements are identified.

Testing for HCV RNA should be carried out by a laboratory operating to the ISO 15189 or equivalent standard. Further guidance on laboratory testing for BBVs, including management of results from laboratories in other jurisdictions, is provided in **Appendix 1**.

6.14 Health clearance for HCWs who will perform EPPs: HIV

6.14.1 HIV testing of HCWs who will perform EPPs

New HCWs who intend to perform EPPs must be tested for HIV infection with appropriate pre-test discussion. The presence of HIV antibody should not automatically restrict HCWs from performing EPPs. The HCW must be referred to a HIV clinic for confirmation of HIV infection and plasma viral load measured.

Vaccine Induced Sero- Reactivity (VISR) may be encountered when testing HCWs who have participated in HIV vaccine trials. Reactivity in some tests for antibody may also occur for other reasons. Repeat serology and undetectable HIV virus nucleic acid should generally provide assurance if the person is not living with HIV. It is appropriate in these cases to seek advice from a Consultant Microbiologist or Virologist with relevant expertise. Detecting HIV antibody as a consequence of VISR or detection of reactivity on serological tests for other reasons should not prevent HCWs performing EPPs provided additional testing provides a high level of assurance that the person is not living with HIV.

Guidance on laboratory testing for BBVs, including management of results from laboratories outside the jurisdiction, is provided in **Appendix 1**.

6.14.2 Initial health clearance for HCWs living with HIV who intend to perform EPPs

HCWs living with HIV with a plasma viral load equal to or above 200 copies/ml must be restricted from performing EPPs.

Initial clearance to perform EPPs requires a HCW to be on effective combination anti-retroviral therapy (ART) and to have had 2 IVS test results taken no less than 12 weeks apart, with both demonstrating a viral load below 200 copies/ml. For the purposes of initial health clearance, no less than 12 weeks apart is defined as between 12 and 16 complete calendar weeks. The decision to clear individual HCWs to undertake EPPs is the responsibility of an accredited specialist in occupational medicine.

For HCWs currently restricted from EPPs who are already on ART and have a viral load below the clearance threshold of 200 copies/ml, based on an Identified Validated Sample (IVS) test

result at 12 to 16 weeks since their last undetectable IVS viral load result is sufficient proof on which to grant clearance for conducting EPPs.

HCWs performing EPPs who are living with HIV should continue to be periodically monitored (see **Chapter 7**).

6.15 Redeployment and retraining

Employers should assure HCWs living with BBVs that their status and rights as employees will be safeguarded in line with legislation and organisational policy. If for any reason, a HCW is unable to recommence EPP practice, employers should make every effort to arrange suitable alternative work and re-training opportunities, or where appropriate, early retirement, in accordance with good general principles of OH practice. With the opportunity for HCWs living with HIV or HBV to recommence EPPs once the criteria in this guidance have been met, it is anticipated that the number of HCWs requiring retraining will be small (5). There may, however, be a requirement for short term redeployment while the HCW commences antiviral treatment and until a point that their infection is cleared (for HCV), or their viral load for HBV and HIV is reduced below the level required to perform EPPs.

Chapter 7: OH monitoring of HCWs living with BBVs

7.1 Monitoring roles and responsibilities

The model for allowing HCWs living with HBV or HIV to undertake EPPs whilst on therapy relies on continuing care and regular viral load monitoring by both their treating physician and accredited specialist in occupational medicine. Effective monitoring requires close working between these two parties and the HCW to ensure that the policy is being adhered to appropriately, thus minimising the risk of transmission. Healthcare workers' treating practitioners provide ongoing treatment and management of their medical condition, while OH will provide fitness for duty assessments. HCWs living with BBVs should be offered appropriate psychological support from the time of diagnosis and as monitoring continues, both through their treating service and organisational services.

Where a healthcare establishment's OH service does not have its own accredited specialist in occupational medicine, arrangements should be put in place for this advice to be sought from such an individual outside the establishment. Suitable arrangements must be in place for agency or locum staff, or HCWs contracted to provide a service, including oral healthcare workers, to ensure that they have a designated accredited specialist in occupational medicine who is responsible for their monitoring, in accordance with this guidance.

All HCWs living with HBV or HIV who perform EPPs should have their viral load measured regularly using a blood IVS as described in this Chapter. Blood testing for this purpose will usually be carried out by the OH service, but where this would give rise to duplication of testing, local arrangements should be made, where appropriate, and carried out to the recommended standard, between the treating physician and the accredited specialist in occupational medicine, to ensure that blood drawn from HCWs for viral load measurements in other specialist clinics follows the principles of an IVS (see **Appendix 1**). This includes ensuring that there are appropriate checks and balances in place when verifying the identity of an individual presenting for testing and ensuring that there are appropriate checks and balances in place to mitigate risk of sample labelling error. Written consent for use of these results for occupational purposes, including sharing with the accredited specialist in occupational medicine, should be completed at the time of sampling. The OH records are held separately from other hospital clinical notes and can be accessed only by OH practitioners, who are obliged ethically and professionally not to

release records or information without the consent of the individual (see **Chapter 5** for more information).

To support and monitor implementation of the policy and to ensure patient safety, all HCWs living with HBV or HIV, including locum staff, who wish to perform EPPs (and for HCWs living with HBV, clinical duties in haemodialysis units or any other settings involving haemodialysis), and who meet the criteria for clearance, must be monitored by their OH service.

Action taken as a result of an increase in viral load should be recorded locally in OH services, as well as records of restrictions on EPP performance put in place appropriately and, where necessary, risk assessments and Look-back reviews carried out.

OH departments must ensure that they have robust systems in place to appropriately clear and monitor HCWs living with HIV and/or Hepatitis B who perform EPPs. OH departments are expected to seek advice, if required, from the relevant clinicians and the local Department of Public Health.

The roles and responsibilities of the respective individuals involved in the monitoring process for HCWs living with BBVs who are performing EPPs are set out below:

A. Healthcare worker

The HCW must be under the care of an accredited specialist in occupational medicine. They must accept that it is a condition of undertaking EPPs that they consent to ongoing monitoring including:

i. The release of viral load test results to the accredited specialist in occupational medicine if the treating physician undertakes monitoring. Some HCWs may have their viral load tested regularly as part of their clinical HIV care; in these situations, results can be shared with OH, with the HCW's consent, to avoid unnecessary repeat testing. This will be based on local arrangements between the treating physician and the accredited specialist in occupational medicine and must follow the principles of an IVS.
ii. To attend the OH service (or other appropriate service) when arranged and to provide an IVS for viral load monitoring at the appointed times.

iii. To seek advice if a change in health condition may affect their fitness to practise or impair their health or, for those with a history of HBV infection, in order to assess their risk of reactivation of HBV (rHBV), if they start immunosuppressive treatment or develop an illness that compromises their immune system.

iv. To notify OH when they are changing their practice or their place of employment, including informing the new OH service of BBV status and monitoring (where EPPs are involved in new role). HCWs should keep their OH specialist informed of any change in role or place of work so that monitoring records can be updated, any new monitoring arrangements established and their clearance to practice maintained.

v. To notify their accredited specialist in occupational medicine and treating physician if there has been an interruption to therapy or sub-optimal adherence or if they are at risk of rHBV due to immunosuppressive therapy or any illness that may compromise their immune system, or if there has been a risk of therapy failure.

vi. The healthcare worker should provide appropriate consent to the treating health practitioner to communicate any relevant information to the OH specialist, wherein the information may impact on exposure prone procedure (EPP) clearance.

Thus, HCWs agree that by seeking to undertake EPPs, they are giving consent to i and ii, and they are undertaking to satisfy iii to vi.

It is recommended that the OH department puts in writing to the HCW, the requirements they must meet in order to continue practising EPPs.

If the HCW is moving to a new post, they should liaise with their existing OH physician to ensure the transfer and sharing of necessary information about the monitoring of their viral load for ongoing EPP clearance to the OH service of their new employer (see **Section 6.2**).

B. Accredited specialist in occupational medicine

The accredited specialist in occupational medicine is responsible for the monitoring of the HCW, including:

I. Ensuring that appointments are available for testing in accordance with the testing protocol, and timings are followed.

