Mid Essex Hospital Services NHS
NHS Trust

Staff Immunisation and Health Screening Policy	**Policy** **Register No: 08037** **Status: Public**

Developed in response to:	Best Practice
Contributes to CQC Outcomes:	12

Consulted With	**Individual/Body**	**Date**
Director of HR	Bernard Scully	December 2016
Director of Nursing	Catherine Geddes	December 2016
Medical Director	Dr Robert Ghosh	December 2016
Consultant Microbiologist	Dr Louise Teare	December 2016
Matron Infection Prevention	Amanda Kirkham	December 2016
MEHT Clinical Directors		December 2016
MEHT Lead Nurses		December 2016
Professionally Approved By	Louise Teare, Consultant Microbiologist	10 January 2017

Version Number	3.0
Issuing Directorate	Human Resources
Ratified by:	Document Ratification Group
Ratified on:	26th January 2017
Trust Executive Board Date	February 2017
Implementation Date	17th February 2017
Next Review Date	January 2020
Author/Contact for Information	Catherine Paget
Policy to be followed by (target staff)	All Staff
Distribution Method	Intranet & Website
Related Trust Policies (to be read in conjunction with) All Infection Control Policies Consent Policy Investigation of and learning from Adverse Events, Complaints and Claims Policy Risk Management Strategy and Policy Mandatory Training Policy (incorporating training needs analysis grid) Supporting staff in an adverse event incorporating incidents, complaints and claims Waste Policy and Linen Policy Safe Handling and Disposal of Sharps	

Document Review History

Version No	Authored/Reviewed by	Active from Date
1.0	Cathy Paget	2008
2.0	Cathy Paget	June 2013
3.0	Cathy Paget	17 February 2017

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Appendices

1.. Purpose

1.1 The purpose of this policy is to ensure that all employees are adequately screened and appropriately immunised against infectious diseases to reduce the risks of infection transmission to staff and patients.

1.2 Immunisation is to:

- Protect the employee and their family from an occupationally acquired infection
- Protect patients and service users from acquiring infections from staff
- Allow for efficient running of services with minimal disruption due to work restrictions following staff exposure to infectious diseases

2. Introduction

2.1 The Trust acknowledges its responsibilities to do all that is reasonably practicable to reduce the risks of infection to employees and patients and to comply with all specific health and safety legislation.

2.2 The Control of Substances Hazardous to Health (COSHH) Regulations 2002 require all employers to assess the risks from exposure to hazardous substances, including pathogens (named biological agents in COSHH) and to introduce necessary measures to protect workers and others who may be exposed from those risks as far as is reasonably practicable.

2.3 Any vaccine preventable disease that is transmissible from person to person poses a risk to both healthcare workers and their patients. Healthcare workers have a duty of care towards their patients which includes taking reasonable precautions to protect themselves from communicable diseases, including by appropriate immunisations.

2.4 Immunisation is one of the possible control measures available to protect employees from the occupational risk of contracting communicable diseases; however it should not be considered as a substitute to compliance with good infection control principles.

2.5 National guidance lays down certain screening requirements for patient safety. Certain blood-borne virus screening is mandatory for all staff members who perform invasive exposure prone procedures (EPP). If infected with a blood-borne virus, confidential advice must be sought from the Occupational Health & Wellbeing service. Certain cases work practices will be restricted if the employee is deemed to be potentially infectious to patients

3. Scope

3.1 This policy applies to all healthcare workers employed by Mid Essex Hospital Services NHS Trust, including bank, locum, visiting healthcare workers and volunteers.

4. Definitions

Healthcare Worker (HCW)	This is the term used for staff involved in direct patient care. This includes: • Doctors • Nurses • Midwives • Dentists • Healthcare assistants • Occupational Therapists • Physiotherapists • Radiographers Students and volunteers working in these disciplines should be included; for example observers, clinical placement. This group of staff can be subdivided into those who perform exposure prone procedures and those who do not.
New Health care worker	A 'new' HCW is one starting work or training in the NHS for the first-time from August 2007.
Exposure Prone Procedures (EPP)	Exposure prone procedures are those invasive procedures where there is a risk that injury to the worker may result in exposure of the patients open tissues to the blood of the worker. These include procedures where the workers gloved hands may be in contact with a sharp instrument, needle-tips or sharp tissues (e.g. spicules of bone or teeth) inside a patients open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.
Support Staff	This staff group includes staff who can have regular face to face patient contact and/or contact with specimens and/or clinical waste, for example: • Porters • Cleaners • Ward assistants • Housekeeping staff • Incinerator technicians
Non-HCW staff with patient contact	This group includes staff who are not involved with clinical care but have regular face to face patient contact, for example: • Ward clerks • Receptionists in clinical areas
Staff with no regular contact with patients / specimens	This group includes staff who work in administrative or support roles who do not have regular face to face contact with patients, for example: • Non-clinical managers • Secretarial staff • Administration and clerical staff • Support staff working in non-clinical areas

Laboratory Staff	This staff group includes: Staff who work with clinical specimens in the laboratory setting e.g. • Haematology • Biochemistry • Microbiology; and staff who work in this area if they are involved in the handling of specimens or clinical waste, e.g. • Cleaners • Porters • Receptionists • Secretaries
Staff working in special occupational risk areas	Certain work areas have been identified as posing increased risk of vaccine-preventable occupationally acquired infections. These risks include • Infectious disease wards • Mortuary • Incinerator • Microbiology laboratories All staff working in these areas in contact with patients, specimens and/or clinical waste are included in the special risk group.
Staff working in special patient risk areas	Areas of high risk to patients, involve patients who are: • Immunocompromised • In an intensive care setting or • Pregnant • Children (as they may remain susceptible to infections to which they may not have been previously exposed) All staff working in these areas in contact with patients, specimens and/or clinical waste are included in the special risk group.
New entrant (UK)	This term refers to those staff starting in employment (including returnees to the NHS) who have lived in a country with a high prevalence of tuberculosis for a period of **three months or more** within the past five years.
Observers	This term refers to those individuals hosted by the Trust to observe clinical work practices. They should not be involved in direct clinical contact with patients but may have social contact.
Returnee to the NHS	A returnee to the NHS is a new member of staff starting in employment following a period of **three months or more** out of NHS service. This includes returnees who have been working for private or locum agencies in the UK and those who have spent time outside the UK, e.g. • Voluntary service with medical charities • Extended electives • Sabbaticals (including tours of duty with the armed

	services) • Periods of unemployment Staff are only considered returnees **if they have had a period of three months or more out of service in the NHS**.
High prevalence countries for tuberculosis (TB)	High prevalence countries for TB are those where the prevalence is greater than 40 cases per 100,000 population. Up to date lists can be found online at PHE tuberculosis information.
Identified Verified Sample (IVS)	An IVS is defined according to the following criteria: The employee should show proof of identity with a photograph when the sample is taken. Acceptable ID includes: • NHS Trust ID badge • Photo Drivers licence • Passport The sample of blood must be taken in the OH Department Samples should be delivered to the laboratory in the usual manner not transported by the employee. When results are received the clinical notes should be checked for a record that the sample was sent by the OH department at the relevant time.
Temperate Regions	Temperate regions are defined as: • United Kingdom • Rest of Europe • North America • Antipodes • Middle east • Indian sub-continent
Tropical regions	Tropical regions are defined as • Sub-Saharan Africa • Southeast Asia • The Caribbean • Central America
Volunteers	Volunteers are individuals engaged through the voluntary services department to help support services in the Trust. This may involve patient contact and in these circumstances should be screened to the same level as non-HCW with patient contact.
OHP	Occupational Health Physician.
IGRA / T-SPOT	Interferon Gamma Release Assay. These are blood tests to detect infection with Tuberculosis. They do not differentiate between latent infection and disease.

