

Needlestick Injuries and Blood Borne Virus Exposure: Code of Practice

Effective: April 2009

Review: March 2012

1. Introduction

Exposure to blood or other potentially infectious body fluids may result in the transmission of blood-borne viruses (BBVs) including HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV). This code of practice is intended to reduce the risk of transmission of these infections following needlestick or other exposures. It is primarily concerned with occupational risks for health care staff and students, but may also be applied to patients attending the A & E department after needlestick or other exposures in the community, when HBV infection is generally likely to be the most important risk. This policy must also be applied to patients or visitors at risk who have received a needlestick injury or blood borne virus exposure.

Advice about other possible occupational risks for health care staff following such exposures, such as less common BBV's or transmissible spongiform encephalopathies (e.g. CJD), should be obtained from the Occupational Health Department, a medical microbiologist, medical staff in Virology at the Health Protection Agency (contact via NGH switchboard) or the doctor on call for Infections Diseases.

1.1 Important Principles

- 1.1.1 All staff will receive training in inoculation incidents as outlined in the Mandatory Training policy.
- 1.1.2 Follow Plan for Action following needlestick injuries (Appendix A)
- 1.1.3 Potential exposure incidents should be reported on the Trust's Datix Incident/Accident reporting system.
- 1.1.4 A risk assessment of all incidents (type of injury and donor risk factors) should be carried out (using Appendix B) by the most senior clinician available at the time and faxed to the Occupational Health Department. The risk assessment should not be carried out by the individual who has sustained the injury.
- 1.1.5 For source patients of unknown serological status, urgent serological testing for BBV infection with informed consent should be the norm. When patients are incapable of giving consent, responsibility for testing must be undertaken by the senior physician and in accordance with the Mental Capacity Act. Bloods should be phoned through then sent to FRH Microbiology Laboratories urgently, bloods being sent from the RVI or NGH should be sent on the hopper using a transport tube available from Leazes reception RVI, General Office NGH or A&E NGH or if done out of hours via hospital taxi.
- 1.1.6 The recipient of the Needlestick injury should contact Occupational Health immediately between 8am and 5pm or A&E NGH/RVI, EAU FRH/ RVI outside of these hours for immediate advice and follow up. All incidents occurring outside of 8am and 5pm must be reported to Occupational Health by the recipient as soon as possible. All donor blood tests for BBV should be

followed up urgently by occupational in hours or the senior physician who took the blood from the patient out of hours. The recipient must be informed of the results of any blood tests.

2. Prevention of Inoculation Injuries

2.1 The purpose of this code of practice is to ensure the safety of hospital personnel and applies to all staff involved in clinical practice.

2.2 General Precautions

1. Blood or body fluid from any individual must be regarded as potentially hazardous.
2. Ensure that all cuts or lesions are covered with a waterproof dressing whilst on duty.
3. Hands must be washed before and after carrying out procedures.
4. Disposable gloves should be worn if exposure to blood or body fluids is anticipated, including mopping up spillages.
5. Great care is required when cleaning non-disposable instruments.

2.3 Prevention of Needlestick/sharp Injuries

1. Never re-sheath needles.
2. Take a sharps box with you when undertaking a procedure so that the sharp may be disposed of immediately.
3. Never allow sharps boxes to become more than two thirds full.
4. It is the responsibility of the senior person on duty to ensure that sharps boxes are checked and changed when two thirds full.
5. Never shake the sharps box contents down. Sharps can fly out of the box causing injury.
6. Always place sharps boxes well away from public access areas at a suitable height, e.g. work surface level or waist level. Never place on the bottom shelf of a trolley or on the floor.
7. Always concentrate on the task in hand and do not allow yourself to be sidetracked.
8. Never leave a used needle or blade unattended. Always dispose of your equipment safely, before undertaking another task.
9. If you find a sharp/needle in an inappropriate place, always take extra care. Report the incident to your Manager.
10. Ensure that needles/sharps do not adhere to gauze, cotton wool swabs, drapes etc, during aseptic/sterile procedures on the ward or in theatre. For

example, never put theatre drapes onto a used scrub trolley as sharps can adhere to drapes from disposable pads. If used sharps cannot be disposed of immediately into a sharps bin during a clinical procedure on the ward, use a galipot or container to keep them safe until they can be disposed of correctly.

