Document Control

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Superseded Documents Transmissible Spongiform Encephalopathy Agents (TSEs) Including CJD and vCJD Policy			
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CONTENTS

1. Purpose

1.1. This document sets out Northern Devon Healthcare NHS Trust's management of known or suspected cases of Transmissible Spongiform Encephalopathy agents (TSEs), sometimes known as prion diseases. These are fatal degenerative brain diseases which occur in humans and certain animal species.

1.2. The policy applies to all Trust staff.

1.3. Implementation of this policy will ensure that best practice is adhered to and patients, visitors and staff are kept safe from this transmissible disease.

2. Definitions

2.1 BSE – Bovine spongiform encephalopathy

2.2 CJD – Creutzfeldt - Jakob Disease - A progressive neurological and ultimately fatal disease of humans believed to be caused by a prion, or a small protein, which alters the structure of a normal brain protein, resulting in destruction of brain neural tissue. Those affected usually have rapidly progressive dementia and cerebellar ataxia, dying within a few months of onset. CJD is generally distinguished into three types:

2.2.1 Familial CJD – An inherited form of CJD associated with mutations in the prion protein gene

2.2.2 Iatrogenic CJD – CJD occurring as a result of surgical or medical procedures, during which accidental exposure to human prions has occurred

2.2.3 Sporadic CJD – of unknown origin. This is the most common form of CJD affecting about 1 in a million people

2.3 Prions – (short for proteinaceous infectious particles) are infectious protein structures that replicate through structural conversion of the normal host prion protein to a disease-associated form.

2.4 SEAC – Spongiform Encephalopathy Advisory Committee

2.5 Transmissible spongiform encephalopathies (TSEs) – These are neurological diseases of humans and animals, believed to be caused by prions that affect the structure of brain tissue, are incurable and fatal. Examples in humans include CJD and Kuru. Examples in animals include scrapie (a disease of sheep and goats) and BSE (a disease of cattle, sometimes referred to as "mad-cow disease").

2.6 Variant CJD (vCJD) - A new form of CJD found in the UK in 1996 and thought to be the result of eating food prepared from BSE infected cattle. Those affected often present with psychiatric and sensory symptoms; progressive neurological signs such as tremor, ataxia and gait disturbance follow; the length of illness is longer than other types of CJD but ultimately remains fatal. It generally affects younger people.

2.7 Variably Protease-Sensitive Prionopathy (VPSPr) is a recently described human prion disease, which appears to be a rare sporadic disorder affecting patients in an age range similar to those affected by sporadic CJD.

3. Responsibilities

3.1 Role of the Chief Nurse

The Chief Nurse is responsible for:

Acting as a second point of contact to support

Ensuring that a replacement main contact is identified should the original author be re-deployed or leave the organisation

3.2 The Infection Prevention and Decontamination Group

Monitoring compliance with the policy

Ensuring that the policy is approved after review and prior to publishing

3.3 Ward/ Departmental Managers

Responsibility for implementation of this policy lies with the Senior Nurse (usually Ward Manager) or Departmental Manager in Charge of the areas to which these statements apply unless specifically stated otherwise in the text.

3.4 Infection Prevention and Control Team

The Infection Prevention and Control Team are responsible for providing support to managers in the implementation of this Policy

3.5 Clinical Staff

It is the responsibility of all Trust Clinical Staff to follow the guidance contained in this Policy and report any problems with compliance to their line manager.

3.6 Role of the Named Nurse or Deputy

It is the responsibility of the Named Nurse or Deputy to:

- Plan the individual care for each patient following these guidelines. Advice on management of patients must be sought from the Infection Prevention & Control Team when it is not possible or appropriate to adhere to the statements in this policy.
- Inform those about to receive the patient into their care such as Community Nurse, Nursing/ Residential Home or other ward of the patient's TSE status and current care and treatment plans.
- Inform the Infection Prevention & Control Team immediately of any patients identified as TSE positive in transfer letters or other communication when patients are admitted direct from non-North Devon hospitals/ institutions.

4. Contacting the Infection Prevention and Control Team

4.1 The Infection Prevention and Control Team can be contacted in hours on 01271 322680 (ext 2680 internal at North Devon District Hospital), via bleep 011 or out of hours by contacting the on-call Medical Microbiologist via North Devon District Hospital switchboard.

