

Document Type:	Policy	
Reference Number : 1920	Version Number: 6	Next Review Date: 6 November 2023
Title:	Hepatitis B Immunisation for Adults Exposed to an Increased Risk of Infection Policy	
Document Author:	Clinical Lead, Torbay Drug and Alcohol Service	
Applicability:	All nursing and medical staff employed within the Torbay Drug and Alcohol Service	

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1 Purpose

- 1.1 Transmission of Hepatitis B through injecting drug use is a major public health problem. Injecting drug users who have not been protected by hepatitis B immunisation are at high risk of acquiring and subsequently transmitting Hepatitis B immunisation are at high risk of acquiring and subsequently transmitting Hepatitis B (Department of Health 2009).

2 Introduction

- 2.1 This document summarises the Torbay and South Devon NHS Foundation Trust (TSDFT) position on the immunisation of Torbay service users coming into contact with substance misuse services and consenting to a hepatitis B immunisation.
- 2.2 This policy is of particular relevance to known intra-venous drug users, but immunisation should be offered to all users of Torbay Drug & Alcohol Service
- 2.3 This policy is set within the context of the Nursing and Midwifery Council (NMC) code of professional conduct and accountability. (17.9)
- 2.4 All standards to be followed are as out set in Immunisation against Infectious disease (DOH 2009). (17.7)

3 Roles and Responsibilities

- 3.1 This policy refers to registered nurses and medics working within Torbay and South Devon NHS Foundation Trust (TSDFT), Substance Misuse Services. It is recognised that doctors will not always be present in the building whilst nurses immunise service users.
- 3.2 The nurse/medic administering the vaccine has a responsibility to ensure that there is a valid Prescription and Medication and Administration Record (PMAR) prescription in place. The prescription should be completed by the patients prescribing doctor or non-medical prescriber. The vaccine cannot be administered without a current, signed prescription from a qualified prescriber.
- 3.3 In the case of a prescription being used: the prescriber has a responsibility to ensure that the prescription clearly indicates the client's name, case number and date of birth (or age). It is the prescriber's responsibility to ensure that these are accurate. It is the prescriber's responsibility to ensure that the correct immunisation schedule is indicated and that the correct dose and frequency of immunisation is prescribed. The prescription must be dated and signed by the prescriber in indelible black ink prior to vaccine administration. The prescription must state clearly the route of administration, in the case of Hepatitis B immunisation this is intramuscular.
- 3.4 As the fourth dose of Hepatitis B immunisation on the rapid and accelerated schedules is 12 months after the initial three doses there needs to be a separate prescription or record sheet for this. It is the nurse/medic administering the vaccine who needs to ensure that this prescription or record sheet is in place prior to administering this fourth dose.
- 3.5 If the administration schedule is changed from rapid to accelerated or standard the prescription must be changed to accommodate this before administration of this immunisation schedule. It is the responsibility of the nurse/medic administering the vaccine to ensure that the prescription has been rewritten by the prescriber prior to administering any further doses of vaccine.
- 3.6 The approved prescription sheets – PMAR (appendix 4) are to be used for this purpose.
- 3.7 It is essential that informed consent to immunise is obtained prior to any vaccine being administered. The pre immunisation assessment (appendix 2 and 3) will assist with this process. Under no circumstances should any vaccine be administered without the patients informed consent and without completing the pre vaccination assessment process. This consent does not need to be in writing but the pre immunisation discussion and agreement to have vaccination does need to be clearly documented in the patients record (17.7, 17.9 and 17.12).

4 Obtaining and storing the vaccinations

- 4.1 Stock medicines for use in clinics and community hospitals may be obtained by authorised members of staff from the TSDFT Pharmacy Department at Torbay Hospital, according to the 'Standard Operating Procedure for ordering of Medicines (17.12)
- 4.2 The pharmacy order must be signed by a designated / named senior nurse in the Team.
- Stock delivery must be checked and receipt signed by Registered Nurse.
- 4.3 The drugs on a community clinic's stock list must be previously agreed with the Deputy Chief Pharmacist, TSDFT Pharmacy Department and the Service Manager for TSDFT Drug & Alcohol Service.
- 4.4 A separate identified lockable medical refrigerator must be available to be used exclusively for the storage of vaccinations requiring cold storage between 2-8 degrees Celsius.
- 4.5 The refrigerator must be kept locked at all times
- 4.6 The temperature of the refrigerator must be monitored and recorded daily on the designated form when in use, using a maximum/minimum thermometer and the refrigerator should be cleaned regularly and records kept, as per the TSDFT Policy for maintenance of cold chain in handling of medicines requiring cold storage and associated SOP.