11. If handed a sharp instrument, e.g. scissors, scalpel, never take the sharp end first, use a receiver to take the instrument.

3. Risks of Blood Borne Virus (BBV) Infection

In the health care setting transmission of BBV infection most commonly occurs after a sharp injury with exposure to blood. Other body fluids including amniotic fluid, breast milk, cerebrospinal fluid, pleural and peritoneal fluid, blood contaminated saliva, semen, synovial fluid, any other blood stained body fluid, exudates from burns or skin lesions and unfixed tissues or organs also carry some risk.

The risk of transmission of infection depends on:

- The virus involved
- The type of exposure/injury
- Risk factors in the source patient

3.1 The virus involved

The occupational risk of transmission following a significant needlestick/sharp injury has been shown to be about 1 in 3 when the source patient is infected with HBV and is HBe antigen positive in an unvaccinated recipient, about 1 in 30 when the patient is infected with HCV and about 1 in 300 when the patient is infected with HIV.

3.2 The type of exposure/injury

Transmission of BBV can occur after significant contacts or injuries. These are:

- Percutaneous injury due to a needlestick or other sharps injury (highest risk)
- Exposure of mucous membranes, including the eyes or mouth, or of broken skin
- Bites that break the skin of the person bitten

Four factors associated with increased risk of occupationally acquired HIV infection are:

- Deep injury
- Visible blood on the device which caused the injury
- Injury with a needle which has been placed in a source patient's artery or vein
- Terminal HIV-related illness in the source patient.

There is no evidence of transmission of BBV after exposures such as:

- Exposure of intact skin
- Exposure to vomit, faeces or urine (unless visibly blood stained)
- Exposure to sterile or uncontaminated sharps

3.3 Risk Factors in the Source Patient

Not all patients with BBV have had their infections diagnosed. Therefore all blood and body fluids and tissues are regarded as potentially infectious and staff should scrupulously avoid contact with them in all circumstances. Informed consent for testing of the donor patient for HIV and HCV antibodies and HbsAg should be sought urgently (see Section 5.0). This consent should be obtained by someone other than the Needlestick recipient.

4. Staff Duties and Post-Exposure Procedures including reporting arrangements (See Appendix C)

4.1 Following any exposure:

- Skin, wound or non intact skin should be washed with soap and water, but without scrubbing. Antiseptics and skin washes should not be used.
- Free bleeding of puncture wounds should be encouraged gently but wounds should not be sucked.
- Exposed mucus membranes, including conjunctivae, should be irrigated copiously with water, before and after removing any contact lenses.
- Record the source of the exposure (patient's name, unit number etc), on the Risk Assessment Form (appendix D).

4.2 Staff **MUST** report the injury/contamination to the nurse in charge of the clinical area or their supervisor/manager and they, during normal working hours report without delay to the Occupational Health Department. The on-call for Infectious Diseases can be contacted for advice on risk assessment, counselling and need for PEP and must be contacted if the risk is high or involves a known positive patient.

4.3 Managers must ensure staff attend the Occupational Health Department (in office hours) A&E NGH/NGH, EAU RVI & FRH as soon as possible after the incident to enable appropriate follow up care to be given.

4.4 The responsibilities for action following incidents are summarised in appendix A.

4.5 Outside normal working hours, staff must report the injury to the nurse in charge of the clinical area or their supervisor/manager and then report to the Accident and Emergency Department, NGH/RVI, the Emergency Admissions Suite at the Freeman Hospital or RVI. The on-call for Infectious Diseases can be contacted for advice on risk assessment, counselling and need for PEP and must be contacted if the risk is high or involves a known positive patient.

4.6 Patient's or visitor's exposures should be notified to the manager of the clinical area and then the Infectious Diseases on call. Their management will follow the policy as detailed for staff. Incidents involving exposure of patients or visitors should be notified with consent to their GP.