5. Management of Transmissible Spongiform Encephalopathy Agents

Other relevant Infection Prevention & Control policies must be adhered to (unless specific advice in this policy contradicts them), in particular:

- Decontamination Policy
- Waste Policy
- Standard Infection Control Precautions Policy
- Management of Inoculation Injuries Policy
- Prevention of Inoculation Injuries Policy

5.1 General information about prions & TSE

There are several recognised TSEs in humans including Creutzfeldt-Jakob Disease (CJD) and Kuru. They are thought to be caused by prions (infectious protein particles) which do not share the same properties as viruses or bacteria.

5.1.1 Distribution of infectivity in tissues

Prions are not uniformly distributed in the tissues of affected individuals and infectivity levels vary at different stages of incubation. The infectivity of tissues varies between types of TSE. Further details in National Guidance[1] (Annex A).

- **High infectivity for CJD & vCJD is found in**
  - Brain
  - Spinal cord
  - Cranial nerves, specifically the entire optic nerve and only the intracranial components of the other cranial nerves
  - Cranial nerve ganglia
  - Posterior eye
  - Pituitary gland

- **Medium infectivity for CJD & vCJD:**
  - Olfactory epithelium
  - Spinal ganglia

- **Medium infectivity for vCJD only:**

  Lymphoid tissue including but not limited to
  - Tonsils
  - Appendix

- Spleen
- Thymus
- Adrenal Gland
- Lymph nodes and gut-associated lymphoid tissue including gastrointestinal tract sub-mucosa

- **Low infectivity from blood, other body fluids (including CSF) and most other tissues.**

Prions exhibit an unusual resistance to conventional chemical and physical (heat) decontamination.

TSEs are not highly contagious and do not seem to spread from an infected individual to an uninfected individual by normal contact.

There have not been any confirmed cases of occupational transmission of TSEs to humans.

5.2 Patient Risk Groups

When considering measures to prevent transmission to patients or staff in the healthcare setting, it is useful to make a distinction between different patient groups:

- **symptomatic patients**, i.e. those who fulfil the diagnostic criteria for definite, probable or possible CJD, i.e. those who fulfil the diagnostic criteria for definite, probable or possible CJD or vCJD, asymptomatic. Extra precautions will be required for some surgical procedures and ward care. See rest of policy and National Guidance[1] for further details.
- **patients "at increased risk"** i.e. those with no clinical symptoms, but who are "at increased risk" of developing CJD, because of their family or medical history. In most routine clinical contact, no additional precautions are needed for the care of patients in the "at increased risk" patient groups. However, when certain invasive interventions are performed, there is the potential for exposure to the agents of TSEs. In these situations it is essential that control measures are in place to prevent iatrogenic CJD transmission. See National Guidance[1]: relevant sections.
- **Patients identified as not at increased risk and not symptomatic (as defined above)**. No special precautions are required for these patients

5.3. Assessment of all patients undergoing surgery or endoscopy or ophthalmology procedure for CJD/vCJD

There are specific precautions for **symptomatic patients (definite, probable and possible)** and **asymptomatic patients at risk of CJD** as defined in the policy, section 5.2. It is the responsibility of the surgeon to identify those patients which meet these definitions. The Infection Prevention & Control Team must be informed if such a patient is identified.

5.3.1 Assessment of all patients undergoing surgery or endoscopy or ophthalmology procedure who are asymptomatic for CJD/vCJD

In order to identify asymptomatic patients at risk of CJD/vCJD:

All patients about to undergo any elective or emergency surgical or endoscopic procedure should be asked the question in 5.4

All ophthalmology patients must have their surgery categorised as high or low risk (National Guidance[1]: (Annex L). If high risk then they must be asked the questions in 5.5 (in addition to 5.4) plus perform the actions in 5.6

All patients who will undergo surgery which may involve contact with high risk tissues must be asked the questions in 5.5 (in addition to 5.4) plus perform the actions in 5.6. With the exception of ophthalmology patients (see above) this is unlikely to occur in NDHT. High risk tissues are defined as:

- Brain
- Spinal cord
- Implanted dura mater grafts prior to 1992
- Cranial nerves, specifically:
  - the entire optic nerve
  - only the intracranial components of the other cranial nerves
- Cranial nerve ganglia
- Posterior eye, specifically:
  - posterior hyaloid face
  - retina
  - retinal pigment epithelium
  - choroid
  - subretinal fluid
  - optic nerve
- Pituitary gland

5.3.2 Assessment of patients undergoing surgery or endoscopy or ophthalmology procedure who have symptoms that may be due to CJD/vCJD

Patients who have symptoms that are or may be due to CJD/vCJD should be assessed as per National Guidance[1] (Annex B). If they satisfy a definition of definite, probable or possible CJD/vCJD further actions will be required, see 5.8.