5. Roles and Responsibilities

5.1 The Infection Prevention Committee

5.2 The Director of Infection Prevention & Control and the Infection Control team will provide expert advice as appropriate in relation to all matters covered in this policy. In the production of this policy the Infection Prevention Committee is responsible for receiving information from and advising on:

- Reports of infections and infection control problems including national reports and initiatives that may affect patient or staff health
- Specific requirements for the management of infection outbreaks that require staff screening and vaccination
- Infection control programmes undertaken by the Occupational Health & Wellbeing service

5.3 The Health and Safety Committee

5.3.1 The Health and Safety Committee is the forum for consulting with elected representatives of employee safety and staffside safety representatives on matters of health and safety and welfare as required under legislation. The Committee meets on a quarterly basis.

5.4 The Chief Executive

5.4.1 The Chief Executive has overall responsibility for ensuring Mid Essex Hospital Services NHS Trust has robust, complete and up to date procedures in place to govern and guide activities so that legal and national requirements are met.

5.5 The Director of Infection Prevention and Control (DIPC)

5.5.1 The DIPC is responsible for ensuring that the Trust has strategies to prevent avoidable HCAIs. The DIPC has corporate responsibility for infection prevention and control throughout the Trust as delegated by the Chief Executive Officer. They also monitor trends relating to needlestick, sharps and body fluid exposure incidents within the Trust.

5.6 Managers

5.6.1 Section 9 of the Health and Safety at Work Act 1974 requires that employers provide a healthy and safe working environment for their employees. It is the responsibility of line managers to ensure that their staff members comply with this policy.

5.6.2 All managers must

- Ensure that Trust employment processes are followed correctly
- Ensure that staff members do not start work until they have received appropriate health clearance
- Not allow their staff to undertake EPPs until health clearance is issued (this information is provided on the OH health clearance certificate)
- Ensure that risk assessments have been undertaken for all tasks involving exposure to infectious diseases

- Ensure that all new staff attend OH for an immunisation review in a nurse clinic within the first month of commencing in post if recommended following health screening and act upon the OH advice received
- Ensure that staff re-attend OH for appropriate follow-up screening as required
- Keep records of staff members who are not immune and therefore should not work in high risk clinical areas, and ensure that individual risk assessments are performed in these cases with advice from OH and/or infection control
- Contact infection control and/or OH for further advice if specific disease outbreaks occur in their work area
- Ensure that all staff members handling food and anyone working in a food handling area knows to report the symptoms of infection and if they have close contact with someone with these symptoms

5.7 **All employees**

5.7.1 Section 7 of the Health and Safety at Work Act 1974 requires that employees follow all health and safety policies designed to protect their health whilst at work.

5.7.2 Healthcare professionals have a responsibility under their professional codes of conduct to ensure that they are not at risk of infection or transmission of a disease that may affect patient safety.

5.7.3 All employees must:

- Provide accurate vaccination history when requested and allow for their immunisation data to be held by their manager on an electronic record
- Attend OH for screening tests or immunisation review if requested to do so by their manager, OH or infection control
- Inform OH if they know themselves to be infected with a blood borne virus and attend for OH appointments when requested
- Keep personal records of vaccinations and immunisation status for future reference
- Attend OH in good time for screening when required
- Advise their manager if they are not immune and at risk of infection or transmission of infectious disease in the workplace
- Attend review appointments with an OH practitioner, for advice and guidance if they decline any recommended vaccination (managers will be informed if not immune and employee work practices may be restricted)
- Contact OH if they have any queries regarding immunisation requirements

5.8 **The Occupational Health & Wellbeing Service**

5.8.1 The Effective Management of OH and Safety Services in the NHS require all OH services to provide a comprehensive occupational immunisation programme including:

- Tuberculosis
- Rubella
- Measles
- Varicella (chickenpox)
- Hepatitis B
- Other conditions where occupationally relevant

5.8.2 The Occupational Health & Wellbeing service will:

- Undertake health screening on employment in line with current employment processes
- Perform appropriate screening if individuals provide inadequate evidence of immunity/ non-infectivity
- Issue health clearance for EPP roles only when appropriate screening results have been obtained
- Advise on immunisations required for specific work areas
- Offer appropriate immunisations to all staff
- Offer appointments at the request of line managers
- Provide screening to determine immunisation status
- Document immunisation status of staff in their OH clinical record and provide copies of immunisation / infection screening records for the individuals to collect from the Occupational Health & Wellbeing service
- Provide individuals with an updated immunisation report following each immunisation / infection screening activity
- Recall staff for further vaccination / screening when required
- Provide confidential advice and support to staff that have, or develop an infectious disease

5.9 Non Substantive Staff

5.9.1 Agency staff / students / honorary contracts / work placements / Contractors

5.9.2 The Trust requires any staff undertaking work on behalf of the Trust to comply with the vaccination and screening standards outlined within this policy. Those in the Trust responsible for agency contracts will ensure that the organisations they are contracting with comply with Department of Health guidance and the standards within this policy.

5.9.3 Workers from agencies, educational establishments, honorary contract holders (including observers) or individuals on work placement within the Trust who are in patient contact or contact with clinical materials must be screened and immunised to the same standard as Trust staff. The organisation responsible for the individual must ensure that workers are appropriately screened and vaccinated in line with this policy.

5.9.4 If the individual is to perform EPPs, full EPP screening is required. This includes clinical students, agency/locum staff and contract ancillary workers. If these staff access OH services from another provider they should be

advised of the screening and immunisation standards required by the Trust if working or due to work within the Trust.

5.9.5 Vaccination will only be performed in the Trusts Occupational Health department for staff employed by organisations that have an agreement with the OH department to provide such services. Access to appropriate Occupational Health advice is mandatory for all staff whose work involves patient contact.

5.10 **Volunteers**

Most volunteers have very limited patient contact and it would be most unlikely that volunteers would attend to very sick or vulnerable patients. Volunteers should ensure that their routine vaccinations are up to date with their GP. Line managers will ensure that volunteers are not deployed to help with infectious cases and information will be provided for volunteers. Individual cases may require additional risk assessment.

6. Health Screening

6.1 Staff immunisation and infection screening is an important control measure for preventing the spread of infectious diseases. Immunisation and infection screening is performed when staff are appointed to post. Those staff members who are in clinical roles / work in a clinical environment or with clinical specimens are required to complete a pre-placement Health Questionnaire is assessed by the Occupational Health & Wellbeing service.