4.7 In all cases a Trust accident/incident record **must** be completed using the DATIX system straight away. The Datix incident number will be required at Occupational Health, A+E, or EAU. – see the Trust Operational Policy and Procedure for Accident and Incident Reporting for further details. A confidential central database will be used to record all significant exposure incidents.

5. Testing and Counselling

Testing of the source patient for blood borne viruses should be the norm, the patient must be consented for testing. Consent given should be recorded within the patients notes and on the laboratory request form, tests will not be performed if patient consent is not confirmed on the laboratory consent form.

To arrange for testing of the donor specimen for BBV contact Freeman Hospital Microbiology Serology Department during office hours and the on-call MLSO out of hours. Forms should indicate that a needlestick incident is involved and that consent has been obtained. Timely delivery to the laboratory should be arranged. Test results should be available ideally within 8 hours and not more than 24 hours after bloods is taken.

- 5.1 A risk assessment of the source patient concerning possible indicators of BBV infections including risk factors, previous tests and suggestive medical history will be undertaken (see appendix D). All source patients will be counselled and informed consent for testing for HBV, HCV and HIV obtained. In hours this should ordinarily be done by the senior clinical staff on the source patient's ward/unit (but not by the recipient of the injury) with support as necessary from Occupational Health and/or the Infectious Diseases on-call. (Appendix A).
- 5.2 Section 1(1)(f) of the Human Tissue Act 2004 allows "relevant material" (which is defined as anything containing cells and would therefore include tissue, whole blood and other body fluids) to be used to obtain scientific or medical information about a person which may affect another person "if done with appropriate consent".

This means that where a source patient lacks the capacity to consent (e.g. because they are unconscious), his/her tissue etc can only be lawfully tested for serious communicable diseases if it is reasonably held to be in his/her best interests in accordance with the Mental Capacity Act 2005. In light of this the GMC withdrew its guidance that set out exceptional circumstances in which the testing of an existing sample might be justifiable.

In the event of a deceased patient being the source of a needlestick injury and whose HIV status is unknown, the taking and testing of samples requires consent in accordance with the Human Tissue Act 2004. Assuming the deceased did not give consent (or refuse it) while alive, this can be obtained from a "nominated representative"(if appointed) or by a person in a "qualifying relationship" to the deceased.

In the event of a Needlestick occurring from an unconscious patient Infectious Diseases should be contacted to discuss PEP and further action.

- 5.3 For all significant occupational exposures, a baseline blood specimen for storage must be taken from the exposed health care worker (see appendix E) by Occupational Health or out of hours in A&E NGH, EAU RVI or FRH. This sample must be a validated sample (the identity of the care worker must be confirmed and documentation needs to occur in notes) as this may be tested later, with the member of staff's consent, for HBV, HCV or HIV infection.

Collection of baseline samples should also be considered for exposures in non-health care settings where the source patient is known to be, or strongly suspected to be, infected with a BBV. Baseline samples will be stored for 2 years.

- 5.4 For patients with known HIV infection, details of past and current antiretroviral therapy should be obtained and the Infectious Disease Consultant / on call registrar contacted for discussion regarding PEP.

6. Post Exposure Prophylaxis (Appendix D)

6.1 HIV infection

6.1.1 The following regime is now recommended for PEP starter packs:

One Truvada Tablet (300mg tenofovir and 200mg emtricitabine FTC)) once a day

Plus

Two Kaletra film-coated tablets (200mg lopinavir and 50mg ritonavir) twice a day.