All patients about to undergo any elective or emergency surgical or endoscopic procedure who have symptoms which could be due to CJD should be assessed and if they fall into any of the categories in 5.2 then guidance for such patients in this policy must be followed and the Infection Prevention & Control team informed.

5.4 Requirement for all surgical and endoscopy patients

All patients about to undergo any elective or emergency surgical or endoscopic procedure should be asked the question:

"Have you ever been notified that you are at risk of CJD or vCJD for public health purposes?"

The actions to be taken following the patient's response to the above question are:

Patient's response	Action
No	Surgery or endoscopy can proceed using normal infection control procedures unless the procedure is likely to lead to contact with high risk tissue.

Yes	Please ask them to explain further. Special infection control precautions should be taken and the Infection Prevention & Control team should be consulted for advice. See National Guidance[1] (Annex J)
Unable to respond	Surgery or endoscopy can proceed using normal infection prevention and control procedures unless the procedure is likely to lead to contact with high risk tissue. If this is the case, please refer to National Guidance[1] (Annex J)

The patient's response should be recorded in their medical notes for future reference

5.5 Additional questions for all patients undergoing surgery which may involve contact with high risk tissue including High Risk Posterior Segment Eye Surgery

These patients must be asked the questions in National Guidance[1] (Annex L, table J1).

	Question to Patient	Notes to clinician
1	Have you any history of CJD or other prion disease in your family? If yes, please specify.	Patient should be considered to be at risk from familial forms of CJD linked to genetic mutations if they have or have had: i) Genetic testing, which has indicated that they are at significant risk of developing CJD or other prion disease; ii) A blood relative known to have a genetic mutation indicative of familial CJD; iii) 2 or more blood relatives affected by CJD or other prion disease
2	Have you ever received growth hormone or gonadotrophin treatment? If yes, please specify: i) whether the hormone was derived from human pituitary glands ii) the year of treatment iii) whether the treatment was received in the UK or in another country	Recipients of hormone derived from human pituitary glands, e.g. growth hormone or gonadotrophin, have been identified as at risk of CJD. In the UK, the use of human-derived growth hormone was discontinued in 1985 but human-derived products may have continued to be used in other countries. In the UK, the use of human-derived gonadotrophin was discontinued in 1973 but may have continued in other countries after this time.
3	Have you had surgery on your brain or spinal cord at any time in the past?	(a) People who underwent neurosurgical procedures or operations for a tumour or cyst of the spine before August 1992 may have received a graft of dura mater and should be treated as at risk, unless evidence can be provided that dura mater was not used. Patients who received a graft of human-derived dura mater before 1980 are at increased risk of sporadic CJD. Patients who received a graft of human-derived dura mater between 1980 and August 1992 are at increased risk of both

		sporadic CJD and vCJD. This difference in risk has implications for patient management, in particular gastrointestinal endoscopy. (b) NICE[2] guidance emphasises the need for a separate pool of new neuroendoscopes and reusable surgical instruments for high risk procedures on children born since 1st January 1997 and who have not previously undergone high risk procedures. These instruments and neuroendoscopes should not be used for patients born before 1st January 1997 or those who underwent high risk procedures using reusable instruments before the implementation of this guidance.
4	Since 1980, have you had any transfusions of blood or blood components (red cells, plasma, cryoprecipitate or platelets*)? If yes, have you either: i) received more than 50 units of blood or blood components? or ii) received blood or blood components on more than 20 occasions? Where possible, please provide the names of all the hospitals where you received blood or blood components.	Patients who have received blood from more than 80 donors have been identified as at increased risk of vCJD. Information on this is available from the HPA: http://www.hpa.org.uk/vCJDpresurgicalassessment * This does not include: • Autologous transfusion • Plasma products such as IVIG, albumin, coagulation factors and anti-D

The patient's response should be recorded in their medical notes for future reference.

Patient's response	Action
No to all questions	Surgery or endoscopy can proceed using normal infection prevention & control procedures.
Yes to any of questions 1, 2 3 or 4	See National Guidance[1](Annex L).