6.2 This questionnaire is designed to determine if restrictions or further screening / immunisation is required. This screening is performed by questionnaire and in certain situations face to face assessment in OH. If outstanding assessment is required members of staff are requested to attend the Occupational Health & Wellbeing department.

6.3 All members of staff who have direct patient contact will be required to undergo standard screening and immunisation. This includes:

- Tuberculosis (TB)
- Hepatitis B immunisation and screening
- Varicella screen and immunisation where indicated
- Measles, Mumps & Rubella (MMR) screen and immunisation where indicated
- The offer of Hepatitis C and HIV screening

6.4 The staff immunisation screening matrix is found at Appendix 2.

6.5 Additional health checks are required for staff new to the NHS who will be undertaking EPP roles. Additional health checks are also required for existing staff moving to EPP work for the first time. Additional health checks include screening for:

- Hepatitis B surface Antigen
- Hepatitis C antibodies
- HIV

6.6 Health clearance will **not** be issued in the following circumstances:

- Workers recruited to EPP posts with insufficient evidence of hepatitis B, hepatitis C and HIV status
- New staff with symptoms consistent with tuberculosis without recent chest x-ray (CXR) and medical review
- Food handlers who report infection with typhoid / paratyphoid or contact with infected individuals within the last 21 days without receiving further advice from the Health Protection Agency

6.7 In certain circumstances health clearance will be issued if outstanding screening tests and vaccinations are required with advice to the manager that further action is required.

6.8 In the following circumstances individuals are required to attend OH on their **first day of post;** managers are responsible for ensuring staff attend for a further health check if advised on the health clearance certificate:

- New entrants to the NHS are required to attend for BCG scar check and/or IGRA on first day HCWs in special patient risk areas with no history of rubella immunity / vaccination

6.9 In the following circumstances individuals are required to attend OH within **the first month of employment;** managers are responsible for ensuring staff attend the OH department for screening if advised on the fitness certificate:

- Uncertain or no chickenpox / varicella zoster (VZV) immunity
- Uncertain or no rubella immunity – if not performed on first day of employment
- Mantoux test where:
  - No previous reliable BCG evidence
- IGRA where
  - New entrant (UK) to NHS
  - History of previous BCG but no scar and no documentary evidence
  - Positive Mantoux test inconsistent with BCG history
- Special occupational risk areas for diphtheria and/or hepatitis A and/or typhoid vaccine

6.10 The staff groups and screening requirements can be located in the staff immunisation and screening matrix at **Appendix 1.**

7. EPP Screening

7.1 All staff performing EPPs must be screened for hepatitis B. Whether hepatitis C or HIV screening is required will depend on when EPP workers commenced in an EPP post.

7.2 All EPP screening should be performed with an IVS.

7.3 Blood-borne Virus Screening for Non-EPP staff

7.4 All HCWs who <u>do not</u> undertake EPPs are also entitled to access hepatitis B, hepatitis C and HIV screening via Occupational Health. This screening is not mandatory for non-EPP roles however if individuals consider they may be at

risk they should attend for screening. In some situations further screening is recommended, for example non-response to hepatitis B vaccine or unexpected result of TB screening.

7.5 Confidential screening is available via the Occupational Health & Wellbeing service; individuals will be referred to an OHP for further advice if a blood borne virus is identified. Professional codes of practice from regulatory bodies require HCWs to report exposures to communicable diseases. Failure to do so may breach the duty of care to patients. This obligation also applies to staff already in post.

8 Food Handler Screening

8.1 All new members of staff who are appointed to roles which require food handling should complete a supplementary food handler's questionnaire. If identified to an infectious disease which may require further investigation they will undergo further have assessment in the Occupational Health & Wellbeing service.

9 Hepatitis B

9.1 All staff that comes into contact with blood in the course of their work should be vaccinated against hepatitis B. Vaccination is available through the Occupational Health & Wellbeing service for all staff groups within this category.

9.2 Vaccination involves a primary course of three doses of vaccine followed by a blood test to ensure immunity. If immunity is confirmed (i.e. anti HBs >100 iu/l) one five year booster only is recommended. Further boosters may be recommended following occupational exposures to blood or body fluids in line with the Blood Borne Virus Policy.

9.3 If an individual has a poor response (i.e. anti HBs >10 but <100 iu/l) they will be advised to have a further booster vaccination followed by their five year booster.

9.4 If an individual has no response to the vaccine when tested (i.e. anti HBs <10 iu/l) full hepatitis B screen should be undertaken to look for natural infection / immunity (Hepatitis B core antibodies/HbsAg). If negative a repeat vaccination course is performed. If the antibody response remains below10 iu/l then the individual would be classed as a non-responder to the vaccine and advised of appropriate action following a needle stick/mucotaneous incident.

9.5 Vaccination against hepatitis B is mandatory for non-immune HCWs who perform EPPs. Vaccination is available from the Occupational Health & Wellbeing service.

9.6 New HCWs who perform EPPs are required to provide documented evidence of hepatitis immunity/non-infectivity from a confirmed IVS from UK laboratory/ OH department including hepatitis B surface antigen (HBsAg) and antibody (anti HBs) results. If unavailable the HCW is required to attend the Occupational Health & Wellbeing Service for further screening with an IVS to confirm their status.

9.7 Existing staff members who have already undergone screening for hepatitis B for EPP clearance and have a level of antibodies of greater than 100iu/l will not be rescreened unless they present to OH due to concern following a sharps or blood exposure incident.

9.8 If a HCW is known to be a chronic carrier of the hepatitis B virus (ie HBsAg positive) further tests are required to determine if the individual is fit to perform EPPs. All HCWs who have been identified by screening to be HBsAg positive should be seen by an Occupational Health Physician (OHP). All HBsAg positive individuals should be referred to a hepatologist.

9.9 In the following cases EPP clearance will not be authorised:

- HBsAg positive, HBeAg positive
- HBsAg positive, HBeAg negative – viral load $>10^3$ at any time
- HBsAg positive, HBeAg negative – viral load $>10^3$ results within the last 12 months in the absence of antiviral treatment
- HBsAg positive, HBeAg negative – viral load $>10^3$ results within the last three months if on antiviral treatment – assuming viral load has never exceeded 10^3

9.10 The following table indicates Occupational Health monitoring dependent on the outcome of screening:

Status	**EPP clearance expiry**
HBsAg negative, anti HBs unknown as vaccination course incomplete / not provided	One year from date of last HBsAg test
HBsAg negative, anti HBs > 100	None
HBsAg negative, anti HBs 10-100 and anti HBc negative	None
HBsAg negative, anti HBs 10-100 and anti HBc positive – natural immunity	None
HBsAg negative, anti HBs <10 and anti HBc positive – natural immunity	None
HBsAg negative, anti HBs <10, anti HBc negative – True non-responder	One year from date of last HBsAg test
HBsAg positive – e antigen negative, viral load $<10^3$ within the last 12 months	One year from date of last viral load test
HBsAg positive – e antigen negative, viral load test previously less than 10^5 but greater than 10^3. Viral load test less than 10^3 within the last 3 months and on antiviral treatment	Three months from date of last viral load test

9.11 Vaccination against hepatitis B is mandatory for non-immune HCWs who perform EPPs.

10 Hepatitis C

10.1 HCWs that are infected with hepatitis C virus and are RNA positive should not perform EPPs. As there is no vaccine for hepatitis C it is not possible to ensure permanent non-infectivity.