- 6.1.2 Advice about PEP in non-healthcare settings or following other types of exposure, eg rape, can be obtained from the doctor on call for Infections Diseases at NGH or, for children, the doctor on call for Paediatric Infectious Diseases at NGH (contact via NGH switchboard). In the case of sexual assault the GUM department should be contacted to ensure appropriate care is given.
- 6.1.3 PEP should not be offered following exposures to low risk materials (eg urine, vomit, saliva, faeces) unless they are visibly bloodstained.
- 6.1.4 Where the HIV status of the source patient is unknown, assessment of possible infectivity will be necessary. This may depend on information from the history, the examination and the results of previous investigations of the patient. Testing the source patient for HIV antibody should be the norm but will usually entail obtaining informed consent from the patient (see section 5). If the source patient is strongly suspected to be infected with HIV, the health care worker should take PEP until consent has been obtained and the test result is known.
- 6.1.5 If the patient is unable to give consent, or refuses to, but is strongly suspected to be infected with HIV, the health care worker should take PEP, if appropriate, until consent has been obtained and the test result is known (see section 4.2). If there are delays in obtaining test results, if the donor patient has significant risks, the HCW should take PEP until definitive information is available, if necessary by testing without consent. This should be a consultant decision.
- 6.1.6 Advice on whether to recommend PEP can be obtained from the doctor on call for Infections Diseases at NGH (contact via Trust switchboard).
- 6.1.7 PEP is most likely to be effective when initiated as soon as possible (within hours, and certainly within 48-72 hours of exposure) and continued for 28 days. PEP is generally not recommended beyond 72 hours post-exposure

and should only be initiated on the recommendation of an Infectious Disease Consultant.

6.1.8 PEP starter packs are available on Ward 25 at NGH, A&E NGH, EAU RVI and FRH

6.1.9 In certain circumstances the choice of drugs may require modification eg depending on the medical history of the member of staff; depending on whether they are taking any other medication; where the virus may have developed resistance to the recommended drugs; or if the member of staff is pregnant. In ALL circumstances, expert advice should be obtained immediately before starting PEP, from the Infectious Diseases Team at NGH.

6.1.10 Pharmacy will ensure that PEP starter packs are kept in date.

6.2 Hepatitis B Infection

6.2.1 Following significant exposures (see section 2.2) the source patient should be tested urgently, with consent, for hepatitis B surface antigen. If the source patient refuses consent, manage as though exposure has been to an HBsAg positive source (see section 6.2.7). Serological and clinical follow up for other BBV should also be undertaken.

6.2.2 If the source patient is unidentifiable or unavailable for testing, including most needlestick injuries in the community, manage as an unknown source exposure (see section 6.2.4 and table, Appendix A). It is seldom appropriate to test discarded needles and syringes; they should generally be safely disposed of instead. Serological and clinical follow up (including other BBV) should be undertaken.

6.2.3 The exposed member of staff's hepatitis B (HB) vaccination status and anti-HBs results, should be established from existing records or through urgent testing and hepatitis B prophylaxis given according to HBsAg/Ab status of the source patient and the recipient (see table, page 11).

6.2.4 Following unknown source exposures, recipients with no history of hepatitis B (HB) vaccination and those who have previously received only one dose of the vaccine, should be offered an accelerated course of HB vaccine (with doses at 0, 1 and 2 months, and a booster dose at 12 months for those at continuing risk of exposure to hepatitis B). Patients should be given the first dose at presentation and arrangements made to complete the course. Staff, who previously received 2 or more doses of HB vaccine, but are unknown hepatitis B status, should be offered a single dose of the vaccine.

6.2.5 Known responders to HB vaccine, ie hepatitis B surface antibody (anti-HBs) level > 10 miU/ml either following initial course or booster dose(s) of vaccine, will not require prophylaxis after unknown source exposure incidents, though the occasion may provide an opportunity to give a "routine" booster dose of HB vaccine.

6.2.6 Known non-responders to the vaccine, (hepatitis B surface antibody (anti-HBs) level < 10 miU/ml) following a booster dose of HB vaccine, will require hepatitis B immunoglobulin (HBIG), after significant exposures from unknown

sources. This can be obtained by contacting medical staff at the Public Health Laboratory at NGH or via the trust switchboard out of hours.

6.2.7 Following exposures to HBsAg positive sources, staff with no history of HB vaccine, staff who have received only one dose of vaccine and staff who are known non-responders to the vaccine will require hepatitis B immunoglobulin (HBIG). This can be obtained by contacting one of the medical staff in the Public Health Laboratory, NGH or out of hours via the trusts switchboard.