5. Target Group

- 5.1 The identified at risk group includes, current or past injectors, those at risk of becoming injectors and those in close contact with injectors, i.e. sexual partners or living with an injector (17.5 and 17.7).
- 5.2 All adult drug using residents of Torbay will be eligible for hepatitis B immunisation. All clients will receive an assessment of their hepatitis B status at the commencement of treatment and will be offered hepatitis B immunisation at the outset of treatment.
- 5.3 Clients with chronic liver disease or with HIV infection or hepatitis C should not be precluded from immunisation against hepatitis B. Clients with hepatitis are at further risk of infection from hepatitis B; co-infection with hepatitis B may accelerate hepatitis C-related liver damage, as may alcohol use.
- 5.4 It is therefore important to ensure that clients with hepatitis C who have not been infected with hepatitis B are offered hepatitis B immunisation (17.6).

6. Immunisation schedules

- 6.1 The preferred immunisation schedule when vaccinating drug users against hepatitis B is the rapid immunisation schedule (see appendix 1). This schedule is most suited to drug users, who are at a very high risk of hepatitis B exposure and require full immunisation within a short period of time.

It is noted that some clients may enter drug treatment having partially completed hepatitis B vaccination elsewhere; in such instances alternative Immunisation schedules can be followed in order to complete the Immunisation course.

In all other instances however, nurses/medics will commence vaccination according to the rapid immunisation schedule.

- 6.2 Whilst every effort should be made to adhere to a schedule, the Department of Health makes the following statement: -

Where compliance with a more prolonged schedule is difficult to achieve (e.g. in IDUs and genito-urinary medicine clinic attenders), higher completion rates for three doses at zero, one and two months have been reported. (17.7)

Alternative immunisation schedules can therefore be switched to in cases where the client's compliance is such that the rapid immunisation schedule cannot be completed. (See appendix 1 accelerated immunisation schedule and standard immunisation schedule).

- 6.3 In cases of poor compliance to the immunisation schedule, should the nurse/medic be unsure as to how to proceed, she/he should seek advice regarding the scheduling of further doses of vaccine from the clinical lead for the service.

- Accelerated schedule better immune response.

7. Administration of vaccine

- 7.1 The Hepatitis B immunisation checklist form will be adhered to prior to immunisation every time the nurse gives a dose of vaccine (refer to appendix 3).
- 7.2 The expiry date of the vaccine should always be checked before immunising the client and the batch number and expiry date recorded on the prescription/ record form.
- 7.3 Prior to immunisation, the vaccine should be shaken and visually inspected for any colour variation or particulate matter. Once shaken, the vaccine is slightly opaque.
- 7.4 Immunisation will be carried out in accordance with local infection control protocols.
- 7.5 For adults, Engerix B ® should be given intramuscularly in the deltoid region of the arm. It should be noted that the buttock must not be used because vaccine efficacy may be reduced (17.7). (In patients with haemophilia, where there is a risk of

bleeding, subcutaneous injection may be used.) The site where the vaccination is given should be recorded.

- 7.6 Anaphylaxis must be considered and the service-user's physical state checked after the vaccine is administered.

8. Recording

- 8.1 The vaccine, product name, batch number, expiry date, dose administered site of administration, date and time of administration must be recorded accurately on the relevant prescription form (appendix 4) at the time of administration.

- 8.2 This information should then be scanned onto the clients electronic clinical notes within the substance misuse service and a letter sent to their GP (appendix 6) to inform them that the client has received this immunisation in order that they may update their records.

9. Post Vaccination advice and information.

- 9.1 The nurse/medic will provide the client with a reminder card detailing the date of their next vaccination / follow up blood test and ensure that the client is aware of the venue for this.
- 9.2 A letter will be sent to the clients GP advising of completion of the course of vaccination and/ or any follow up arrangement required in the instance of an incomplete course being administered. The client will need to give their consent for this prior to being vaccinated but this should not preclude them from receiving the vaccination.
- 9.3 Advice re: safer injecting, reducing risk of infection and condom use should be given to the client in conjunction with the vaccination.