10.2 HCWs who know they are infected with hepatitis C virus or believe they may have been exposed to hepatitis C infection should seek advice from the Occupational Health & Wellbeing service.

10.3 Hepatitis C screening is mandatory for all EPP workers:

- Who entered in training of EPP dependent specialities from January 2003
- New to the NHS or returners to the NHS in EPP dependent specialities from August 2007
- Who believe they have been exposed to hepatitis C where there is a risk of transmission e.g. hepatitis C positive sharps or blood exposure incident

10.4 Screening consists of a hepatitis C antibody test (anti HCV) and if positive hepatitis C virus RNA test.

10.5 If screening tests identify an individual to be infected with hepatitis C (i.e. hepatitis C virus antibody (anti HCV) positive) they should be seen by an Occupational Health Physician. Further RNA tests are required. All anti-HCV positive individuals will be referred to a hepatologist for further treatment and advice.

10.6 HCWs who respond successfully to treatment with antiviral therapy will be allowed to resume EPP work or training. Successful response is defined as remaining hepatitis C RNA negative for six months after the cessation of treatment. There will be on-going assessment by an OHP. The HCW will undergo continued monitoring with sampling in a further six months and be advised accordingly.

10.7 In the following cases EPP clearance will not be authorised:

- Anti HCV positive, HCV RNA positive
- Anti HCV positive, HCV RNA negative but more than six months since the last test

10.8 The following table indicates Occupational Health monitoring on the outcome of screening:

Status	**EPP clearance expiry**
Anti HCV negative	None
Anti HCV positive, HCV RNA negative	Six months from date of last HCV RNA test

11 HIV

11.1 All new HCWs to the NHS working in a role that requires EPPs are required to have a one off test for HIV prior to commencing work in the NHS.

11.2 All other HCWs are also entitled to access the equivalent screening although it is not mandatory for non-EPP roles.

11.3 HIV screening is mandatory for all EPP workers.

- New to the NHS or returners to the NHS in EPP dependent specialities from August 2007
- Who believe they have been exposed to HIV where there is a risk of transmission e.g. HIV positive sharps or blood exposure incident.

11.4 Screening consists of an HIV antibody test (anti-HIV). EPP clearance will not be authorised if a HCW is identified as being HIV positive until further screening has been undertaken. This must be overseen by a Consultant

Occupational Health Physician in liaison with the individuals treating physician.

11.5 If screening tests identify an individual to be HIV positive the individual should be seen by an OHP.

11.6 All HCWs identified as infected with HIV should be under the care of a specialist physician. If they do not have current access to care they will be referred for further treatment advice.

11.7 In addition HIV infected HCWs not undertaking EPPs should be offered an annual review with an OHP to provide advice and to review their work practices.

11.8 HIV positive HCWs who wish to undertake EPPs are required to attend for regular testing every three months.

12. HIV infected HCWs wishing to undertake EPPs

12.1 Please refer to HIV Positive HCW Policy.

12.2 HIV infected HCWs must meet the following criteria before they can perform EPPs:

Either

- Be on effective combination antiretroviral therapy (ART), and
- Have a plasma viral load <200 copies/ml

or

- Be an elite controller (an elite controller is 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 three separate viral load measurements)

and

- Be subject to plasma viral load monitoring every three months and be under joint supervision of a Consultant OHP and their treating physician, and
- Be registered with the UKAP Occupational Health Monitoring Register (UKAP-OHR)

13. Initial health clearance for HIV infected HCWs who wish to perform EPPs

13.1 If a HCW wishing to perform EPPs is known, or is identified as being HIV positive they should be seen by a Consultant OHP for assessment and have the following screening undertaken prior to EPP clearance being issued:

- Two identified and validated blood sample (IVS) test results taken no less than three months apart (for the purposes of initial health clearance, ‘no less than three months apart’ is defined as between 12 and 16 complete calendar weeks)
- And with viral load levels below 200 copies/ml are required to ensure viral load stability (laboratory testing should be undertaken by a Clinical Pathology Accreditation (UK) Limited accredited virology laboratory)

13.2 The decision to clear individual HCWs for work involving EPPs is the responsibility of the Consultant OHP in consultation with the treating

physician. Advice can be sought from UKAP on the application of the policy as needed.

13.3 The following table indicates Occupational Health monitoring dependent on the outcome of initial screening:

Status	EPP clearance expiry
HIV Antibody negative	None
HIV antibody positive – viral load test three months previously <200 and further viral load test <200 within the last three months and on antiviral treatment	Three months from date of last viral load test

14. On-going monitoring of HIV infected HCW wishing to undertake EPPs

14.1 HIV infected HCWs who are cleared to perform EPPs are subject to viral load testingevery three months while continuing to perform such procedures, (for the purposes of initial health clearance, 'no less than three months apart' is defined as between 12 and 16 complete calendar weeks).

14.2 The three month period should be taken from the date the previous IVS was drawn, and not from the date the result was received.

14.3 Quarterly 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. At each screening test the HCW undertaking EPPs will be given a date for their next screening test to ensure they continue to comply with the guidance and their EPP clearance expiry updated.

14.4 If a HCWs plasma viral load rises above 1000 copies/ml, they should be restricted immediately from carrying out EPPs until their viral load returns to being consistently below 200 copies/ ml in at least two tests done no less than three months apart. The significance of any increase in plasma viral load above 200 copies /ml and below 1000 copies/ml should be assessed jointly by the Occupational Health and treating physicians with input from appropriate local experts (e.g. Consultant virologist or microbiologist).

14.5 The table below sets out the expected course of action for viral load test results below and above the level for EPP clearance (200 copies /ml).

Viral load count test result	Action
<50 copies/ml or below	No action – retest in three months
50-200 copies/ml	A case by case approach based on clinical judgement would be taken which may result in no action (as above) or a second test may be done 10 days later to verify the first result. Further action would be informed by the test result.
>200copies/ml but <1000 copies/ml	A second test should automatically be done 10 days later on a new blood sample to verify the first result. If the count was still in excess of 200 copies/ml, the HCW would cease conducting EPPs until their count, in two

	consecutive tests no less than three months apart, was reduced to <200 copies/ml
1000 copies/ml or above	The HCW would cease conducting EPPs immediately. A second test must be done on a new blood sample 10 days later to verify the first result. If the count was still in excess of 1000 copies /ml, a full risk assessment should be initiated to determine the risk of HCW to patient transmission.

15 Tuberculosis Screening

15.1 All new staff in clinical roles / work in a clinical environment or with clinical specimens should have some screening for TB included in their pre-placement 'health at work screening questionnaire'. Pre-placement health screening should be completed for each new job prior to commencing in a new role. Increased screening is recommended for new entrants (UK) to the NHS and returnees to the NHS who have been exposed to during their absence.