Unable to respond	In the event that a patient about to undergo emergency surgery or endoscopy is physically or otherwise unable to answer any questions, a family member or someone close to the patient (in the case of a child, a person with parental responsibility) should be asked the CJD risk questions prior to the surgery or endoscopy. If the family member or someone close to the patient is not able to provide a definitive answer to the CJD risk questions, the surgery or endoscopy should proceed but all instruments may need to be quarantined following the procedure. The patient's GP should be contacted after the surgery or endoscopy, and enquiries made as to whether the patient is at risk of CJD/vCJD according to the CJD risk questions above.

5.6 Additional actions to be taken during pre-surgery assessment for CJD risk

In addition to asking the patient CJD/vCJD risk questions, the following actions should also be carried out before any surgical or endoscopic procedure involving contact with high risk tissue.

The clinician undertaking the pre-surgery assessment should:

- Check the patient's medical notes and/or referral letter for any mention of CJD/vCJD status
- Consider whether there is a risk that the patient may be showing the early signs of CJD or vCJD, i.e. consider whether the patient may have an undiagnosed neurological disease involving cognitive impairment or ataxia

5.7 Actions to be taken when there is a patient with a new diagnosis of CJD or newly identified as at increased risk of CJD

This applies to any patient under the care of this Trust as a 'look back' exercise will need to be undertaken to review, potentially, every previous healthcare interaction.

5.7.1 Notification

The clinical team must inform the infection prevention & control team.

The infection prevention & control team will ensure that Public Health England is informed. PHE may be informed by the clinical team or the IPC team.

5.7.2 Urgent review of surgical instrument use

Following a report of a new case of CJD/person at increased risk, the infection prevention & control team will work with the relevant departments to ensure surgical instruments (including endoscopes) that have potentially been in contact with high or medium infectivity tissues for CJD, and have been through fewer than 20 cycles of use, are decontaminated as normal and removed from general use until the situation can be clearly risk assessed. See 5.8.2

5.7.3 Risk assessment of previous surgical instrument use

Working with PHE and using the guidance for Public Health Action[3] (section 8) perform a risk assessment to ascertain if patients have been exposed as a result of a surgical procedure. If an exposure has occurred then a 'surgical incident' will be declared and the actions outlines in the above document will be followed. These actions include identifying and informing patients who may be at increased risk of CJD.

5.8 Management of patients symptomatic or at risk of CJD/vCJD

5.8.1 Surgery or endoscopy (including nasal endoscopy) or ophthalmology procedure

If the procedure involves **tissues that are medium or high risk** then single-use disposable surgical instruments and equipment should be used, and subsequently destroyed by incineration; **If single use instruments cannot be used special precautions are required**: see National Guidance[1] (Annexes F (endoscopy), J (Surgery endoscopy), L (Opthalmology) M (surgery) and others).

If surgery involves only "**low risk" tissue** special precautions for instruments are not required.

For all procedures:

- Wherever appropriate and possible, the intervention should be performed in an operating theatre
- Where possible, procedures should be performed at the end of the list, to allow normal cleaning of theatre surfaces before the next session;
- Only the minimum number of healthcare personnel required should be involved;
- Protective clothing should be worn, i.e. liquid repellent operating gown, over a plastic apron, gloves, mask and goggles, or full-face visor; for symptomatic patients, this protective clothing should be single-use and disposed of in line with local policies; for patients "at increased risk" of CJD, this protective clothing need not be single-use and may be reprocessed;
- Single-use disposable surgical instruments and equipment should be used where possible, and subsequently destroyed by incineration or sent to the instrument store; if single use instruments cannot be used see National Guidance[1] (Annexes F, L, M and others). If surgery involves only "low risk" tissue special precautions for instruments are not required. See National Guidance[1].
- Effective tracking of reusable instruments should be in place, so that instruments can be related to use on a particular patient.

5.8.2 Quarantining of surgical instruments

Some instruments that have been used on symptomatic or "at risk" patients must not be re-used, but may be quarantined. If instruments are to be quarantined it is important that cleaning and disinfection is carried out promptly following use.

Instruments that come into contact with tissues designated as high or medium infectivity should be kept separate from those that only come into contact with tissues designated as low infectivity.

Re-usable instruments that have come into contact with tissues designated as high or medium infectivity should be washed to remove gross soil. Care should be taken to avoid splashing and generating aerosols, by holding instruments below the surface of the water in a sink into which water is running and draining out continuously, for example in a sink in the theatre sluice room. Instruments should not be held directly under a flowing tap as this is likely to generate splashes. Operatives should wear protective gloves and either a visor or goggles, and care must be taken to avoid penetrating injuries. The sink does not require high level decontamination afterwards – the dilution effect from the running water will be sufficient to remove contamination.