10. Contra-indications

- 10.1 Care must be taken to ensure that no contra-indications are present and Engerix B[®] product guidelines state the following:
- 10.2 Engerix B[®] should not be given if service-user reports current or recent history of high temperature. The nurse/medic administering the vaccine needs to check the clients temperature if concerned. (Minor infections without fever or general upset are not reasons to postpone vaccination).
- 10.3 It should not be given to those with a known hypersensitivity to any component of the vaccine or to clients showing signs of hypersensitivity after previous Engerix B[®] administration.
- 10.4 It should not be given to those who have a definite history of a severe local or general reaction to a preceding dose. The following reactions should be regarded as severe:

Local: An extensive area of redness and swelling which becomes indurated and involves a major part of the circumference of the upper arm.

General: Fever equal to or more than 39.5°C within 48 hours of vaccine; Anaphylaxis; bronchospasm; laryngeal oedema; generalised collapse. Prolonged unresponsiveness; convulsions or Encephalopathy occurring within 72 hours.

- 10.5 Any adverse reaction must be reported to the dispensing pharmacist, prescriber and manufacturer immediately. This should be reported as an incident on Datix and the Yellow card in the British National Formulary must be completed by the prescriber or nurse administering the vaccine.

11. Precautions and warnings

- 11.1 In Human Immunodeficiency Virus (HIV) infected patients, as also in haemodialysis patients and persons with an impaired immune system, adequate anti-HBs antibody titres may not be obtained after the primary immunisation course and such patients may therefore require additional doses of vaccine (17.7).
- 11.2 Because of long incubation period of Hepatitis B, infection may be present at the time of immunisation. If so, immunisation may be ineffective.
- 11.3 If service-user presents with objective symptoms of active Hepatitis-B infection then anti-body testing should be performed at this point.

12 Pregnancy and lactation

- 12.1 The immunisation of pregnant at risk women will be considered after consultation with the prescriber.
- 12.2 The effect of hepatitis B on foetal development has not been assessed. Sources state that no risks to the foetus from maternal vaccination have been reported (17.1) and information available on the outcome of those immunised during pregnancy does not reveal any cause for concern. Hepatitis B infection in pregnant women may result in severe disease for the mother and chronic infection of the new born. Immunisation should not be withheld from a pregnant woman if she is in the high risk category (17.7).
- 12.3 The immunisation of women who are breast feeding will only be considered after consultation with the prescriber.
- 12.4 No information is available regarding the use of Engerix B® in lactation, but American literature indicates that the vaccine is not contraindicated during lactation (17.1). This view is supported by the Department of Health (17.7).

13 Adverse reactions

- 13.1 Nurses should be aware of possible adverse reactions, associated with the Engerix B® vaccine.

-
- 13.2 **Common**
Engerix B® vaccine is generally well tolerated and the most common reactions, occurring in up to half of vaccines, are mild transient local soreness, erythema (superficial redness of the skin) and or induration (hardening) at the injection site. These symptoms usually resolve within 2-3 days and would not normally be a contra-indication to administration of further doses of vaccine.
- 13.3 **Rare**
Body as a whole: fatigue, fever, malaise, influenza- like symptoms
Central and peripheral nervous system: dizziness, headache, paraesthesia
Gastro-intestinal system: nausea, vomiting, diarrhoea, abdominal pain
Liver and biliary system: abnormal liver function tests
Musculoskeletal system: arthralgia, myalgia
Skin and appendages: rash, pruritis, urticaria
- 13.4 **Very rare**
Body as a whole: anaphylaxis, serum sickness
Cardiovascular: syncope, hypotension
Central and peripheral nervous system: paralysis, neuropathy, neuritis (including Guillain-Barre syndrome, optic neuritis and multiple sclerosis), Encephalitis, encephalopathy, meningitis, convulsions
Musculoskeletal system: arthritis
Respiratory system: bronchospasm like symptoms
Skin and appendages: angioedema, erythema multiforme
Vascular extracardiac: vasculitis
White cell and reticulo-endothelial system: lymphadenopathy
- 13.5 Although documented reactions to immunisation are rare, an anaphylactic shock pack **containing adrenaline 1:1000 (1mg/ml) must be available at every immunisation session** (17.11).
- 13.6 In the event of an anaphylactic reaction to immunisation, adrenaline should be administered, 999 call made for emergency assistance, and if required, basic life support started.
- 13.7 Adrenaline will be administered in accordance with current TSDFT anaphylaxis protocols.
- 13.8 Any reaction to immunisation should be recorded and reported in line with TSDFT incident reporting procedure and documented in the case file.
- 14 Handling of vaccine**
- 14.1 Vaccines will be handled and stored in accordance with the TSDFT Policy for maintenance of cold chain in handling of medicines requiring cold storage and SOP. and in line with guidelines from public health (17.12)