15.2 Screening for TB is included in the Health at Work questionnaire:

- An assessment of family or personal history of TB
- Signs and symptoms enquiry
- History of Chest X-Ray (CXR) and results
- A history of living / working overseas to assess if new entrant (UK)

15.3 A staff member will not be cleared as fit to commence work if the individual has symptoms consistent with TB until fully investigated with a CXR and referred to the chest clinic for further investigations.

15.4 Individuals with a past history of TB are requested to provide a medical report detailing treatment and response to treatment prior to health clearance.

15.5 Enhanced screening is performed for staff members working with direct patient contact either providing clinical care or support staff. They should provide evidence of:

- Previous BCG and documented scar check from Occupational Health department or
- Mantoux Test
- IGRA test result

15.6 If no documentary evidence is available the staff member must:

- Attend the Occupational Health & Wellbeing service prior to commencement in post for a BCG scar check and/or Mantoux / IGRA testing.

15.7 New entrants (UK) should have had an IGRA test +/- CXR (unless possibly pregnant) prior to commencement in post. Returnees to the NHS who are new entrants (UK) require an equivalent level of screening.

15.8 In addition to standard screening new entrants (UK) are required to:

- Attend Occupational Health prior to commencement in post for BCG scar check and IGRA test

15.9 Screening is undertaken in line with the two algorithms at Appendix 1.

16 Referral for Medical Assessment for TB

16.1 All staff that has symptoms suggestive of TB, either identified through the Pre-placement process or via contact with the Occupational Health & Wellbeing service for existing staff should be discussed with the OHP as soon as possible for further assessment. Part of this assessment may include organising a CXR, if not recently performed. An appointment must be arranged with the OHP and an IGRA test completed, if not recently completed. Managers will not be routinely advised of attendance unless fitness for work issues or work restrictions are necessary.

16.2 If the CXR is normal and no symptoms consistent with TB are present the staff member may continue at work but is required to attend an appointment with the OHP. If the CXR is abnormal advice will be sought from the chest clinic.

16.3 Staff with a positive IGRA test, or a positive Mantoux test >15mm not in keeping with the individuals BCG history will be referred to the chest clinic.

16.4 If a staff member fails to attend the chest clinic for review following an Occupational Health referral the chest clinic will notify OH of non-attendance. If there is persistent non-attendance the individual's manager will be informed by OH that the individual has not complied with the policy and must attend OH for review and follow further advice.

16.5 Occasionally staff may be referred to the chest clinic via another route (e.g. GP referral) that may also require work restrictions and OH advice. In such situations the TB specialist nurse should inform OH to ensure the individual has received appropriate advice.

17. Symptom Advice

17.1 All staff when attending the Occupational Health & Wellbeing service will also be advised about symptoms of TB and the importance of prompt reporting of symptoms and seeking treatment advice.

18. Occupational Exposure – Symptom Reminders

18.1 If there is a TB incident within a clinical area, OH should be advised of the staff in contact with the patient and reissue further information on symptoms. This should be coordinated by the manager responsible for the work area where the incident occurred.

19. Vaccination Requirement

19.1 **BCG**

19.2 Although vaccination with BCG does not preclude TB, it has been shown to be 70-80% effective against the more severe forms of the disease eg TB meningitis, but less effective at preventing the respiratory disease. Protection will reduce over time and is expected to last 10-15 years.

19.3 In 2005 the national vaccination campaign for vaccinating all school age children was discontinued and vaccination is now only provided for certain

risk groups. HCWs and staff with potential occupational exposure to TB e.g. microbiology laboratory and pathology staff should receive BCG vaccination.

19.4 HCWs, laboratory workers and support staff potentially exposed to patients, clinical specimens and/or waste should be vaccinated with BCG when there is:

- No past history of vaccination or
- No past history of positive skin test for TB
- No past history of a positive IGRA test for TB
- Mantoux test within last 3 months less than 6mm
- No evidence of HIV infection or other contraindications

19.5 Vaccination is mandatory for high risk work areas.

19.6 There is no data on the protection afforded by BCG vaccine when it is given to adults aged 35 years or over, however NICE guidelines on tuberculosis recommend BCG in all unvaccinated HCWs regardless of age. Where the HCW is over 35 years of age an individual assessment of risk should be made prior to vaccination.

19.7 Non HCW staff in regular patient contact, for example ward clerks, volunteers and receptionists would not be routinely vaccinated.

19.8 If an employee declines BCG when it is recommended the employee should be referred to the OH Physician and have the risks explained. The individual's manager will be informed and they should assess workplace risks and the individual may be restricted from working within high risk clinical areas.

20. Rubella

20.1 Rubella vaccine is a single vaccination encompassed in the MMR vaccine. Prior to MMR it was given as a single vaccine.

20.2 All HCWs with regular patient contact, and support staff should provide evidence of immunity to rubella. Sufficient evidence would be either:

- Evidence of vaccination against rubella with a single dose of vaccine or
- Evidence of immunity by blood test – Rubella IgG or
- Evidence of two doses of MMR vaccination

20.3 If insufficient evidence of immunity is provided at initial assessment on employment, the individual will be required to attend the Occupational Health & Wellbeing service for vaccination. Staff members working in special patient risk areas are required to attend prior to commencement in role.

21. Measles

21.1 Measles vaccine is encompassed in the MMR vaccine. Two doses of the vaccine administered one month apart are considered sufficient to assume immunity. Immunity is presumed if born prior to 1958 and a definite history of disease is sufficient; however in high risk areas documentary evidence of immunity is required.

21.2 All HCWs and non-HCW staff in regular patient contact should provide evidence of immunity to measles. Sufficient evidence would be one of:

- Evidence of immunity by blood test – Measles IgG positive

- Written evidence of having received two doses of MMR

21.3 Routine serology testing following vaccination is not required.

21.4 If insufficient evidence of immunity is provided on employment, the individual will be required to attend the Occupational Health & Wellbeing service for vaccination.

22 Mumps

22.1 Mumps vaccine is encompassed in the MMR vaccine. Two doses of the vaccine administered one month apart are considered sufficient to assume immunity.

22.2 No routine screening is performed on any staff group for mumps infection. Many staff will be vaccinated through receiving the MMR vaccine.

22.3 If members of staff are concerned about non-immunity to mumps alone, vaccination should be accessed via their GP.

23. Chickenpox (Varicella zoster – VZV)

Chickenpox immunisation for HCWs and staff in direct patient contact was introduced in 2003.

23.1 HCW and non-HCW staff in regular patient contact in high risk areas should provide evidence of immunity to chickenpox. Sufficient evidence would include:

- History of chickenpox illness and shingles infection if childhood spent in temperate region
- Evidence of immunity by blood test – Varicella zoster IgG
- History of vaccination against varicella – two doses of VZV vaccine three months apart

23.2 Chickenpox is a common childhood illness in the UK; a history of past infection is considered adequate evidence of immunity if raised in the UK or other temperate regions. A history of illness is less reliable to confirm immunity on tropical regions. Serological testing of individuals born and raised in these areas is required and vaccination administered if appropriate.