After washing, instruments should be reprocessed through the Sterile Services Department in the usual manner before quarantining. No special precautions are necessary because of the high dilution factor involved in the washer/disinfection process. It is important to ensure that the set is tracked through the whole decontamination cycle. After reprocessing the instruments should be placed in an impervious rigid plastic container with a close-fitting lid. The lid should be sealed with heavy duty tape and labelled with the patient's identification details (i.e. name, date of birth and hospital number).

CSSD manager and Infection Prevention & Control Team should be consulted regarding the necessity and means of quarantining.

See National Guidance[1] (Annex E)

5.8.3 Laboratory Procedures

TSEs have been classified in hazard group 3 and should be handled at containment level 3.

Samples from patients in risk groups (see 6.8) that are of low infectivity (i.e. blood, urine, faecal specimens CSF and swabs) can be handled in the same way as for any other patient.

Specimens from patients in risk groups should be marked with infection risk stickers

Specimens of high and medium infectivity tissues from patients in risk groups should be handled with special precautions in the laboratory

Instruments that come into contact with specimens of high and medium infectivity tissues from patients in risk groups should be destroyed by incineration.

See NDHT laboratory protocols and National Guidance[1]

5.8.4 Occupational Exposure

Although cases of CJD/vCJD have been reported in healthcare workers, there have been no confirmed cases linked to occupational exposure. The highest potential risk in the context of occupational exposure is from exposure to high infectivity tissues through direct inoculation (e.g. as a result of "sharps" injuries, puncture wounds or contamination of broken skin). Exposure of the mucous membranes (e.g. conjunctiva) should also be avoided.

Healthcare personnel who work with patients with definite, probable or possible CJD or vCJD, or with potentially infected tissues, should be appropriately informed about the nature of the risk and relevant safety procedures.

Any inoculation incident involving blood or body fluids should be dealt with according to the Trust's Inoculation Injuries Policy.

5.8.5 General Ward Procedures

Available evidence suggests that normal social or routine clinical contact with a CJD or vCJD patient does not present a risk to healthcare workers, relatives and others in the community. Isolation of patients with CJD or vCJD is not necessary, and they can be nursed in an open ward using standard infection control precautions.

5.8.6 Blood and Body Fluids

At present, there is no evidence of infectivity in saliva, body secretions or excreta; CSF may contain low levels of prions. Any potential exposure to these potentially infectious body fluids should be managed with standard infection control precautions. Generally most infectivity is likely to be concentrated in the central nervous tissue. In vCJD, infectivity is also likely to be present in lymphoid tissue, albeit at a lower level.

5.8.7 Spillages

Follow standard infection prevention & control precautions to clear up spillages on the ward of blood, body fluids and cerebrospinal fluid (CSF).
Potentially infectious materials should be removed using absorbent material, and any waste (including cleaning tools such as mop-heads) disposed of as clinical waste. Disposable gloves and an apron should be worn when removing such spillage(s), and disposed of as clinical waste.

5.8.8 Invasive Procedures

Due to the unusual resistance of the TSE agents, single-use disposable equipment should be used wherever practicable, and all other small items of equipment contaminated whilst obtaining specimens should be destroyed by incineration.
Body secretions, body fluids (including saliva, blood, cerebrospinal fluid [CSF] and excreta) are all low risk for CJD. It is therefore likely that the majority of samples taken or procedures performed will be low risk. Contact with small volumes of blood (including inoculation injury) is considered low risk, though it is known that transfusion of large volumes of blood and blood components may lead to vCJD transmission.
When taking samples or performing other invasive procedures, the possible infectivity of the tissue(s) involved must be considered, and if necessary suitable precautions taken. It is important to ensure that only trained staff who are aware of the hazards carry out invasive procedures that may lead to contact with medium or high risk tissue.
Body secretions, body fluids (including saliva, blood, cerebrospinal fluid [CSF] and excreta) are all low risk for CJD.
Blood and body fluid samples from patients with, or "at increased risk" of, CJD should be treated as potentially infectious for blood-borne viruses and handled with standard infection prevention and control precautions as for any other patient, i.e.;

- use of disposable gloves and eye protection where splashing may occur;
- avoidance of sharps injuries and other forms of parenteral exposure;

- safe disposal of sharps and contaminated waste in line with locally approved arrangements; and
- single-use disposable equipment should be used wherever practicable.