15 Training and Supervision

- 15.1 All nurses administering the vaccine will receive generic training and be competent in all aspects of Hepatitis B immunisation.
- 15.2 All registered nurses will attend resuscitation and anaphylaxis training annually.

16 Monitoring and Auditing

- 16.1 Resuscitation equipment will be checked prior to every vaccination session and on a weekly basis for proper working order and expiry dates by a nominated staff member, who will keep a written record of this. Oxygen will be checked on a weekly basis.
- 16.2 An annual audit of the Hepatitis Immunisation Programme will be undertaken utilising the NDTMS fields on HALO by service manager of TDAS.
- 16.3 Training: - nurses' attendance at anaphylaxis and resuscitation training will be monitored in accordance with TSDFT mandatory training guidelines.

17 References

- 17.1 Briggs GG, Freeman RK, Yaffe SH, (2002) Drugs in Pregnancy and Lactation Sixth Edition p1413/v
- 17.2 CDC. Hepatitis B virus: a comprehensive strategy for eliminating transmission in the United States through universal childhood vaccination. Recommendations of the Immunization Practices Advisory Committee (ACIP). MMWR 1991,;40 (No. RR-13):1-25. Cited in Briggs et al. (2003) above.
- 17.3 Communicable Disease and Public Health Vol 2 No 3 Sept 1999 pg 154-156
- 17.4 Cunningham R (2000) "Hepatitis B: vaccination and current treatment" Prescriber 5 April 2000
- 17.5 Department of Health (2007) Drug misuse and dependence guidelines on clinical management. London: The Stationary Office.
- 17.6 Guidance for the prevention, testing and management of hepatitis C in primary care (appendices on hepatitis A and B vaccination guidance) RCGP (2007).
- 17.7 Immunisation against infectious diseases – www.dh.gov.uk/greenbook (updated 2009) chapters 2, 3, 4, 17, 18.(Last viewed 28/10/2016)
- 17.8 National Treatment Agency (2006). Models of Care Update, Department of Health.
- 17.9 NMC code of professional conduct: standards for conduct, performance and ethics (2008)
- 17.10 Royal College of Nursing, (1999). Administration of Medicines – Immunisations. (093). RCN website (www.rcn.org) 5 November 1999. [Cited in Vaccine

Administration Taskforce (2001). "UK Guidance on Best Practice in Vaccine Administration", Shire Hall Communications.]

17.11 TSDFT: Anaphylaxis & anaphylactic shock protocol [0337](#)

17.13 TSDFT: Cold Chain Policy [1913](#)

18. Further Information

18.1 Links to policies.

18.2 Best Practice Information.

18.3 Forms/Recording Documentation

20. Appendices

[Appendix 1 - Rapid Immunisation Schedule](#)

[Appendix 2 - Hepatitis B Vaccination Assessment – Part 1](#)

[Appendix 3 - Hepatitis B vaccination assessment – Part 2](#)

[Appendix 4 – P-MAR](#)

[Appendix 5 - Flow Chart for Hepatitis B Vaccination and Follow-up](#)

[Appendix 6 – GP letter advising of vaccination](#)

Appendix 1

Rapid immunisation schedule – 4 doses of Engerix B® vaccine

	Dose 1	Dose 2	Dose 3	Dose 4	Blood test
Day of vaccination:	Day 0	Day 7	Day 21	Month 12	Month 14
Time interval between doses:		7 days after dose 1	14 days after dose 2	12 months after dose 3	2 months after dose 4
Dose containing:	20 micrograms of Engerix B® vaccine	Blood test to check immune response			

Accelerated immunisation schedule – 4 doses of Engerix B® vaccine

	Dose 1	Dose 2	Dose 3	Dose 4	Blood test
Day of vaccination:	Day 0	Month 1	Month 2	Month 12	Month 14
Time interval between doses:		One month after dose 1	One month after dose 2	12 months after dose 3	2 months after dose 4
Dose containing:	20 micrograms of Engerix B® vaccine	Blood test to check immune response			