II. Taking appropriate action when those who should present for tests do not do so, for example, notifying the relevant manager of the HCW's non-attendance and restriction from EPP practice.
III. Ensuring that IVS samples are collected, tested, and results managed appropriately.
IV. Interpreting the viral load results in relation to clearance to perform EPPs.
V. Notifying the HCW that they are cleared to perform EPPs.
VI. Advising the employer if the HCW is no longer fit to perform EPPs
VII. Advising and maintaining timely communications with treating physicians when required.
VIII. Providing appropriate support to the HCW

C. Treating physician

The treating physician is responsible for:

i. The clinical management and support of the HCW.
ii. Advising and maintaining timely communications with the accredited specialist in occupational medicine responsible for monitoring the HCW.
iii. Advising the HCW what constitutes a risk of therapy failure (for example, an interruption to therapy or sub-optimal adherence).
iv. Notifying the accredited specialist in occupational medicine if there has been a risk of therapy failure.

7.2 Monitoring and ongoing clearance for HCWs who will perform EPPs: Hepatitis B

HCWs who are HBsAg positive should not be restricted from performing EPPs or clinical duties in haemodialysis units or any other settings involving haemodialysis if HBV DNA viral load is less than 200 IU/mL (either whilst on continuous antiviral therapy, from natural suppression, or after a minimum of 12 months after stopping a course of antiviral therapy during which time there must have been 2 HBV DNA tests 6 months apart, the first being no less than 6 months after ceasing treatment) and their HBV DNA levels are monitored every 6 months by their accredited specialist in occupational medicine.

Those who have ceased treatment need to show that they have a viral load that does not exceed 200 IU/mL at least one year after cessation of treatment before a return to unrestricted working practices can be considered, through 2 tests 6 months apart (see **Section 7.4**). Any health care worker living with HBV returning to unrestricted EPP working practices would be subject to the same 6 monthly re-testing as recommended for other health care workers living with HBV.

The 6-month monitoring period should be taken from the date the previous IVS was drawn, and not from the date the result was received. Six-monthly viral load testing can be performed no earlier than 24, and no later than 28 complete calendar weeks after the date of the preceding specimen taken for OH monitoring purposes.

If a HCW's plasma viral load is equal to or above 200 IU/mL, they must be restricted immediately from performing EPPs until their viral load returns to being stable below 200 IU/mL (see **Section 7.8).** The significance of any increase in plasma viral load above the cut-off, identified through routine monitoring, should be assessed jointly by the accredited specialist in occupational medicine, treating physician and with input from appropriate local experts (for example, consultant virologist or microbiologist as required).

Table 1 below sets out the expected course of action for HBV DNA level test results below and above the level for EPP clearance, **after the HCW has satisfied the initial clearance criteria**. Guidance on laboratory testing for BBVs, including management of results from laboratories outside of the jurisdiction, is provided in **Appendix 1.**

Table 1: HBV DNA level results and actions for HCWs subject to ongoing monitoring

HBV DNA Level	ACTION
<60 IU/mL	No action. Retest in 6 months.
>60 but <200 IU/mL	A case-by-case approach based on clinical judgement should be taken which may result in no action (as above) or recommending that a second test should be done 10 days later to verify the viral load remains below the threshold. Further action will be informed by the test result.
200 IU/mL or above	The HCW must cease conducting EPPs immediately. A second test must be done on a new blood sample 10 days later to determine the viral load remains at ≥200 IU/mL. If the repeat viral load is still ≥200 IU/mL, the HCW must cease conducting EPPs until their viral load, in 2 consecutive tests no less than 4 weeks apart, is reduced to <200 IU/mL. If the repeat viral load is <200 IU/mL then further action should be informed by the test result as above. Depending on the viral load, follow actions in the relevant box above. If test results are unexpected (for example, from very high viral load to low viral load) then seek further advice from a virologist A full local risk assessment (see **Chapter 8**) should be triggered to determine the risk of HCW to patient transmission. At a minimum, this will include discussion between the HCW, accredited specialist in occupational medicine and the treating physician on the significance of the result in relation to the risk of transmission. The MOH must be included in this risk assessment. The need for public health investigation or action (for example, patient notification) will be determined by a risk assessment on a case by case basis – see **Chapter 8** for further details

7.3 Resuming exposure prone procedures

If a HCW does not attend for their monitoring appointment, then they should cease conducting EPPs. Six-monthly monitoring can be performed no later than 28 complete calendar weeks after the preceding IVS specimen taken for OH monitoring purposes.

If a HCW does not attend for the missed viral load test within this timeframe (for whatever reason) then resumption of EPPs requires 2 IVS taken no less than 4 weeks apart with both showing a viral load result below 200 IU/ml.

HCWs living with HBV who take a career break from performing EPPs or clinical duties in haemodialysis units or any other settings involving haemodialysis, may wish to continue monitoring during this period to facilitate a return to EPPs or clinical activities. Individuals with a break in their monitoring record must meet the criteria for initial clearance before returning to performing EPPs or clinical duties in renal units or any other settings involving renal dialysis.

7.4 Treatment issues

It is for the HCW to decide, in collaboration with their treating physician, whether they wish to take antiviral therapy for OH reasons when it is not clinically indicated, taking account of possible advantages and disadvantages.

Breakthrough infection, with increases in serum HBV DNA and in serum alanine aminotransferase (ALT) levels can be associated with the emergence of resistant virus. With successful antiviral treatment, the rate of viral replication in HCWs should be suppressed to levels where the risk of emergence of drug-resistant strains is likely to be low. Early detection of the emergence of resistance, through the 6 monthly viral load monitoring by the treating physician, can be achieved by using sensitive HBV DNA assays, as is recommended here, allowing consideration of an early change in antiviral therapy before patients have been put at appreciable risk.

If breakthrough infections occur due to the development of resistant strains, and HBV DNA levels rise above 200 IU/mL, then it is recommended that the HCW be restricted from performing EPPs (or clinical duties in haemodialysis units or any other settings involving

haemodialysis) until such time as they have been re-stabilised on different antiviral drugs. This would be demonstrated by HBV DNA levels of less than 200 IU/mL on 2 consecutive tests performed no less than 4 weeks apart.

HCWs should be advised by their treating physician of the importance of notifying them of missed doses, drug interactions, or other factors that might influence their viral load, as soon as is practicable and before further EPPs are performed.

The HCW should also notify OH of any potential change to their health status as it may impact on their fitness to perform EPPs.

It is recommended that if a HCW stops antiviral treatment for any reason, they must immediately cease to perform EPPs or clinical duties in haemodialysis units or any other settings involving haemodialysis and seek the advice of their treating physician if this has not already been obtained. The HCW must be restricted from performing EPPs for 12 months if they remain off antiviral therapy. To resume EPPs after this 12-month period, the HCW must demonstrate a viral load result of below 200 IU/mL through 2 consecutive IVS tests 6 months apart. The first test should be conducted at a minimum of 6 months after treatment cessation.

Upon return to performing EPPs, the HCW should undertake 6 monthly testing as recommended in these guidelines.

7.5 Reactivation of HBV (rHBV)

There is a risk of reactivation of hepatitis B when a person becomes immunosuppressed. This is becoming more common due to the increased use of therapeutic immunosuppressive agents in organ transplants and inflammatory and autoimmune illnesses. Reactivation may occur in 2 main settings:

- In those who have current infection (HBsAg positive) but a low or negative HBV DNA level (viral load)
- In those with past, cleared, infection (HBsAg negative, hepatitis B core antibody [HBcAb] positive)

Such a reactivation increases HBV viral load and can contribute to a risk of transmission. An increase in viral load in a previously HBsAg negative HBcAb positive individual, or the appearance of HBV DNA in a previously HBV DNA negative case or an increase of viral load ≥200 IU/mL in a previously detectable but below 200 IU/mL individual may all indicate reactivation of HBV. However, increase in viral load level may be due to other factors including reactivated HBV and a case-by-case approach should be taken to determine if reactivated HBV has occurred. In all cases a retest in 10 days is advised.