24. Poliomyelitis

24.1 Polio vaccine is part of the UK national vaccination campaign. Usually five doses of polio containing vaccine administered at appropriate intervals are considered to give satisfactory long-term protection. If the national vaccination schedule is strictly followed the course is usually complete by the age of 15.

24.2 If a course is interrupted and incomplete it is recommended it is resumed and not repeated. The previous oral vaccine has now been replaced by an injectable form of vaccine (included in Td/IPV) which can be used to continue a course.

24.3 Individuals born before 1962 may not have been immunised or have received low-potency polio vaccine. Those who have not received a full five doses should seek advice from their GP or OH.

24.4 All HCWs and support staff should provide evidence of polio immunisation by history of vaccination in childhood.

24.5 All staff working in high risk areas where they regularly handle faecal specimens who are more likely to be exposed to polio virus, evidence of a booster vaccination is required every ten years. These staff groups include:

- Microbiology staff
- Mortuary staff

25. Tetanus

25.1 Primary vaccination against tetanus is usually completed in infancy along with polio vaccination. The first booster is provided three years after the primary course and the second booster dose of Td/IPV should be given to all individuals ideally ten years after the first booster dose.

25.2 No enhanced tetanus vaccination is required outside the standard vaccination campaign.

26. Diphtheria

26.1 Primary vaccination against diphtheria is usually completed in infancy along with polio and tetanus vaccination. The first booster is provided three years after the primary course and the second booster should be given to all individuals ideally ten years after the first booster dose.

26.2 Diphtheria history should be checked for all Microbiology laboratory staff and it is recommended that all staff are vaccinated in line with the national vaccination programme.

26.3 Members of staff who have not received a primary vaccination course will be required to have a full vaccination course. If a booster vaccine is given the individual should attend three months later for repeat blood test to confirm immunity and repeat boosters at ten year intervals thereafter.

26.4 The cut-off level for diphtheria immunity is 0.01 iu/ml for microbiology laboratory staff.

27. Typhoid

27.1 Typhoid fever is rate in the UK as standards of sanitation are high. Usually cases of typhoid or paratyphoid are imported associated with foreign travel or contact with someone who has travelled to an area where typhoid is endemic.

27.2 The only work area identified as having increases occupational risk of contracting typhoid is the microbiology laboratories; staff potentially at risk in these work areas should be vaccinated and receive booster vaccinations every three years**.**

28. Hepatitis A

28.1 Hepatitis A is not included in the national vaccination programme. Improvements in living standards and hygiene have led to a marked fall in the incidence of the disease. Certain risk groups that are vaccinated against hepatitis A include:

- Those with chronic liver disease
- Men who have sex with men

- Haemophiliacs
- IV drug users and
- Those travelling to countries where it is recommended

28.2 These individuals should access vaccination by their GP.

28.3 Most HCWs are not at increased risk of occupationally acquired hepatitis A; routine vaccination is not indicated for all healthcare staff.

29. Influenza

29.1 The Department of Health recommends annual immunisation against seasonal flu for HCWs because it has been shown, in some healthcare settings to reduce morbidity and mortality of patients.

29.2 The Occupational Health & Wellbeing service offers annual flu vaccinations to all Trust staff, actively encouraging uptake amongst frontline staff.

30. Other vaccine preventable infections

30.1 Currently vaccine against the following is not routinely performed for occupational reasons:

- Meningitis C
- Anthrax
- Smallpox

30.2 If certain staff groups are identified to be at increased risk of these infections a risk assessment should be performed and the need for vaccination discussed with the Occupational Health Physician.

31. Infected Healthcare Workers

31.1 Blood-borne virus infections

31.2 If a staff member is identified as having hepatitis B, hepatitis C or HIV whilst in employment an assessment of the individuals work activity will be required. If the individual has worked in a role that may have involved EPPs the Occupational Health Physician should notify the Medical director and director for public health who will review the situation and decide whether a patient notification exercise is warranted, consulting as necessary:

- The Consultant incommunicable Disease Control
- Regional Epidemiologists
- Regional Directors of Public Health
- UKAP

31.3 Hepatitis B and hepatitis C are notifiable diseases; the Occupational Health Physician should ensure the local health protection agency is informed of the diagnosis.

32. Other infections

32.1 If a staff member believes him/herself to be infected with an active infectious disease e.g. chickenpox, measles, TB the individual should restrict him/herself from work and contact the Occupational Health & Wellbeing service or Infection Control team for further advice. If an infectious disease is confirmed further contact tracing may be required.

33. Confidentiality

33.1 Occupational Health records are confidential and are separate from hospital notes. Occupational Health practitioners are ethically and professionally obliged not to release notes or information without the consent of the individual concerned.

33.2 If a HCW is identified as infected, consent is sought to disclose information if there is considered to be a risk to patients or public health. Information on infected HCWs will only be disclosed without consent in exceptional circumstances (where justification made) where it is considered necessary for the purposes of prevention of the spread of infection.

33.3 Maintaining the confidence of a BBV infected HCW in this respect is very important but it is also very important that the HCW is counselled at an early stage about their responsibilities if a patient notification exercise is possible. It is important that HCWs do not share the information with anyone other than those who really need to know. In particular, HCWs should not discuss the problem with colleagues at work. A HCW may wish to inform their manager in confidence (if not already aware), although this is not mandatory.

33.4 In routine screening managers are informed of work restrictions only where relevant to the role, for example if a hepatitis C infected HCW works in a non-EPP role no additional restrictions are put in place.

33.5 Any breach of confidentiality will be considered as a serious matter and may result in disciplinary action, which may, in accordance with the Trusts disciplinary procedure lead to dismissal.

33.6 Immunisation status will not generally be regarded as medically confidential. Such information may be made available and held by managers in each clinical area.

34. Reporting Infections under RIDDOR

34.1 If an infection is considered occupationally acquired this should be reported to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).

35. Vaccination Records and Recalls for Vaccination

35.1 Under the COSHH Regulations (regulation 11) a health record should be maintained with the dates and record of immunisation status. This should address the individual's fitness for work or if additional restrictions are required. This should be accessible by the individual's manager to ensure appropriate control measures are in place to protect the individual at work.

35.2 This record should:

- Include personal details of the individual
- Include dates and records of immunisation / protection status and when further action is required
- Address the individuals fitness for work or any special precautions that should be taken to protect the individual against occupationally acquired infections

35.3 A health record should not include confidential clinical information but should contain an Occupational Health assessment of immune status and if a further risk assessment is required. It is not the same as a clinical record as it needs

to be accessible by the employer. For example, a manager needs to know whether someone is immune or not, but not necessarily the level of immunity or any reasons for lack of immunity which would be recorded within the clinical records.

35.4 The Occupational Health & Wellbeing service maintains a clinical record on each staff member of the Trust that includes each employees screening and vaccination results. Recalls are generated from this to remind staff for vaccination. Managers are responsible for ensuring their staff members attend for vaccination when recalls are generated.

36. Electronic Storage of Immunisation Records (Cohort)

36.1 The Cohort Occupational Health database has the facility to record immunisation and infection screening data and vaccination recalls. Reports can be provided to managers on their staff immune status and recalls for vaccination are sent by Occupational Health. Individuals can be provided with a copy of their records.