Routine schedule – 3 doses of Engerix B® vaccine

	Dose 1	Dose 2	Dose 3	Blood test
Day of vaccination:	Day 0	Month 1	Month 6	Month 8
Time interval between doses:		1 month after dose 1	5 months after dose 2	2 months after dose 3
Dose containing:	20 micrograms of Engerix B® vaccine	20 micrograms of Engerix B® vaccine	20 micrograms of Engerix B® vaccine	Blood test to check immune response

Appendix 2

Hepatitis B vaccination assessment – Part 1

Client name/ DOB		
NHS number		
Agency name		
A Discussion with client		
1 Does the client have an understanding of hepatitis B virus?	Yes	No
2 Please summarise your discussion with the client, why they are potentially at risk and whether vaccination is indicated (at risk includes current or past injectors, those at risk of initiation into injecting, those in close contact / living with current or past injectors, sex working / having unprotected sex)		
3 Is vaccination indicated?	Yes	No
If vaccination is not indicated at this time please reassess in three months		
B Clients choice(s)		
4 Does the client wish to be vaccinated?	Yes	No
5 If client declines vaccination, please explain why		
If client declines vaccination but is identified as at risk provide information on risk of BBVs and transmission / prevention and review at next appointment – Follow up with advice letter		
If client accepts vaccination then complete part 2 of the vaccination assessment prior to vaccinating		
C Action taken in support of client's choice		
6. Commenced vaccination programme		
Date started		
7 Declined vaccination programme, please confirm:		
Client received verbal information on hepatitis B	yes / no	
Client received leaflet regarding hepatitis B	yes / no	
Plan to review HBV vaccination / risk with client on (date):		
Completed by	Date	

Hepatitis B vaccination assessment – Part 2

Pre vaccination Checklist

Client name/ DOB	
NHS number	
Agency name	

1 Has the client been immunised against hepatitis B before?

YES → Check whether client completed a full course of vaccination. (Protective immunity after a full course of immunisation lasts approximately 5 years). Offer a blood test to check immune status.

NO → Continue

3 Does the client have a history of hepatitis and/or jaundice? Yes

Cause unknown → Offer a blood test to check immune status

Hepatitis B → Not necessary to vaccinate

Hepatitis A or C → Continue

HIV → Continue

No History → Continue

4 Is the client suffering from an acute illness, sore throat or high temperature now or have they done so during the past week?

YES → Check temperature, if still above normal range Immunisation should be postponed until fully recovered

NO → Continue

5 The following ingredients are contained in Engerix B vaccine; Aluminium oxide hydrated, yeast proteins, thiomersal, polysorbate 20, sodium chloride, disodium phosphate, dehydrate, sodium dihydrogen phosphate, water for injection and Hepatitis B surface antigen.

In order to establish whether the client has a known allergic reaction to any component of the vaccine, ask the client to disclose any known allergies.

Does the client have a known allergic reaction to any component of the Vaccine or history of renal insufficiency?

YES → Do NOT vaccinate

NO → Continue

6 Has the client ever experienced an unacceptable adverse local or general reaction to any preceding dose of hepatitis B immunisation?

- UNSURE → If there is any doubt, defer immunisation and seek guidance from medical staff
- YES → Do NOT vaccinate
- NO → Continue

7 (Female clients only) Clarify whether the client is pregnant?

- UNSURE → Defer vaccination until situation can be clarified
If client opts to have pregnancy test, advise her to have the test no less than 1 week after a missed period, to reduce the chances of a false negative result.
- YES → Defer vaccination, and liaise with Consultant or Medical Officer to establish whether immunisation is appropriate.
- NO → Continue

8 Has the client given verbal informed consent to course of vaccination, and follow up, including reminder letters?

- YES → Continue
- NO → Do not vaccinate if client is unable or unwilling to give informed consent

9 Does the client agree to a letter being sent to his/her GP, clarifying details of immunisation, following either completion of immunisation or discharge from this service?

- YES NO

10 Give client record card with due dates of future vaccinations. At 4th injection give date for follow up blood test. Give information re; reduction of risk, (condom use and needle exchange provision).