Testing for past Hepatitis B infection is not part of routine EPP clearance. HCWs may already be aware of past hepatitis B infection or may become aware as part of standard investigations pre-immunosuppression. Clinicians starting immunosuppressive treatment or diagnosing a condition conferring risk of rHBV should arrange to test for current and past hepatitis B infection.

The following is recommended when there is a risk of hepatitis B reactivation:

- All EPP workers who are HBsAg positive but not on antiviral therapy for hepatitis B, and EPP workers who are HBsAg negative and HBcAb positive, should be advised by the treating physician managing the immunosuppression, and/or the hepatologist they are under, to inform the accredited specialist in occupational medicine responsible for their monitoring, of the decision to start immunosuppressive treatment or of any illness that may compromise their immune system
- The accredited specialist in occupational medicine should liaise with treating physicians starting the immunosuppressive treatment and hepatologist or microbiologist/virologist regarding options of starting prophylactic antiviral therapy and/or more regular monitoring of HBV infection markers. There may need to be a period of stopping EPPs until it is established that the virus has not reactivated.
- If the virus does reactivate, the HCW must not return to EPPs until their viral load is stabilised and below 200 IU/mL in 2 IVS samples at least 4 weeks apart.
- HCW who are HBsAg positive but not on antiviral therapy should typically be offered antiviral prophylaxis before starting immunosuppressive treatment

- The rationale and decision on management options should involve the HCW, the treating physicians managing the immunosuppression and the accredited specialist in occupational medicine and a hepatologist or Consultant in Infectious Diseases.

7.6 Monitoring and clearance for HCWs who will perform EPPs: Hepatitis C

HCWs who have detectable circulating HCV RNA indicating active or current infection must be restricted from carrying out EPPs.

HCWs who have antibodies to HCV but do not have circulating detectable HCV RNA, either as a result of treatment-induced sustained viral response, or spontaneous clearance (i.e. HCV RNA not detected 12 weeks or more post-cessation of treatment, or following natural clearance) should be allowed to perform EPPs, subject to guidance in **Chapter 6**.

Guidance on laboratory testing for BBVs, including management of results from laboratories outside of the jurisdiction, is provided in **Appendix 1**.

7.7 Monitoring and ongoing clearance for HCWs who will perform EPPs: HIV

7.7.1 Monitoring of HCWs who will perform EPPs

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

Either

i. be on effective antiretroviral therapy AND

ii. have a confirmed plasma viral load less than 200 copies/mL

OR

iii. be an elite controller (defined as a person living with HIV who is not receiving antiretroviral therapy and who has maintained their viral load below the limits of assay detection for at least 12 months, based on at least 3 separate viral load measurements taken no less than 12 weeks apart.)

AND

iv. be subject to plasma viral load monitoring every 12 weeks

v. be under joint supervision of an accredited specialist in occupational medicine and their treating physician

HCWs living with HIV who are cleared to perform EPPs are subject to viral load testing every 12 weeks while continuing to perform such procedures. The 12-week period should be taken from the date the previous IVS was drawn, and not from the date the result was received. For this purpose, viral load testing can be performed no earlier than 10, and no later than 14 complete calendar weeks after the date of the preceding specimen taken for Occupational Health monitoring purposes.

If a HCW's plasma viral load rises above 1,000 copies/ml, they must be restricted immediately from performing EPPs until their viral load returns to being consistently below 200 copies/ml in at least 2 consecutive tests no less than 12 weeks apart. The significance of any increase in plasma viral load above 200 copies/ml and below 1,000 copies/ml should be assessed jointly by the accredited specialist in occupational medicine, microbiologist/virologist and treating physician.

Table 2 below sets out the expected course of action for repeat viral load test results below and above the level for monitoring, **after the HCW has satisfied the initial clearance criteria**. Note that Table 2 applies only to viral load test results for HCWs subject to ongoing monitoring.

Guidance on laboratory testing for BBVs, including management of results from laboratories in other jurisdictions, is provided in **Appendix 1**.

*Table 2: HIV viral load test results and actions for HCWs subject to **ongoing monitoring***

Viral load test result	Action
<50 copies/ml or below	No action. Retest in 12 weeks.
≥50 but <200 copies/ml	A case-by-case approach based on clinical judgement should be taken which may result in no action (as above) or a recommendation that a second test should be done 10 days later to verify the viral load remains below the threshold. Further action will be informed by the test result
≥200 copies/ml but <1,000 copies/ml	A second test should be done 10 days later in all cases, on a new blood sample to determine if the viral load remains above the threshold.

	If the repeat viral load is still ≥200 copies/ml, the HCW should cease conducting EPPs until their viral load, in 2 consecutive tests no less than 12 weeks apart, is reduced to <200 copies/ml. If the repeat viral load was <200 copies/mL then further action will be informed by the test result. Depending on the viral load, follow actions in the relevant box above. If test results are unexpected (for example, from very high viral load to low viral load) then seek further advice from the medical director of the testing laboratory and treating clinician and discuss possible reasons with the HCW.
≥1,000 copies/ml	The HCW must cease conducting EPPs immediately. A second test must be done on a new blood sample 10 days later to determine if the viral load remains ≥1,000 copies/ml. If the repeat viral load is <1,000 copies/ml further action will be informed by the test result (viral load). See actions in the boxes above based on the viral load level detected. If test results are unexpected (for example, from very high viral load to low viral load) then seek further advice from the medical director of the testing laboratory and treating clinician and discuss possible reasons with the HCW. If the count is still ≥1,000 copies/ml, a full risk assessment should be triggered to determine the risk of HCW to patient transmission. At a minimum, this will include discussion between the accredited specialist in occupational medicine and the treating physician on the significance of the result in relation to the risk of transmission. The MOH must be included in this risk assessment. The need for further public health investigation and action (for example, patient notification) will be determined by a risk assessment on a case-by-case basis

7.8 Resuming exposure prone procedures

If a HCW does not attend for their monitoring appointment, then they must cease conducting EPPs. Twelve-weekly monitoring can be performed no later than 14 complete calendar weeks after the preceding IVS specimen taken for Occupational Health monitoring purposes.

If a HCW does not attend for the missed viral load test within 14 weeks from the date the previous IVS was drawn (for whatever reason) then resumption of EPPs requires demonstration of consistent viral load suppression to very low or undetectable levels, by 2 samples taken no less than 12 weeks apart demonstrating viral load below 200 copies/ml.

HCWs living with HIV who take a career break of more than 14 weeks from performing EPPs may wish to continue 12 weekly monitoring during this period to facilitate a return to EPPs. Individuals with a break in their monitoring record must meet the criteria for initial clearance before returning to EPP activities.

7.9 Treatment issues

HCWs should be advised by their treating physician of the importance of notifying them of missed doses, drug interactions, or other factors that might influence their viral load, as soon as is practicable and before further EPPs are performed. If there is any suggestion that the HCW's infection is no longer controlled by their antiretroviral treatment, the treating physician overseeing the case may consider it appropriate that viral load tests are performed sooner than the next 12-week test.

The HCW should also notify OH of any potential change to their health status as it may impact on their fitness to perform EPPs.

7.10 Spontaneous HIV Viral Control (Elite Controllers)

People with spontaneous HIV viral control (elite controllers) comprise a small proportion (0.2 to 0.55%) of all people living with HIV, who may not be receiving antiretroviral therapy and have maintained their viral load below the limits of assay detection for at least 12 months, based on at least 3 separate viral load measurements.

A HCW who meets the definition of being an elite controller can be cleared for EPP activities without being on treatment but must remain subject to 12 weekly viral load monitoring to ensure they maintain their viral load below 200 copies/ml and to identify any rebound promptly.

7.11 Failure to attend or refusal to test (HBV, HIV and HCV)

All HCWs living with BBVs who are performing EPPs should be advised by their accredited specialist in occupational medicine and their treating physician of the importance of periodic monitoring of their viral load and the implications of not doing so.