5.8.9 Sample labelling

Samples should be marked with an 'Infection Risk' label, the 'High Risk' box on the Pathology form ticked, and the laboratory should be informed in advance that a sample is being sent.

5.8.10 Bed linen

Used or fouled bed linen (contaminated with body fluids or excreta) should be removed from the bed and washed and dried by the usual means. No further handling or processing requirements are necessary.

5.8.11 Childbirth

In the event that a patient becomes pregnant, it is important to ensure that patient confidentiality is properly maintained, and that any action taken to protect public health does not prejudice individual patient care.

Childbirth should be managed using standard infection control precautions. The placenta and other associated material and fluids should be treated as if infected, and disposed of unless they are needed for investigation, in which case the precautions for dealing with infected tissue should be followed (see Sample labelling above).

5.8.12 Community Healthcare

People should not be dissuaded from routine contact with CJD patients, so long as normal infection control precautions are observed when handling body fluids, in which case gloves and aprons should be worn.
No special measures over and above standard infection control precautions are required for caring for CJD patients in the community. Although CJD and vCJD are not thought to present a risk through normal social or routine clinical contact, those caring for patients at home should be advised of the standard infection prevention & control practices that would apply to any patient.

5.8.13 After Death

On the death of a patient from known or suspected CJD or vCJD normal infection control measures should be followed.

Prior to transportation to the mortuary, the deceased patient should be placed in a body bag which should be labelled as High-Risk or Danger of Infection, in line with normal procedures for deceased patients where there is a known infection risk. A Death Notice/Information label must be completed as detailed in the Trust's Care of the Deceased Policy. The potential source of infection must be indicated.

If a post mortem examination is required refer to National Guidance[1] (Annex H)

5.9 Children born since 1 January 1997

The prevalence of CJD in children born since 1 January 1997, who are unlikely to have been exposed to BSE or CJD via diet or blood transfusion, is close to zero.

Therefore new reusable surgical instruments for high-risk procedures should be purchased and used solely on those children born after 1 January 1997 who have not previously undergone high-risk procedures. These instruments should not be used on children who have been identified as being at risk of any form of CJD, including inherited CJD.

High risk procedures for this section include surgery involving the brain and the posterior eye.

See National Guidance[1] (Annex L) and NICE[2]

6. Monitoring Compliance with and the Effectiveness of the Policy

Standards/ Key Performance Indicators

Monitoring compliance with this policy will be the responsibility of the Lead Nurse Infection Prevention & Control. This will be undertaken by auditing all new and reviewed policies before they are presented to the Board for ratification to ensure they are compliant with this policy on a rolling basis. Where non-compliance is identified, support and advice will be provided to improve practice.

Key performance indicators comprise:

- Percentage of elective patients that are screened for CJD/vCJD risk before surgery
- Percentage of emergency patients that are screened for CJD/vCJD risk before surgery
- Percentage of ophthalmology patients that are screened for CJD/vCJD risk before surgery

Process for Implementation and Monitoring Compliance and Effectiveness

After final approval, the author will arrange for a copy of the policy to be placed on the Trust's intranet. The policy will be referenced on the home page as a latest news release.

Information will also be included in the Chief Executive's Bulletin which is circulated electronically to all staff.

Line managers are responsible for ensuring this policy is implemented across their area of work.

Monitoring compliance with this policy will be the responsibility of the Infection Prevention and Control Team.

7. Equality Impact Assessment

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age			x	
Disability			x	
Gender			x	
Gender Reassignment			x	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership			x	
Pregnancy			x	
Maternity and Breastfeeding			x	
Race (ethnic origin)			x	
Religion (or belief)			x	
Sexual Orientation			x	

8. References

1. National Guidance. DH Minimise transmission risk of CJD and vCJD in healthcare settings. https://www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group

2. NICE Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease (CJD) via interventional procedures. Interventional procedures guidance [IPG196] Published date: November 2006. https://www.nice.org.uk/guidance/ipg196

3. Public health action following a report of a new case of CJD or a person at increased risk of CJD. PHE 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/474338/CJD_public_health_action_new_case_301015.pdf

9. Associated Documentation

- Incident Reporting Policy, Corporate Affairs, May 2007
- Guidance for writing a procedural document, Corporate Affairs, July 2007