Date: _____ Completed by: _____

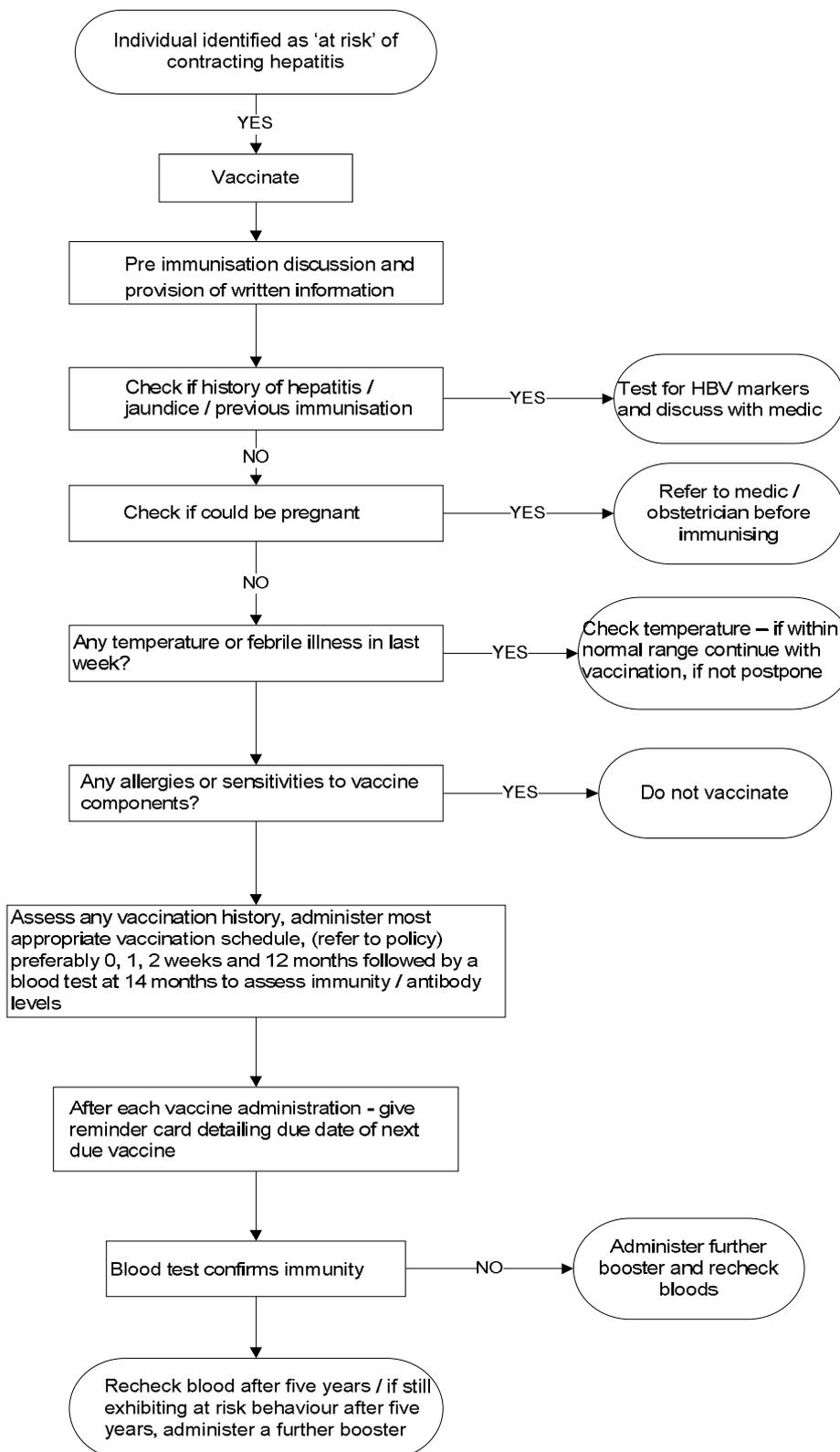
IMPORTANT NOTE

Before giving each subsequent dose of vaccination i.e. 2nd, 3rd and 4th injections, ensure you repeat questions 4, 6 and 7

Please check this is the only medication you will be administering and there is not additional current Prescription/Medication Administration Record.