Where a HCW does not attend for their appointments at the specified interval or attends but refuses to have their viral load tested, the accredited specialist in occupational medicine must inform the HCW's employer that they are no longer cleared to perform EPPs, until it has been established that the HCW has an up-to-date viral load which does not exceed the cut-off. The accredited specialist in occupational medicine should make reasonable efforts to inform the HCW that this step has been taken, for example by copying them on the correspondence.

7.12 Management of accidental exposure

There may be occasions when a HCW living with a BBV is aware of accidentally exposing a patient to their blood or body fluid. These incidents should be managed in accordance with local needlestick injury policies and ***Guidelines for the Emergency Management of Injuries (EMI) and Post-exposure prophylaxis (PEP)***.

Chapter 8: Investigation of a HCW diagnosed with BBV: risk assessment process, indications for undertaking a look back review, and look back procedures

8.1 Notification of BBV in a HCW.

Maintaining patient safety is of the utmost importance for any health services provider. Several HSE strategies, policies and frameworks e.g. the Incident Management Framework, Open Disclosure Policy and Patient Safety Strategy outline some key priorities to continuously improve patient safety. These include effective risk management, incident management, openness and transparency, and good governance.

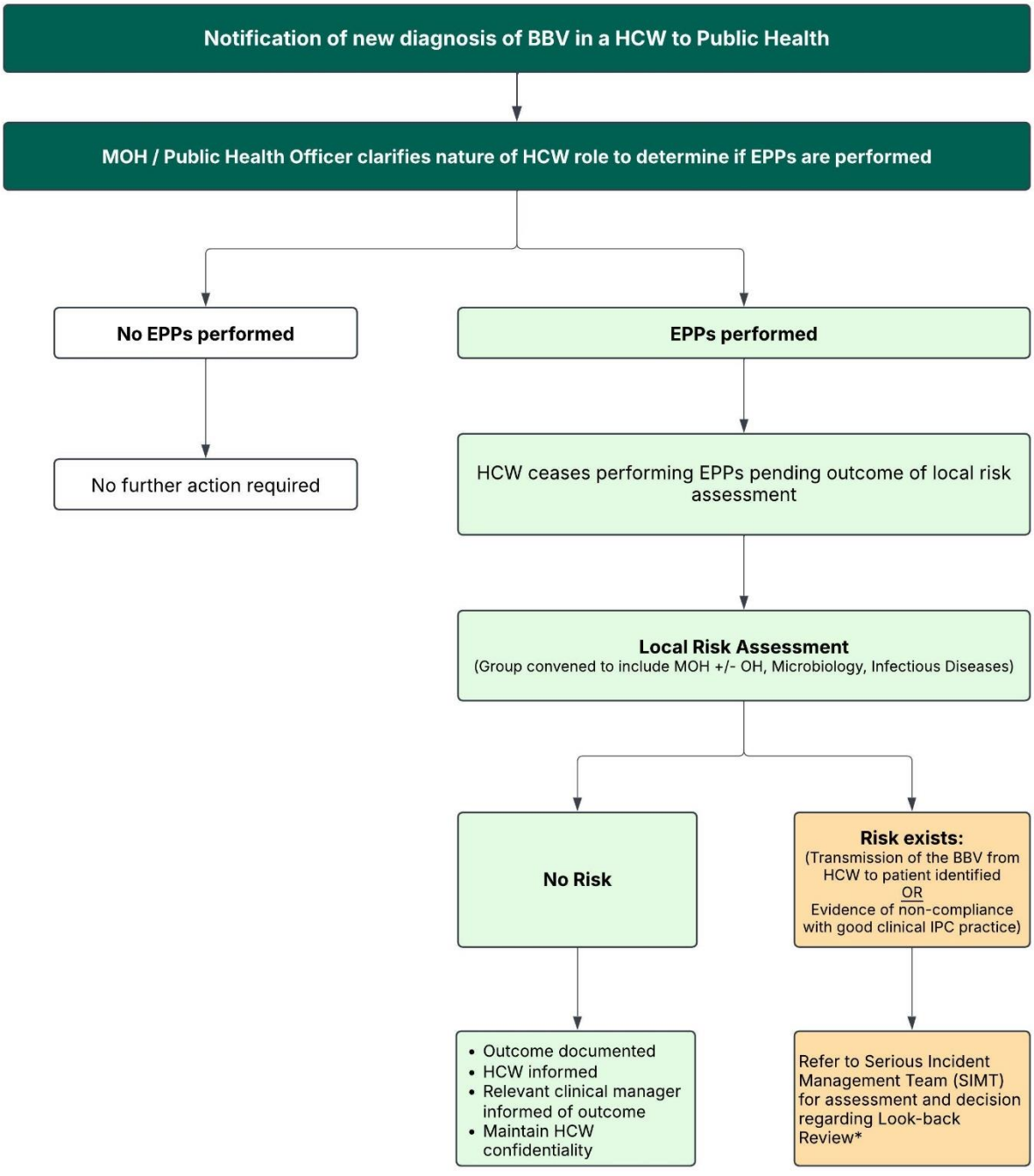
All newly diagnosed cases of hepatitis B, hepatitis C and HIV are statutorily notifiable. Cases are actively followed up by the **Medical Officer of Health** (MOH). The MOH has the responsibility and authority to investigate and control notifiable infectious diseases and outbreaks, under the Health Acts **1947** and **1953; Infectious Disease Regulations 1981** and subsequent amendments to these regulations. If a case of HIV, HCV or HBV is notified in a HCW, the Medical Officer of Health, or health officer on the advice of the Medical Officer of Health, clarifies the nature of the HCW's role. If, based on this initial enquiry, it is identified that the person may be undertaking EPPs, the MOH/health officer liaises with the relevant clinical manager of the relevant service and the OH service to clarify the situation. If EPPs are undertaken, then the HCW must stop performing EPPs pending the outcome of a local risk assessment. If the HCW is self-employed, the MOH will liaise directly with the HCW to clarify the nature of the role. If EPPs are undertaken, the self-employed HCW must stop performing EPPs until the local risk assessment has been completed.

A formal, structured local risk assessment is undertaken by relevant experts, including OH, clinical microbiology, and/or infectious diseases. The MOH must be included in this risk assessment. This process should involve as few people as possible, **on a strictly confidential and need-to-know basis**, to preserve the HCW's confidentiality and that of patients receiving treatment from the HCW, for example as set out in the HSE **Integrated Employee Wellbeing and Welfare Strategy.**

A risk assessment form (**Appendix 8**) can be used to guide this risk assessment investigation.

See **Figure 1** below summarising the process that should be followed when a new diagnosis of a BBV in a HCW is notified to Public Health.

Figure 1: Actions following notification of a BBV in a HCW



Look-back review should be conducted in line with "HSE Guideline for Conducting a Look-back Review**"*

8.2 Process for local risk assessment

The local risk assessment team should collect information to assess the following factors that would increase the risk of BBV transmission from HCW to patient.

- Details of the HCW's infections (for example, when acquired, treatment and adherence with same, viral load etc.)
- Details of the HCW's practice (for example, types of procedures undertaken, patient contact).
- Evidence of a confirmed or highly likely transmission. This would likely be identified from investigation of an index case of BBV infection where exposure by a named HCW is the only plausible risk factor.
    - It is important to note that identification of a BBV in a patient cared for by the HCW is not sufficient to establish transmission from the HCW to the patient. Careful consideration of the timeline is essential, and subtyping/sequencing should be used to assess evidence of HCW to patient transmission if available and required.
- Practice/s in the work environment or by the individual or identified breaches that could have resulted in significant exposure to the blood or body fluids of the HCW for example, lack of use of appropriate PPE, needlestick injuries or observed poor IPC practice.
- Consideration of other elements of HCW's conduct or circumstances (that may have led to difficulty in compliance with treatment of their BBV infection and/or their compliance with good IPC practice).
- Any action or omission by OH or other departments that could be considered a breach of guidance (e.g. lack of EPP clearance) or could put patients at risk should also be considered and followed up according to local policy.

This will identify any factors that may impact on the HCW's ability to practise safely and/or increase the risk of transmission of a BBV from the HCW to patients. It is envisaged that, in most situations, this will not be the case and a LBR will not be required.