6.2.8 Specific hepatitis B prophylaxis is not required for exposures to HBsAg negative sources or non-significant exposures, but exposed staff who have not previously received HB vaccine and who are at continuing risk of exposure to hepatitis B should start a course of vaccine. Staff who have received part of a course should complete it as originally planned.

6.3 Hepatitis C

6.3.1 Following significant exposures (see section 3.2) the source patient should be tested with consent for hepatitis C antibody. Patients who are hepatitis C antibody positive should also be tested for HCV RNA.

6.3.2 Any Needlestick injury involving a patient who is HCV positive should be discussed with the ID On Call and follow up of the recipient arranged with ID.

7. Follow up Action

7.1 All health care workers occupationally exposed to HIV, HCV or HBV should have follow up counselling, post-exposure testing and medical evaluation whether or not they have received PEP. Healthcare workers employed in roles classified as EPP must attend all follow up appointments and have post-exposure testing performed within the Occupational Health Department.

7.2 Occupational exposures to patients who are known to have a BBV infection should be reported in confidence to the PHLS Communicable Disease Surveillance Centre (CDSC).

7.3 Any acute illness compatible with a diagnosis of a BBV infection that occurs during the follow up period should be reported to the Occupational Health Department or Department of Infectious Diseases and appropriate diagnostic tests performed.

7.5 All high risk injuries, recipients put on PEP, recipients requiring HBIG or rapid hep B vaccination or with exposure to HCV RNA positive material should be followed up by Infectious Diseases who will liaise closely with the Occupational Health Department

7.6 Any occupationally acquired BBV infection should be reported to CDSC.

8. Monitoring

Incident reports from Datix including inoculation incidents will be reported by the Health and Safety Advisors to the Health and Safety Committee on a quarterly basis. In addition, the Lead Nurse Manager for Occupational Health will present a detailed analysis of inoculation incidents (including those reported to RIDDOR and where prophylaxis given) quarterly to the Health and Safety Committee. The Health and Safety Committee will

review both reports, develop action plans to correct any identified deficiencies and monitor these through to completion.

Author: Deputy Lead Nurse Manager, Occupational Health Service

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Plan of action following needlestick injuries.

8am - 5 pm weekdays

Recipient

1. Wash area with soap and running water immediately.
2. Encourage bleeding if skin is broken.
3. Inform nurse in charge of clinical area.
4. Complete DATIX incident form and take a note of the incident number.
5. Report injury to Occupational health using DATIX incident number.

Nurse in Charge

1. Ensure protocol is followed and incident form completed.
2. Release staff member from work to attend Occupational Health for immediate follow up.

SHO/Registrar/Consultant based in clinical area

1. Perform risk assessment of patient
2. Consent donor for HIV/HBV and HCV antibody tests, if unable to consent e.g. donor unconscious, contact Infectious Diseases on-call.
3. Take blood from donor or needlestick injury in red topped tube, send to Freeman Hospital Microbiology **urgently, marked needlestick injury donor** and indicate on form that consent was obtained.
4. Phone FRH Microbiology Department to advise of lab request .

5pm - 8 am and weekends/bank holidays

Recipient

1. Contact nurse in charge of clinical area
2. Report to A & E at NGH/RVI, EAU at FRH/RVI.
3. Fill in incident form via DATIX and **report injury to Occupational Health during next office hours using Datix incident number.**

Nurse in charge of clinical area:

1. Inform Registrar on-call.
2. Ensure protocol is followed and incident form completed.

Nurse in charge of A & E/EAU RVI/FRH

1. Ensure protocol followed.
2. Liaise with medical registrar on-call to ensure protocol is followed, especially blood taken from donor and ID physician on-call is contacted for high risk injuries.

Registrar on-call

1. Risk assessment of patient.
2. Consent donor for HIV/HBV and HCV antibody tests.
3. Take blood from donor of needlestick injury in red topped tube, send to Freeman Hospital Microbiology **urgently** marked needlestick injury donor.
4. Phone FRH Microbiology Department to ensure blood tests are performed urgently results should be available within 8 hours
5. If high risk needlestick injury or in any doubt contact ID physician on-call.