Appendix 5

Flow Chart for Hepatitis B Vaccination and Follow-up



Appendix 6

GP letter advising of vaccination

GP name / address
Torbay Drug & Alcohol Service
Walnut Lodge
Walnut Road
Chelston Torquay
TQ2 6HP

01803 604330

Date

Re: client name / address / DOB/ NHS No

This patient has receiveddoses of hepatitis B vaccine
at....., the last dose was administered on.....
They are due a further vaccination / blood test (delete as appropriate) on
.....

Enclosed for your records is a copy of the prescription sheets with details of the
dates administered, batch numbers and expiry dates.

Please contact us with any queries.

Yours Sincerely,

(NAME)
(DESIGNATION)

Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	1920		
Document title:	Hepatitis B Immunisation for Adults exposed to an Increased Risk of Infection Policy		
Purpose of document:	Transmission of Hepatitis B through injecting drug use is a major public health problem. Injecting drug users who have not been protected by hepatitis B immunisation are at high risk of acquiring and subsequently transmitting Hepatitis B immunisation are at high risk of acquiring and subsequently transmitting Hepatitis B (Department of Health 2009).		
Date of issue:	6 November 2020	Next review date:	6 November 2023
Version:	6	Last review date:	October 2020
Author:	Clinical Lead, Torbay Drug and Alcohol Service		
Directorate:	Community		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Care and Clinical Policies Group Meeting Clinical Director of Pharmacy		
Date approved:	16 October 2020		
Links or overlaps with other policies:	Pharmalogical Management of Substance Misuse in the Community Prescribing Guidelines 1893 Blood Borne Virus testing policy for Substance Misuse Services 1847 Anaphylaxis & anaphylactic Shock Protocol 0037 – Version 3 Operating Policy (No Number) Injectable Medicines Policy for Registered Professionals 1923 SOP Hepatitis B Immunisation order/receipt/recording keeping procedure; SOP1866 Hepatitis B Immunisation Procedure 1992 Cold Chain Policy 1913		

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes <input type="checkbox"/>
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	<i>Please select</i>	
	Yes	No
Does this document have implications regarding the Care Act? <i>If yes please state:</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does this document have training implications? <i>If yes please state:</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Does this document have financial implications? <i>If yes please state:</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is this document a direct replacement for another? <i>If yes please state which documents are being replaced:</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
21 July 2016	2.0	Review	VC
12 July 2012	3.0	Review	VC
17 October 2014	4.0	Review	KB
9 December 2016	5	Revised	Care and Clinical Policies Group Clinical Director of Pharmacy
6 November 2020	6	Revised	Care and Clinical Policies Group Clinical Director of Pharmacy

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on ICON.

<https://icon.torbayandsouthdevon.nhs.uk/areas/mental-capacity-act/Pages/default.aspx>

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Rapid Equality Impact Assessment (for use when writing policies and procedures)

Policy Title (and number)	Policy: Hepatitis B Immunisation for Adults exposed to Increased Risk of Infection with Substance Misuse Services: 1920		Version and Date	V5 November 2016	
Policy Author	Clinical Lead Torbay Drug and Alcohol Service				
An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.					
EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population? <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>					
Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)					
Age	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Sexual Orientation	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Race	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Gender	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Religion/Belief (non)	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Gender Reassignment	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Pregnancy/ Maternity	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Marriage/ Civil Partnership	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees)					Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Please provide details for each protected group where you have indicated 'Yes'.					
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion					
Is inclusive language ⁵ used throughout?					Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Are the services outlined in the policy/procedure fully accessible ⁶ ?					Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Does the policy/procedure encourage individualised and person-centered care?					Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?					Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
If 'Yes', how will you mitigate this risk to ensure fair and equal access?					
EXTERNAL FACTORS					
Is the policy/procedure a result of national legislation which cannot be modified in any way?					Yes <input type="checkbox"/> No <input type="checkbox"/>
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)					
Review of existing Policy					
Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?					
ACTION PLAN: Please list all actions identified to address any impacts					
Action	Person responsible		Completion date		
AUTHORISATION:					
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them					
Name of person completing the form	Clinical Lead Torbay Drug and Alcohol Service		Signature		
Validated by (line manager)	Graham Shiels		Signature		

Please contact the Equalities team for guidance:

For Devon CCG, please email d-ccg.equalityanddiversity@nhs.net & d-ccg.QEIA@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes No

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our [GDPR](#) page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdf@nhs.net,
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [Data Protection](#) site on the public internet