8.2.1 Local risk assessment outcome: No risk

If no risks are identified, and an incident, defined in the HSE incident management Framework as *an event or circumstance which could have, or did lead to unintended and/or unnecessary harm*, has not occurred, then the details and conclusions of the local risk assessment should be

documented and the HCW informed of the outcome. In the situation that no risk has been identified, and it is not an incident, confidentiality of the HCW should be maintained. The same relevant clinical manager of the service should be informed that there is no risk.

See **Chapter 5** for further information on confidentiality concerning the healthcare worker living with a BBV.

If at a later stage new risks or issues of concern are raised or identified, for example poor IPC practice or other clinical concerns, then the risk assessment must be repeated, and the necessary mitigations put in place to prevent risk of transmission.

8.2.2 Local risk assessment outcome: Risk exists.

IF

1) transmission of the BBV from the HCW to a patient has been identified**

OR

2) there is evidence of non-compliance with good clinical practice (in relation to declaration and monitoring of BBV status or IPC practice) in the absence of evidence of HCW to patient transmission

then risk exists, and Referral to the Senior Accountable Officer is required.

A Serious Incident Management Team (SIMT) is established, and within HSE, the Senior Accountable Officer (SAO) is accountable for the governance of the incident management (see **HSE Incident Management Framework** for more information). The Regional Executive Officer (REO) is the SAO for all incidents within his/her health region. The new integrated model of service delivery facilitates coordination of actions across hospitals and other sites, if required. The MOH in the health region where the incident has occurred also has statutory responsibility and authority to investigate and control notifiable infectious diseases. The SAO must notify the MOH and involve them in this process. The SIMT, working with the MOH, will carry out a separate LBR risk assessment (as described in HSE Guideline for Conducting a Look-back Review) and, pending the outcome of this, make the decision as to whether a LBR is required.

** It is important to note that identification of a BBV in a patient cared for by the HCW is not sufficient to establish transmission from the HCW to the patient. Careful consideration of the timeline is essential, and subtyping/sequencing should be used to assess evidence of HCW to patient transmission if available and required.

The SIMT should consider the level of review, the level of independence, commissioner of the review, scope of the review, who will be assigned to undertake the review and the support requirements for persons affected. The REO may delegate the role of Chair of the SIMT to the MOH. This is in line with the HSE Performance and Accountability Framework.

Where it is determined that a LBR is warranted, this must be prompt. The aim of a LBR is to identify any other potential transmission events from the health care worker and the actions required may include reviewing specific EPPs undertaken, providing information to patients, and offering testing for BBVs, and providing necessary treatment where appropriate. The **HCW's confidentiality** should be preserved as far as reasonably practicable, and support should be provided using local staff support policies, such as the HSE's Supporting Staff following an adverse event.

Previously, if a HCW who carried out EPPs was identified as having a BBV, and the diagnosis had not been made in the context of a proven transmission event from the HCW to an index patient, a crossmatching exercise was advised to identify any transmissions that could then lead to wider patient notification action.[††]

A review of the past 20 years of UKAP's experience of the investigation and management of HCWs with a BBV found that the risk of transmission of any BBV from HCW to patient is extremely low and the risk versus benefit (cost versus benefit) of undertaking large, resource-intensive lookback exercises does not support the routine use of this approach.

A review of lookbacks carried out to investigate potential exposure to BBVs in healthcare settings in Ireland over a 14-year period revealed that despite testing over 2000 patients, there was no HCW to patient transmission. Therefore, it is advised that the initial local risk assessment following the identification of a HCW living with a BBV no longer requires a cross-matching exercise be undertaken, however it may be recommended if concerns are identified.

[††] A **cross matching exercise** can be done either by obtaining a list of positive tests from the relevant microbiology laboratory and investigating whether any individuals had treatment which may have exposed them to the healthcare worker living with a BBV, or alternatively by compiling a list of patients who were potentially exposed and comparing this against laboratory records of positive tests and then ascertain whether they were treated by the healthcare worker)

8.3 General principles of bloodborne virus infection prevention and control

IPC standard precautions including safe injection practice are designed to protect HCWs and patients from infection caused by a broad range of pathogens including BBVs. These principles and practices must be followed when caring for all patients to minimise the risk of exposure to blood products and any associated BBVs.

Guidance for clinical HCWs on minimising the risk of exposure to blood products and any associated BBV can be found in the **National Clinical Guideline No. 30 - Infection Prevention and Control (IPC)**. The measures recommended will also minimise the risk of transmission from HCWs to patients and from patient-to-patient.

8.4 Links to guidance documents and webpages

National Guideline for Infection Prevention and Control in HSE Dental and Orthodontic Services
Patient safety strategy 2019-2024 (hse.ie)
Performance and Accountability Framework 2023 (hse.ie)
Integrated Employee Wellbeing And Welfare Strategy (hse.ie)
HSE Enterprise Risk Management Policy 2023
HSE Guideline for Conducting a Look-back Review 2022
HSE Supporting Staff Guidance
HSE Data Protection Policy
Directory of INAB Accredited Medical Laboratories

8.4.1 Regulatory bodies for statements on professional responsibilities

Irish Medical Council (IMC)
Guide to Professional Conduct & Ethics for Registered Medical Practitioners - 9th Edition

Dental Council of Ireland (DCI)
Professional Behaviour and Ethical Conduct
Infection Control – Dental Council of Ireland

Nursing and Midwifery Board of Ireland (NMBI)

Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives

Pre-hospital Emergency Care Council (PHECC)

Code of Professional Conduct and Ethics

CORU

Codes of Professional Conduct and Ethics

8.4.2 Additional guidance and documents

UK Advisory Panel for Healthcare Workers Living with Bloodborne Viruses (UKAP), and guidance on categories of exposure prone procedures can be found at the **UKAP webpage.**

Appendix 1. Laboratory testing arrangements for health clearance and monitoring

Identified and validated samples (IVS)

Those commissioning tests to establish or monitor a healthcare worker's BBV status should ensure that IVS are used; that is, they should ensure that samples tested are from the HCW in question and not open to fraudulent submission of samples or tampering with samples or results. HCWs should not transport or submit their own samples or the samples of a colleague to a laboratory outside of their role an IVS process.

The standards for OH data recording are:

- Laboratory test results required for clearance for undertaking EPPs, and ongoing monitoring thereafter must be derived from an IVS

Fitness for work will not be determined by OH if the sample is not derived from an IVS. **An IVS is defined by as meeting the following criteria:**

- The HCW should show a proof of identity with a photograph (current driver's licence or passport) when the sample is taken
- The sample of blood should be taken in the Occupational Health service or other approved relevant service
- Samples should be delivered to the laboratory in the usual manner, not transported by the HCW
- When results are received from the laboratory, the clinical notes should be checked

for a record that the sample was sent by the Occupational Health service, at the relevant date

Blood testing for the purpose of ongoing monitoring of HCWs living with HIV or HBV who perform EPPs will usually be carried out by the OH service but where this would give rise to duplication of testing, local arrangements should be made between the treating physician and the OH service to ensure that blood drawn from HCWs living with HBV or HIV for viral load measurements in GUM, sexual health or infectious diseases settings follows the principles of an IVS.

All samples sent for BBV testing for EPP clearance purposes should be accompanied by a request which contains as a minimum:

- Forename
- Surname
- Date of birth
- Purpose of testing 'clearance for EPP'
- Information on whether the HCW is, or is not, taking antiviral therapy

A unique patient identifier such as Individual Health Identifier (IHI) should be provided if available.

Testing arrangements

Laboratories must operate a quality system (ISO15189:2022 or equivalent), accredited to provide the assays used in healthcare clearance and monitoring for bloodborne virus infection, and must use assays that comply with relevant national regulations and professional guidance. Results from laboratories outside of this jurisdiction can only be accepted if they are accredited to the same international standard (ISO 15189:2022) as INAB. The hours of service, specimen requirements and target turnaround time (TAT) subject to local agreement and will vary between laboratories. Accredited specialists in occupational medicine should consider the TAT of their local laboratory when scheduling appointments for OH monitoring to ensure repeat viral load results will be available within the required 14 complete calendar weeks from the date of the preceding specimen taken for OH monitoring purposes

The use of personal identifiers in requests for laboratory tests may be avoided and care taken to ensure that the number of people who know the HCW's identity is kept to a minimum. However, full person identifiers must always be used when sending results in the first instance.