Risk Assessment form

Name of person completing assessment _____
Contact number _____
Date _____ Time _____ Ward/dept _____

Donor Patient Sticker

Question	Yes	No
1) Is this individual HIV positive?		
2) Is this individual a carrier of Hepatitis B?		
3) Is this individual a carrier of Hepatitis C?		
4) Is there a history of recreational drug injection?		
5) Is there a history of bi-sexual, homosexual practice, prostitute contact, sexual contact with partner from area with high prevalence for blood borne virus (BBV)?		
6) Is there a history of frequent changes of sexual partners?		
7) Has this individual had major trauma or surgery abroad where routine screening of blood products may be questionable?		
8) Has this individual received plasma products prior to 1985 (in the UK)?		
9) Has this individual been resident or worked in an area where BBVs are endemic?		
10) Does this individual have multiple tattoos?		
11) Does this individual have multiple piercings?		
12) Has this individual received a blood transfusion prior to 1992 (in the UK)?		
13) Does this individual have a disorder which requires transfusions of blood or blood products?		

IMPORTANT: All donors of needlestick injuries must be consented and tested for HIV, HBV and HCV serology. Test results must be available within 8 hours.

If YES to Q 1-9 or high index of suspicion for BBV infection: High risk, phone ID on-call for advice about post exposure prophylaxis (PEP).

If YES to Q 10-14: Medium risk, consider pep but may wait for serology – phone ID if in doubt.

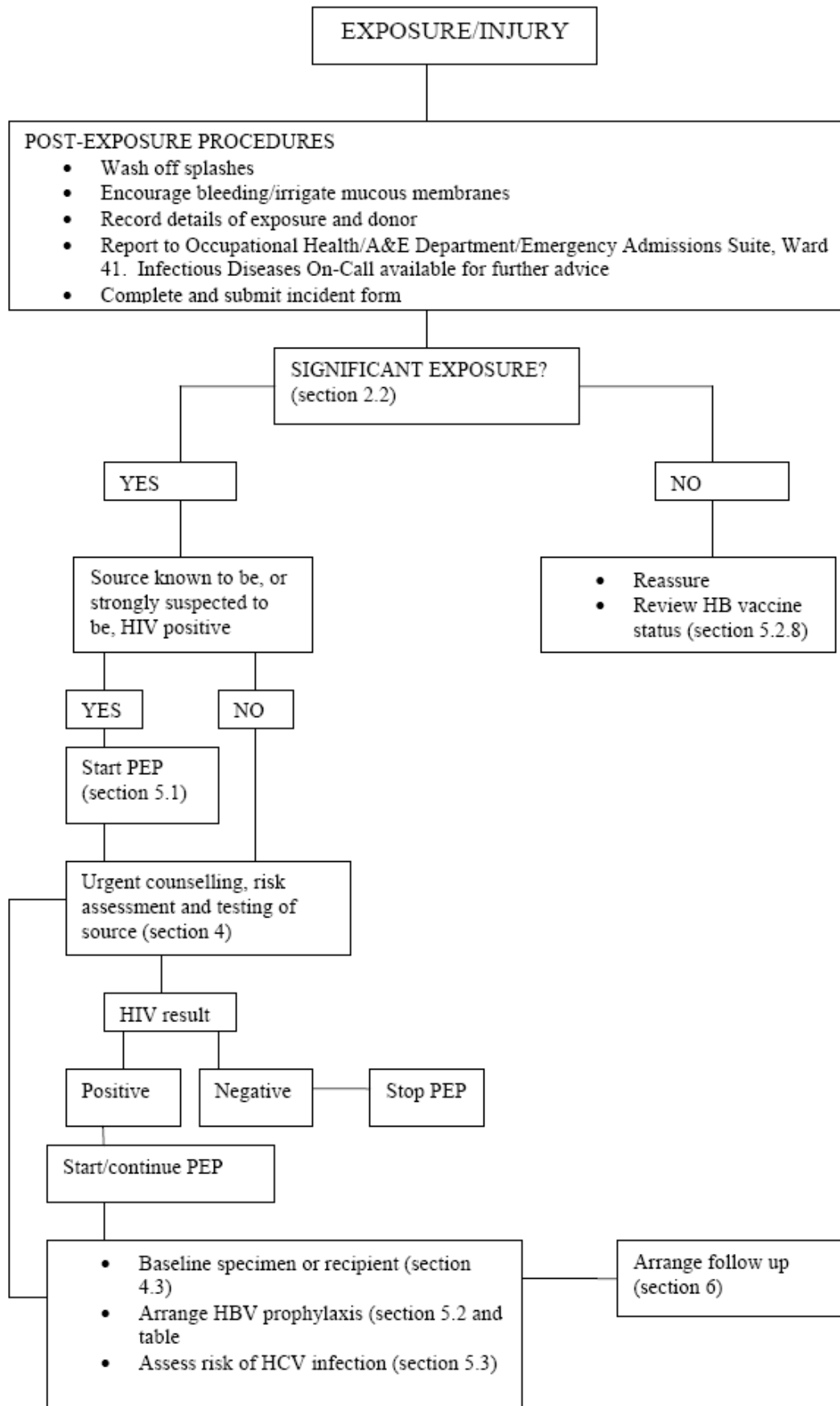
If NO/don't know to all questions: Await serology on donor patient.