36.2 Currently full electronic access to immunisation status is unavailable; managers are responsible for ensuring that a health record is maintained, including vaccination data, for their staff and ensuring that members of staff attend for vaccination updates. Anonymised data can be provided at directorate level and standardised reports can be made available to managers upon request.

37. Information to Staff

37.1 Information for staff on vaccination / immunisation including the immunisation matrix is available on the staff intranet.

38. Equality and Diversity

38.1 Mid Essex Hospital Services NHS Trust is committed to a Policy embracing the Equality Act 2010 in all its employment practices and strives to eliminate all unfair discrimination, harassment, bullying and victimisation. Equality of opportunity is a high priority within Mid Essex Hospital Services NHS Trust and the Trust will not unlawfully, unfairly or unreasonably discriminate or treat individuals less favourably on the grounds of gender, marital status, sexual orientation, religion or belief, disability, age, race, nationality or ethnic origin.

39. Breaches of Policy

39.1 Where there is evidence that a breach of this policy has occurred resulting in potential harm to a patient or another staff member then whilst maintaining confidentiality, it is the responsibility of all staff to report this breach themselves on Datix as soon as reasonably possible and then to the most senior manager available who will then advise the Occupational Health Service and instigate an appropriate investigation.

39.2 Any member of staff who unreasonably refuses to cooperate with the requirements of the policy will be considered unprotected against infection which may affect areas of deployment and, in some cases, their continued employment.

40. Audit and Monitoring

40.1 Monitoring

40.2 Compliance with this policy will be monitored through audit by the Occupational Health Department who report to the Health and Safety Committee on a quarterly basis.

40.3 Audit of Compliance

40.4 To ensure compliance with this policy an audit of this policy will be undertaken quarterly. This will involve selection of a sample of records to be checked against relevant criteria from the policy.

40.5 The outcomes of the audit (which may be in the form of exception reporting) will be presented in report format to the Committee responsible for the development and monitoring of any identified actions within the scope of the audit.

40.6 The audit report should contain the following:

- Scope
- Period covered
- Findings
- Recommendations / Action plans

40.7 A summary of key learning points will be disseminated to all staff through the staff newsletter and to Divisional Managers.

41. Communication and Implementation

41.1 Staff will be made aware of this policy through reference at Corporate Induction and dissemination via Staff Focus. The document will be stored for access to all on the MEHT Intranet under HR Policies and will be available also on the Trust website.

42. References

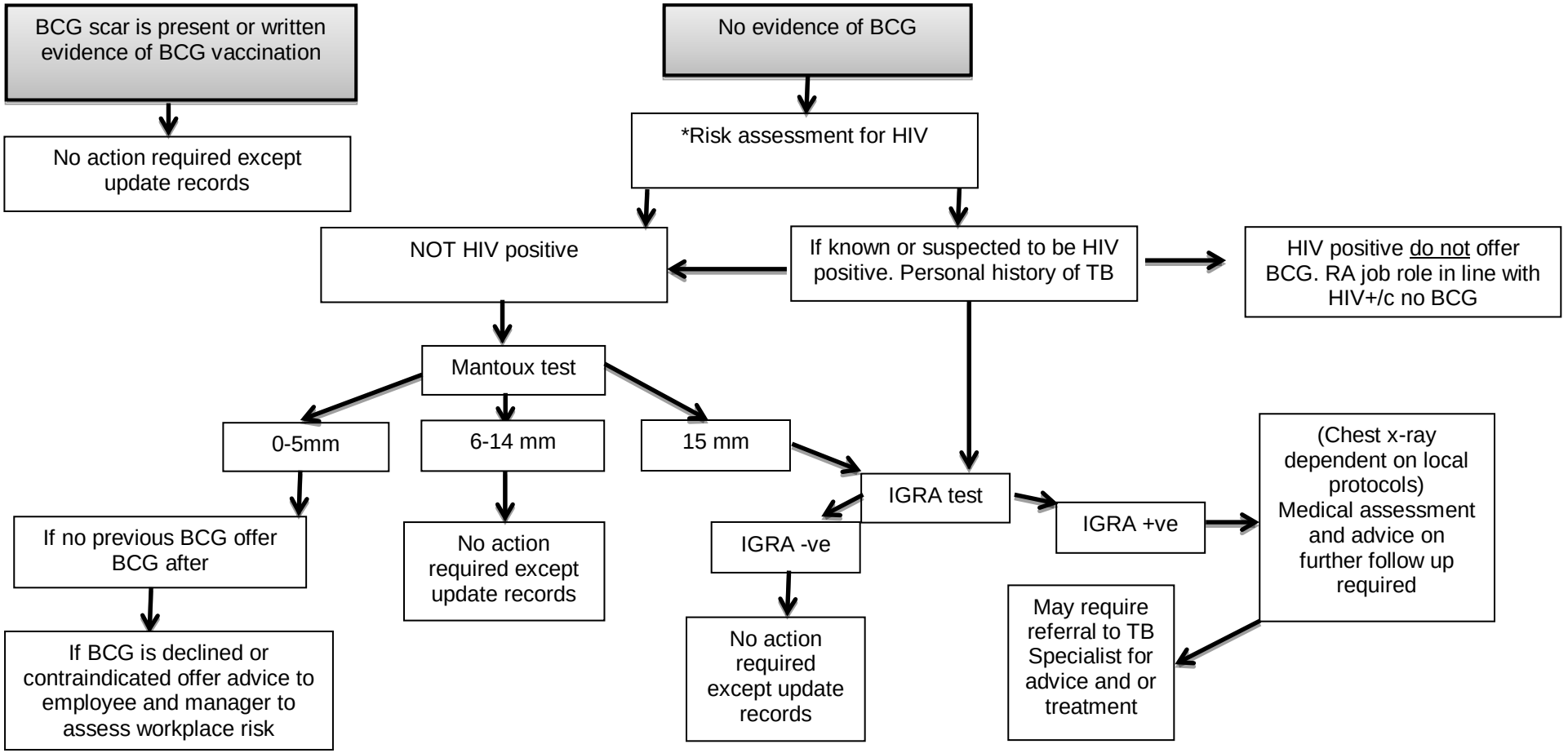
1. The Health and Safety at Work etc. Act United Kingdom Parliament (1974)
2. Hepatitis B infection (Health Services Circular 93)
3. Protecting health care workers and patients from hepatitis B (Health Service Guidance HSG (93) 40)
4. Hepatitis B infection (HSC 2000/020 Hepatitis B Infected HCWs)
5. Hepatitis C infection (HSC 2002/010 Hepatitis C Infected HCWs)
6. AIDS/HIV infected health care workers guidance on the management of infected health care workers and patient notification
7. Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New health care workers
8. Guidance for clinical health care workers: protection against infection with blood borne viruses. London: DH, 1998
9. Immunisation of healthcare and laboratory staff in: Immunisation against infectious disease (The Green Book), Chapter 12. DH 2006

10. Chickenpox (Varicella) Immunisation in health care workers. CMO Letter
11. Tuberculosis – Clinical diagnosis and management of Tuberculosis and measures for its prevention and control. NICE Clinical Guideline 33
12. Immunisation of the Health Care Worker. ANHOPS

Appendix 1:

Pre-placement assessment for healthcare workers, NOT from a TB high-risk area or country

All new staff who will be working with patients or clinical specimens will undergo a TB symptom questionnaire prior to starting work- If symptomatic refer to a TB specialist, not fit for work until further advice received. The person can be declared fit for work if no symptoms are reported.