All tests for clearance and monitoring must be conducted by a laboratory operating a quality system that conforms to ISO15189, preferably a laboratory within Ireland with an established working relationship with the OH service. Laboratories accredited to the ISO15189 standard elsewhere also provide this service.

For this reason and because the clearance for EPPs for HCWs living with HIV requires 2 IVS samples taken not less than 12 to 16 weeks apart, HCWs living with HIV who move into Ireland from outside the jurisdiction who need clearance for EPPs will need to wait at least 12 weeks while both tests are completed before they can commence EPP work. HCWs living with HBV

who move into Ireland from another jurisdiction abroad who need clearance for EPPs will need to wait at least 4 weeks for EPP clearance tests to be completed.

Hepatitis B viral load testing

Commercially available HBV viral load assays have been developed that use a WHO International Standard for Hepatitis B Virus Nucleic Acid Amplification Techniques. The International Standard and CE marked quantitative HBV DNA PCR assays calibrated to this standard are now widely available and it is now standard practice for HBV viral load assay results to be reported in international units per millilitre (IU/mL). Bioassays, including quantitative HBV DNA PCR (viral load) testing, use complex biological systems to test activity and therefore are variable from test to test. By using a biological reference material or standard of known concentration, bioassay results can be compared and calibrated to give a consistent result, no matter when or where the bioassay is performed. The WHO international standards are calibrated in units of biological activity which are assigned following extensive studies involving multiple international laboratories.

Viral load testing can be undertaken by an accredited virology laboratory provided an IVDR-compliant/CE marked assay, which is standardised to the WHO international standard for HBV nucleic acid amplification techniques, is used and HBV DNA levels are reported in international units per millilitre (IU/mL).

Appendix 2. Process of transferring to another accredited specialist in occupational medicine: EPP role

When transferring OH monitoring of a HCW living with a BBV (including students) to a new OH service or healthcare organisation, the current accredited specialist in occupational medicine should consider including in the transfer summary:

- Approximate dates of employment and clearance
- Consent of HCW to transfer the HCW's EPP related health records.
- Relevant medical information and compliance testing history.
- The receiving physician is an accredited specialist in occupational medicine.
- Contact details of the treating doctor.

Appendix 3. Process of transferring to another accredited specialist in occupational medicine: non-EPP role

If a HCW subject to monitoring wishes to stop undertaking EPPs, for example because of moving jobs, they are recommended to inform their current accredited specialist in occupational medicine in writing. HCWs should also consider providing the reason for halting monitoring and the date of stopping EPPs, including confirmation from the employer about their new non- EPP role. Those who are self-employed could provide a self-statement confirming their new non-EPP role. The accredited specialist in occupational medicine is advised to notify the HCW when monitoring will cease.

Appendix 4. Evidence base: BBV transmission from HCW to patients.

This appendix outlines a summary of the evidence of transmission of BBVs from HCWs to patients. Initial searches were undertaken by UKAP at the time of publication. The Research and Guideline Development Unit (RGDU) undertook supplementary searches in October 2023 and May 2024, including published studies from 2005 to 2024, which revealed no new instances of transmission of any BBV from HCWs to patients.

HIV

Worldwide, there have been three reports of healthcare associated HIV transmission from HCWs during EPPs; a Florida dentist (9), where the exact route of transmission was never established, a French orthopaedic surgeon (10), and a gynaecologist in Spain (11). A further transmission has been reported involving a French nurse who was living with HCV co-infection (12); this did not involve an EPP and the exact route of transmission remains unclear. Genetic relatedness of virus in the HCW and patient(s) was demonstrated in all four cases. These four cases of transmission involved HCWs who were not undergoing antiretroviral therapy at the time of transmission.

The risk of HIV transmission from a HCW to their patient was reviewed by a Tripartite Working Group using data available from PNEs undertaken between 1988 and 2008. No cases of HCW to patient HIV transmissions were identified despite over 10,000 patients being tested (13). The group concluded that the risk of HIV transmission from an untreated HCW living with HIV to a patient during EPPs was extremely low for the most invasive procedures and negligible for less invasive procedures; this risk could be reduced even further by ART, if the HCW's viral load is suppressed to a very low or undetectable level. Therefore, from the evidence reviewed, it was recommended that HCWs living with HIV may undertake EPPs if they were either on effective ART and had a plasma viral load less than 200 copies/ml or were an elite controller and subject to viral load testing every 3 months (14).

Hepatitis B

By the end of 2018, there had been 9 episodes of documented transmission of HBV from surgeons to patients in the UK since 1991, when HBV vaccination became widespread. There has also been transmission of HBV from a doctor to 2 patients which did not involve EPPs.

Worldwide, since 1970 there have been more than 40 clusters where over 400 patients contracted hepatitis B from a HCW (15-19).

Further cases of HBV transmission were, however, subsequently reported in HCWs living with HBV who were HBeAg negative. These HCWs were found to have high HBV DNA levels and in 2000, guidelines were issued which restricted HBeAg negative HCWs who had HBV DNA levels above 10^3 gEq/mL from performing EPPs or clinical duties in haemodialysis units. The practice of HCWs with levels below 10^3 gEq/mL, was not restricted subject to annual testing of their HBV DNA levels (16). The lowest documented HBV DNA level at which transmission was found to be reported was 10^4 gEq/mL

Hepatitis C

The first reported incident in the UK, of HCV transmission from a HCW to a single patient was in 1994 (20). As at the end of 2015, there had been 11 incidents of HCWs living with HCV transmitting the virus to 28 patients in the UK. With the exception of two, all HCWs were surgeons and all but three of these transmissions have been in the highest category EPP. The three exceptions occurred in non-EPPs; one involving a repair of a paraumbilical hernia, one from a midwife to a mother in a post-natal ward and the third from an anaesthetist to a patient. The route of transmission in these cases has never been identified (21-23).

Six documented international cases involving surgeons have also been described in the literature, resulting in the acquisition of HCV in 23 patients (24, 25). In addition, there have been three cases involving anaesthesiology HCWs who transmitted HCV to nine patients, with two of these HCWs having initially acquired their infection from a patient (26-28).

Recent reviews have highlighted the issue of substance misuse by HCWs, resulting in the transmission of HCV to large numbers of patients. In these cases, the HCWs were addicted to injectable anaesthetic opioids and in some cases, it was established that the HCW would partly inject themselves with the opioid before injecting the patients, resulting in subsequent transmission of the virus (drug diversion) (29).

Appendix 5. Guideline Development Group

Group members

NAME	TITLE	ORGANISATION
Dr Grant Jeffrey	Director Workplace Health and Wellbeing Unit, National Clinical Lead Occupational Health (Co-Chair)	HSE Workplace Health and Wellbeing Unit
Dr Derval Igoe	Consultant in Public Health Medicine – sí Health Protection (Co-Chair)	HSE Public Health: National Health Protection Office
Dr Keith Ian Quintyne	Consultant in Public Health Medicine sí Health Protection	Research and Guideline Development Unit (RGDU) HSE Public Health: National Health Protection Office
Dr Randal Parlour	Unit Coordinator	Research and Guideline Development Unit (RGDU) HSE Public Health: National Health Protection Office
Dr Michelle Williams	Senior Researcher and Project Manager	Research and Guideline Development Unit (RGDU), HSE Public Health: National Health Protection Office
Dr Cillian DeGascun	Consultant Medical Virologist & Laboratory Director	National Virus Reference Laboratory
Emer O'Donovan	Assistant Director of Nursing, Antimicrobial Resistance, and Infection Control Team	AMRIC, Office of the Chief Clinical Officer
Prof Eavan Muldoon	National Clinical Lead, National	Mater Misericordiae University Hospital (MMUH)