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FOR OFFICE USE ONLY

Recipient of Injury_____

Contact Telephone number_____



HEPATITIS B VIRUS (HBV) PROPHYLAXIS					
	Significant Exposure			Non-significant Exposure	
HBV status of recipient	HBsAG positive source	Unknown source	HBsAG negative source	Continued risk	No further risk
≤ 1 dose JIB vaccine pre-Exposure Reassurance	Accelerated course HB vaccine ¹ HBIG ²	Accelerated course of HB vaccine ¹	Initiate course of HB vaccine	Initiate course of HB vaccine	No HBV prophylaxis Reassure
≤ 2 doses HB vaccines pre-exposure (anti-HBs not known)	One dose of HB vaccine followed by second dose HB vaccine one month later	Finish course of HB vaccine	Finish course of HB vaccine	Finish course of HB vaccine	No HBV prophylaxis Reassure
Known responder to HB (anti-HBs.10miU/rn 1 either following initial course or booster doses(s) of vaccine	Consider booster dose of HB vaccine ²	Consider booster dose of HB vaccine ²	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	No HBV prophylaxis Reassure
Known non-responder to HB vaccine (anti-HBs<10miU/ml 2 – 4 months post vaccination	HBIG ² consider booster dose of HB vaccine	HBIG ² consider booster dose of HB vaccine	No HIBG consider booster dose of HB vaccine	No HBIG consider booster dose of HB vaccine	No HBV prophylaxis Reassurance
<p>¹ An accelerated course of vaccine consists of doses space 1, 1 and 2 months. A booster is given at 12 months to those at continuing risk of exposure to hepatitis B (HB)</p> <p>² Hepatitis B immunoglobulin (HBI6) is obtained by contacting one of the medical staff in the Public Health Laboratory, NGH or the Virology doctor on call (rota available at switchboard)</p>					

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Needlestick Injuries and Bloodborne Virus Exposures: Code of Practice	Policy Author:	Dr E Ong Dr A Price Dr H Paterson B Goodfellow Deputy Lead Nurse OH
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).	No	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d)	Can we reduce the impact by taking different action?	N/A	

Comments:	Action Plan due (or Not Applicable): N/A
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Name and Designation of Person responsible for completion of this form: Barbara Goodfellow Deputy Lead Nurse Occupational Health Date: 26/03/2009
Names & Designations of those involved in the impact assessment screening process: Barbara Goodfellow – Deputy Lead Nurse OH Ray Fagg Lead Nurse Manager OH
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(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Helen Lamont, Deputy Director Nursing & Patient Services, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.