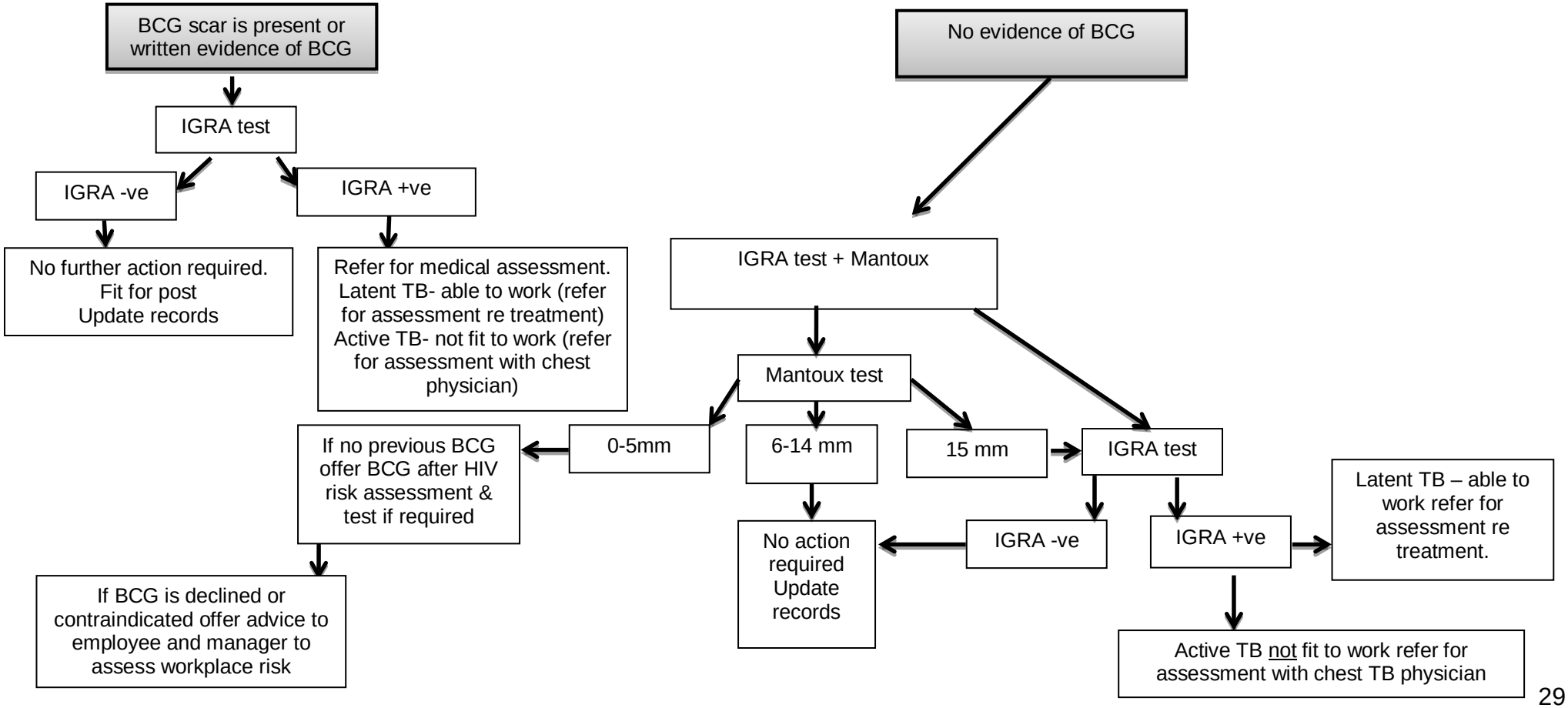


***** BCG is contraindicated in symptomatic HIV-positive individuals. In countries such as the UK where the risk of TB is low, it is recommended that BCG is withheld from all those known to be or suspected to be HIV positive, regardless of clinical status. (Immunisation against infectious disease 2006- 'The Green Book')
http://webarchive.nationalarchives.gov.uk/20080910134953/http://dh.gov.uk/en/publichealth/healthprotection/immunisation/greenbook/dh_4097254 Accessed 11/5/15

Pre-placement Assignment for NHS workers from a country or area of high TB incidence

(40 cases per 100,000 Ref: WHO data at Public Health England at https://www.gov.uk/government/organisations/public-health-england)

All new staff who will be working with patients or clinical specimens will undergo a TB symptom questionnaire prior to starting work- If symptomatic refer for further investigation, not fit for work until further advice received.



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http://webarchive.nationalarchives.gov.uk/20080910134953/http://dh.gov.uk/en/publichealth/healthprotection/immunisation/greenbook/dh_4097254 Accessed 11/5/15

Appendix 2 Immunisation Matrix

	Immunisations									Screening									
Occupation / Department	**BCG**	**Hep B**	**MMR**	**Varicella**	**Influenza**	**Typhoid**	**Hep A**	**Polio ****	**Dip / Tet****	**HAWQ***	**Hep B Ab**	**HBsAg**	**T SPOT or Mantoux**		**Hep C**	**HIV**	**Measles**	**Rubella**	**Varicella**
Doctors (Non-EPP)	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Doctors (EPP)	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nursing Staff (Non-EPP)	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓			✓	✓	✓
Nursing Staff (EPP)	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Midwives (EPP)	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Care Assistants	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Operating Department Technician	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physiotherapists / OTs	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Radiographers	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Pharmacists (Patient Contact)	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Dieticians	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Phlebotomists	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Porters	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Security Staff	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Office Staff (No Patient Contact)					✓					✓									
Office Staff (Patient Contact)	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Chaplaincy	✓		✓	✓	✓			✓	✓	✓			✓	✓			✓	✓	✓
Domestics	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Catering Staff	✓		✓	✓	✓			✓	✓	✓			✓	✓			✓	✓	✓

Drivers	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Mortuary Staff	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓			✓	✓	✓
Volunteers (Patient Contact)	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Facilities Staff (Patient Contact)	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Plumbers	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓			✓	✓	✓
*HAWQ Health at Work Questionnaire.	** Polio & Dip/Tet – Childhood Checks																			

Laboratory Staff	Immunisations									Screening									
Occupation / Department	**BCG**	**Hep B**	**MMR**	**Varicella**	**Influenza**	**Typhoid**	**Hep A**	**Polio**	**Dip / Tet**	**HAWQ***	**Hep B Abs**	**HBsAg**	**T SPOT or Mantoux**		**Hep C**	**HIV**	**Measles**	**Rubella**	**Varicella**
Microbiology	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓			✓	✓	✓
Haematology	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Biochemistry	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓
Cytology	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓
Histology	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓
Central	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