	Clinical Programme for Infectious Diseases and OPAT	
Prof Fiona Lyons	National Clinical Lead Sexual Health	HSE Sexual Health Programme/ GUIDE Clinic, St James's Hospital
Dr Gerry McCarthy	National Clinical Lead Emergency Medicine Programme	HSE Emergency Medicine
Dr David Hanlon	National Clinical advisor for Primary Care	HSE, Clinical Design & Innovation
Dr Bernie Tiernan	Regional Dental Inspector	HSE Dublin and North East
Dr Nader Farvardin	Principal Dental Surgeon, Dental Department, St. Conal's Hospital, Letterkenny, Co. Donegal.	Principal Dental Surgeon, Dental Department, St. Conal's Hospital, Letterkenny, Co. Donegal.
Dr Kenneth Mealy	Consultant General Surgeon – si Gastrointestinal Surgery / President of RCSI	Wexford General Hospital / RCSI
Dr Cliona Murphy	Clinical Director, National Women, and infants programme	National Women & Infants Health Programme, HSE
Dr Anne Sheahan	Area Director Public Health HSE South West	HSE South West
Dr Toney Thomas	Director of Nursing, HSE Public Health:	HSE Public Health: National Health Protection Office

	National Health Protection Office	
Ms Marion Commane	Assistant Director of Nursing, Infection Prevention and Control / Senior Manager in National Ambulance Service	ADON in National Ambulance Service
Prof David Robinson	PPI representative	PPI Representative National Patient Forum
Prof George Mellotte	National Clinical Lead for Renal Services, HSE, Consultant Nephrologist, Tallaght University Hospital & Clinical Professor of Nephrology, Trinity College Dublin	National Renal Office, HSE Offices Tallaght University Hospital Trinity College Dublin
Prof Pauline Meskell	Head, Department of Nursing & Midwifery, Faculty of EHS, Health Sciences Building, University of Limerick,	Faculty of EHS University of Limerick
Dr Blánaid Daly	Dean, School of Dental Science/Professor	School of Dental Science and Dublin Dental University Hospital Trinity College Dublin

	of Special Care Dentistry	
Subject Matter Expert Topic Group (SME-TG), also members of GDG		
Dr Grant Jeffrey	Director Workplace Health and Wellbeing Unit, National Clinical Lead Occupational Health, Accredited Specialist in Occupational Medicine	Occupational Health, HSE Workplace Health and Wellbeing Unit
Dr Derval Igoe	Consultant in Public Health Medicine – si Health Protection (co-Chair)	HSE Public Health: National Health Protection Office
Dr Nicola Murphy	Specialist Registrar, Public Health Medicine	HSE Public Health: South southwest region
Dr Sujil Jacob	Accredited Specialist in Occupational Medicine	Occupational Health, HSE Workplace Health and Wellbeing Unit
Dr Grainne McNally	Accredited Specialist in Occupational Medicine	Occupational Health, HSE Workplace Health and Wellbeing Unit
Ms Deborah Moriarty	Rehabilitation Lead, Occupational Health	Occupational Health, HSE Workplace Health and Wellbeing Unit

Orla Kelleher	Director of Nursing, Occupational Health	Occupational Health, HSE Workplace Health and Wellbeing Unit
Grainne Lambe (until July 2024)	Clinical Nurse Manager III, Occupational Health	Occupational Health, HSE Workplace Health and Wellbeing Unit
Dr Claire Rooney (until July 2024)	Specialist Registrar, Occupational Medicine	Occupational Health, HSE Workplace Health and Wellbeing Unit
Dr Jane Salmon	Senior Medical Officer	HSE Health Protection Surveillance Centre
Kristin Concannon (Until January 2025)	Programme Manager	HSE Public Health: National Health Protection Office
Aideen McLoughlin (Until February 2025)	Programme Administrator	HSE Public Health: National Health Protection Office

Appendix 6. Sample Consent for Updated Exposure Prone Procedure Screening

Name: _____	**Address:** _____
DOB: _____	_____
Mobile: _____	_____
Job Title: _____	
	MCRN/PIN: _____

Existing EPP clearance for Hepatitis B and Hepatitis C available: **Yes ☐ No ☐** .
If 'Yes' specify date of clearance and include copy in file - Date: _____

In line with the 'Integrated Guidance on Health Clearance of Healthcare Workers and the Management of Healthcare Workers Living with Bloodborne Viruses (Hepatitis B, Hepatitis C and HIV)', HIV testing is now required for EPP clearance in Ireland. This will apply to all new healthcare workers and healthcare workers with existing EPP clearance who are changing contract or returning to Ireland from work/travel abroad and existing healthcare workers who will be participating in EPP for the first time.

Healthcare workers with existing EPP clearance have a professional ethical responsibility to disclose to Occupational Health if they have any reason to believe that they may have been exposed to a BBV infection or have reactivation of their previous HBV infection, regardless of whether this was in an occupational or non-occupational setting. Full screening will be carried out where indicated or on healthcare worker request.

☐ **I have a valid EPP certificate OR blood results for Hepatitis B Surface Antigen and Hepatitis C virus, taken on an identified validated sample (IVS) and consent to HIV screening taken on an IVS sample, for the purposes of additional Exposure Prone Procedure screening in line with national guidance:**

OR

☐ **I consent to full Exposure Prone Procedure screening (Hepatitis B Surface Antigen, Hepatitis C virus antibody, HIV antibody):**

Employee Signature: _____ **Date:** _____

OH Clinician Signature: _____ **Date:** _____

OH Clinician Name (Print): _____

Clinician Stamp or Print

MCRN/PIN No:

This personal medical information will be kept confidential in your medical file, in the Occupational Health Department. It will only be used to assess your fitness for carrying out exposure prone procedures and identify if any ongoing monitoring is required, should a blood borne virus be detected.

Your manager will ONLY be informed of your fitness to carry out exposure prone procedures and not your serology results

Appendix 7: Sample EPP Clearance Certificate

Name: _____ **DOB:** _____ **Mobile:** _____ **Job Title:** _____	**Address:** _____ _____ _____ **MCRN/PIN:** _____
HR Contact: _____	
Occupational Health Service details: _____	

Fitness outcome:	**Department Stamp**
This is to certify that the above named person is fit to perform Exposure Prone Procedures in accordance with 'Integrated Guidance on Health Clearance of Healthcare Workers and the Management of Healthcare Workers Living with Bloodborne Viruses (Hepatitis B, Hepatitis C and HIV), using an identified validated sample.	
Date of screening (complete A or B as applicable):	
A. Full screening: _____	
B. Existing screening in line with HSE HR Circular 12/2009: _____ Issued By (Location of Issuing OHS): _____ **Additional screening in line with the 'Integrated Guidance on Health Clearance of Healthcare Workers and th** **Management of Healthcare Workers Living with Bloodborne Viruses':** _____	
'Professional codes of practice from regulatory bodies require HCWs who may have been infected with a serious communicable disease, including BBVs, in whatever circumstances, to promptly seek and follow confidential professional advice about the need to undergo testing. This requirement means that HCWs 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 HCWs already in post.' *Integrated Guidance on Health Clearance of Healthcare Workers and the Management of Healthcare Workers Living with Bloodborne Viruses (Hepatitis B, Hepatitis C and HIV).*	
Duration of certification: Indefinite duration ☐ Specified duration ☐ **If 'specified duration', please provide date of expiry of certification:** _____	
Occupational Health Signature: _____ **Print:** _____ **Date of certificate:** _____	

Appendix 8 – Risk assessment

LOCAL RISK ASSESSMENT FORM FOR HEALTHCARE WORKERS PERFORMING EPPS DIAGNOSED WITH A BLOOD-BORNE VIRUS

STRICTLY CONFIDENTIAL

This form should be used in conjunction with **Chapter 8** (Investigation of a HCW diagnosed with BBV: risk assessment process, indications for undertaking a look back review and look back procedures) of the Integrated Guidance on Health Clearance of Healthcare Workers and the Management of Healthcare Workers living with Bloodborne Viruses (Hepatitis B, Hepatitis C and HIV). This form may help guide a local risk assessment and can be used and/or adapted as deemed appropriate.

Case name:	
Date of birth:	
Date of risk assessment	

Names and roles of experts undertaking local risk assessment:

(This assessment must be carried out by a minimum of three experts to include public health/Medical Officer of Health and also drawn from disciplines such as occupational medicine, clinical microbiology and infectious diseases)

Name	Role/Title

DIAGNOSIS

1. **What blood borne virus (BBV) infection(s) has the HCW been diagnosed with? Please give subtype or genotype if known.**

☐Hepatitis B	
☐Hepatitis C	
☐HIV	

2. **How did the infection come to be known about? (Tick relevant box)**

☐ Occupational Exposure Follow Up

☐ STI Screening

☐ Antenatal Screening

☐ Blood Donation Screening

☐ Symptomatic/Seroconversion illness

☐ Other (please specify below)

RISK FACTORS FOR ACQUIRING INFECTION

3. **Does the HCW have any risk factors for their infection? Please tick all boxes that apply.**

☐Sexual exposure to a case of HBV, HCV or HIV or frequent change of partners with condomless sex

☐ Contact of a case in their household setting

☐ Person who injects drugs

☐ Person who uses drugs but does not inject e.g. snorting cocaine

☐ Renal dialysis patient

☐ Recipient of blood/blood products

☐ Recipient of organ/tissue transplant

☐ Occupational exposure (needlestick/blood/ body fluid exposure)

☐ Non-occupational needlestick, other injury involving blood or body fluid exposure

☐ Tattooing since EPP clearance

☐ Body piercing (except earlobe) since EPP clearance

☐ Acupuncture since EPP clearance

☐ Travel to endemic country with sexual or other exposures

☐ Nosocomial exposure (All surgical and dental procedures or any hospital attendance in the past six months)

☐ Diabetes

☐ Other exposure–please provide details _____

☐ No known risk exposure

If yes to any risk factors, please give further details and state whether the risk is ongoing.

4. **When (if known) was the HCW likely to have acquired their infection?**

5. **What was the date of their first positive test and/or diagnosis for their infection?**

Date 1st positive test	Test result

6. **Is there evidence of co-infection with another bloodborne virus?**

☐ Yes

☐ No

If yes, please give details including mode of transmission and treatment history

7. **What were the dates of their last negative tests for HIV, hepatitis B and hepatitis C if known?**

Last negative test for	Test date	Additional comments
HIV		
Hepatitis B		
Hepatitis C		

8. **Note dates and result, including numerical levels, of all relevant tests undertaken. Please add in extra columns as required.**

HIV					
Date (In chronological order)					

HIV					
Setting (Such as STI clinic, OH,Ireland/ abroad)					
Identity validated sample (IVS) standard? (Yes or no)					
Ag/Ab result (Negative or positive)					
HIV RNA viral load (Full number with unit)					
CD4 count					
On treatment? (Yes or no)					

Hepatitis B					
Date (In chronological order)					
Setting (Such as STI clinic, OH, Ireland/ abroad)					
Identity validated sample (IVS) standard? (Yes or no)					
HBV surface Ag [HBsAg] (Negative or positive)					
HBV core Ab [HBcAb] (Negative or positive)					
HBV envelope Ag [HBeAg] (Negative or positive)					

Hepatitis B					
HBV surface Ab [HBsAb] (Negative or positive)					
HBV DNA viral load (full number with unit)					
On treatment (Yes or no)					

Hepatitis C					
Date (In chronological order)					
Setting (Such as STI clinic, OH, Ireland/abroad)					
Identity validated sample (IVS) standard? (Yes or no)					
Viral load (if quantitative) Positive or negative (if qualitative)					
HCV RNA (Negative or positive) Please indicate if SVR12/SVR24 or unknown					
HCV Ab (Negative or positive)					
Genotype					
On treatment? (Yes or no)					

9. Has the HCW been vaccinated for hepatitis B?

☐ Yes

☐ No

If yes, please provide dates and response status.

10. Is stored serum available from any previous tests?

☐ Yes

☐ No

If yes, has it been re-tested?

☐ Yes

☐ No

If serum has been re-tested, please give results, including numerical values.

HEALTHCARE WORKER TREATMENT AND HEALTH STATUS

11. Is the HCW receiving treatment for the BBV infection?

☐ Yes

☐ No

If yes, please give details. If the HCW is taking medication, please comment on their adherence (if known).

12. Is there any known evidence of behavioural, physical, neurological or psychological issues that could impair the HCWs ability to practice safely (for example, follow IPC advice, reporting issues and carrying out procedures safely)?

☐ Yes

☐ No

If yes, provide details.

DOCUMENTED TRANSMISSION TO PATIENTS

13. Have there been any transmissions from the HCW to patients?

☐ Yes

☐ No

If yes, please give details.

OCCUPATIONAL INFORMATION

14. List current employment and details of Exposure Prone Procedure (EPP) work. Depending on the circumstances, previous employer and EPP details may also be required (Add further information as required)

Start date of current employment	Role and specialty	Employer	Details of EPPs performed

15. List dates of clearance by occupational health

Date of clearance	Occupational Health Dept

16. If relevant, have they attended all monitoring tests?

☐ Yes

☐ No

If no, provide further details

17. Has the healthcare worker been restricted from undertaking EPPs?

☐ Yes
☐ No

If yes, on which date? If no, include reasons.

RISKS/ POTENTIAL ISSUES OF CONCERN

18. Has the HCW ever had evidence of a skin condition on his/her hands that potentially created an exit portal for BBVs (e.g. dermatitis)?

☐ Yes
☐ No

If yes, provide details.

19. Has the HCW had percutaneous injuries that exposed a patient to the HCW's blood (both reported and unreported)?

☐ Yes
☐ No

If yes, include details and management of the incident.

20. Has the HCW ever noted blood on his/her hands after removal of surgical gloves following procedures performed on patients?

☐ Yes
☐ No

If yes, include details and management of incident.

21. Are there any areas of concern regarding the HCW's practice? For example, compliance with standard infection prevention and control procedures, appropriate continuous professional development or fitness to practice.

☐ Yes

☐ No

If yes, include details.

22. Has there been any act or breach of guidance by an employer or others (eg EPP clearance not undertaken) that could have put patients at risk?

☐ Yes

☐ No

If yes, include details.

Summary of Risk Assessment findings

Have risks been identified?

Yes	☐
No	☐

If no risk identified, and an incident has not occurred, inform the HCW of the outcome. Store this risk assessment document confidentially. The confidentiality of the HCW should be maintained. If the clinical line manager of the relevant service was contacted by the Medical Officer of Health to confirm that the HCW's role included EPPs, this same clinical line manager should be informed that no risk exists.

If transmission from the HCW to a patient has been identified or risks exist, a lookback review process must be initiated. Inform the Senior Accountable Officer who will establish a Serious Incident Management Team.

Actions taken based on risk assessment findings:

Form completed by:

Name	
Job title	
Signature	
Date	
Name	
Job title	
Signature	

Date	

Name	
Job title	
Signature	
Date	

Name	
Job title	
Signature	
Date	

Name	
Job title	
Signature	
Date	

Name	
Job title	
Signature	
Date	

Appendix 9: List of groups and organisations invited to stakeholder consultation

- HEIs in Ireland
    - DCU, UCC, NUIG, MU, TCD, UCD, RCSI, TUD, AIT, CIT, UL, DKIT, RSCI, National Ambulance Service College/UG
- National Clinical Leads in surgery, emergency medicine, obstetrics and gynaecology, occupational health, renal medicine and hepatology.
- Infectious disease society
- Irish Society of Clinical Microbiologists
- Society for the Study of STDs in Ireland
- NVRL
- Infection Prevention Society
- Irish Patient's Association
- Irish Dental Association
- Academy of Medical Laboratory Science
- All Private Hospitals (Private Hospital Association)
- Irish College of General Practitioners
- National Ambulance Service
- IMC
- NMBI
- Pre-Hospital Emergency Care Council
- The Dental Council
- Health Information and Quality Authority
- Health and Safety Authority
- AMRIC
- NIAC
- Consultants in Emergency Medicine, STI/HIV clinicians and ID Physicians
- Other named stakeholders in Occupational Medicine and Public Health
- Public Health Service Trade Unions

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