

# The Newcastle upon Tyne Hospitals NHS Foundation Trust

## Policy for the Prevention and Management of Needlestick Injuries and Blood Borne Virus Exposures

Version No :	7.0
Effective from	5 August 2015
Expiry Date:	5 August 2017
Date Ratified:	2 June 2015
Ratified by:	H&S Committee OHS and ID

### 1 Introduction

All healthcare workers potentially are at risk from exposure to blood and/or body fluids. Whilst it is accepted that not all blood or body fluids are potentially infective, it is recommended that safer sharps device/needle free device and IPC Standard Precautions be adopted whenever there is the potential for exposure to reduce the risk of transmission of blood-borne viruses.

Exposure to blood or other potentially infectious body fluids may result in the transmission of blood-borne viruses (BBVs) including HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV). Advice about other possible occupational risks for health care staff following such exposures, such as less common BBVs or transmissible spongiform encephalopathies (e.g. CJD), should be obtained from the Occupational Health Department, a medical microbiologist, a medical virologist or the doctor on call for Infectious Diseases.

### 2 Policy Scope

This policy applies to all staff employed or undertaking work for or on behalf of Newcastle Upon Tyne Hospitals NHS Foundation Trust in both hospital and community based settings. Whilst it is primarily concerned with occupational risks for health care staff and students, but may also be applied to patients attending the A & E department after needlestick or other exposures in the community, when HBV infection is generally likely to be the most important risk. This policy must also be applied to patients or visitors at risk who have received a needlestick injury or blood borne virus exposure.

### 3 Aim of Policy

This policy is intended to ensure that where ever possible prevention of sharps injuries is paramount and reduced to a minimum. Use of all sharps/needles are risk assessed and where reasonably practicable replaced by a safer sharps device/needle free device in order to reduce the risk of exposure to blood borne viruses and transmission of these infections following needlestick or other exposures.

### 4 Duties (Roles and Responsibilities)

All employees have a responsibility to follow policies and procedures and ensure they are educated and trained in the use of all safer sharps devices/needle-free

device, and use them safely to reduce the risk of injury to themselves, their patients, colleagues or members of the public. Employees also have a duty of care to familiarise themselves with Appendix A-Guidance for the prevention of Sharps Injuries and Eye Skin/Splashes and Standard Precautions Policy

So that the Trust complies with the law, as an employer it is responsible for ensuring that all health care workers who are exposed to blood, blood viruses or bodily fluids are provided with suitable safer sharps device alternatives to reduce the risk of sharps injury

All Matrons, Sisters/Charge Nurses/Clinical Lead/Manager must ensure that risk assessments are undertaken and safe systems of work are in place, and that staff have received education and training in the use of any sharps, and safer sharps devices/needle free device.

Please see Appendix B for roles and responsibilities for immediate management of a needlestick injury.

## 5 Definitions: Sharps

“**Medical Sharp**” means object or instrument which is used for carrying out activities in healthcare and which is capable of causing injury by cutting or piercing the skin; (Injury includes infection)

“**Safer Sharp**” means a medical sharp that is designed and constructed to incorporate a feature or mechanism which prevents or minimises the risk of accidental injury from cutting or piercing the skin

(Definitions from the “Health and Safety (Sharp Instruments in Healthcare) Regulations 2013”)

## 6 Prevention and Management of Needlestick Injuries and Blood Borne Virus Exposures

### 6.1 Important Principles of the Risk Assessment Process

- **Elimination** - working practices should be regularly reviewed to wherever possible eliminate the use of unnecessary sharps.
- **Engineering controls** – wherever possible medical devices incorporating safety protection mechanisms should be supplied to staff to use e.g. using a Safety-Lok blood collection set in place of a needle and syringe.
- **Safe Systems of Work** – managers will ensure safe systems of work are in place and staff adhere to the Trust’s Waste Management Policy and Procedures
- **Personal Protective Equipment** – staff should use appropriate personal protective equipment such as gloves, visor, apron for procedures where there is a risk of blood or body fluid exposure.
- **Vaccination** – all staff should be offered appropriate vaccination in particular hepatitis B vaccination where there is a risk of exposure to blood or body fluids.

## **6.2 Prevention of Blood and Body fluid Exposures**

All directorate managers Matrons, Sisters/Charge Nurses/Clinical Lead / Manager will ensure there has been an assessment of risk performed in all ward/department areas, and will seek to eliminate risk as far as reasonably practicable. Appendix C provides guidance on the conduct of a prevention of BBV/needlestick injury risk assessment and appropriate risk management strategies.

## **6.3 Prevention of Needlestick/Sharp Injuries**

All staff who undertake work which requires them to use sharps must follow the Guidance for the Prevention of Sharps Injuries and Eye/Skin Splashes (Appendix A). Safety devices to reduce the risk of needlestick injuries must be available in all areas where appropriate.

## **6.4 Reporting and Management of Needlestick Injuries**

- 6.4.1 The recipient of the sharps/needlestick injury should contact Occupational Health immediately between 8am and 5pm or A&E RVI/EAU FRH outside of these hours for immediate advice and follow up. All incidents occurring 5pm and 8am must be reported to Occupational Health by the recipient as soon as possible. All donor blood tests for BBV should be followed up urgently by occupational health in hours or the senior physician who took the blood from the source patient out of hours. The source patient and recipient must be informed of the results of any blood tests.
- 6.4.2 Potential exposure incidents should be reported on the Trust's Datix Incident/Accident reporting system. Source patient details should be recorded on the Risk Assessment Form (Appendix D).
- 6.4.3 A risk assessment of all incidents (type of injury and donor risk factors) should be carried out (using Appendix D) by the most senior clinician available at the time and faxed to the Occupational Health Department. The risk assessment should not be carried out by the individual who has sustained the injury.
- 6.4.4 For source patients of unknown serological status, serological testing for BBV infection with informed consent should be the norm (see section 6.6).
- 6.4.5 Where sharps/needlestick injury occurs in community settings source patient testing is usually impractical, and such exposures will be treated as 'source serological status unknown'. The recipient should otherwise follow the reporting and follow-up pathway described above.

## 6.5 Post-Exposure Procedures (PEP) (See Appendices D & E for Summaries)

### 6.5.1 Following any exposure:

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

6.5.2 In office hours staff must report the injury/contamination to the nurse in charge or their supervisor/manager, and then attend the Occupational Health Department as soon as possible after the incident to ensure appropriate follow up care is commenced.

6.5.3 The responsibilities for action following incidents are summarised in Appendix E.

6.5.4 Outside normal working hours, staff must report the injury to the nurse in charge of the clinical area or their supervisor/manager and then report to the Accident and Emergency Department, RVI, or the Emergency Admissions Suite at the Freeman Hospital. The on-call physician for Infectious Diseases can be contacted for advice on risk assessment, counselling and need for PEP, and must be contacted at any time if the sharps/needlestick involves a source known to be positive for a bloodborne virus.

6.5.5 Patient's or visitor's exposures should be notified to the manager of the clinical area. Their management will follow the policy as detailed for staff with respect to risk assessment of the source patient (if known), but referral to Accident and Emergency should also be arranged to coordinate further clinical management. Incidents involving exposure of patients or visitors should be notified, with consent, to their general practitioner.

6.5.6 In all cases a Trust accident/incident record **must** be completed using the DATIX system within 24 hours by the Ward/Area Manager – see the Trust Operational Policy and Procedure for Accident and Incident Reporting for further details. A confidential central database will be used to record all significant exposure incidents.

## 6.6 Testing and Counselling

- 6.6.1 In the hospital setting testing of the source patient for blood borne viruses should be the norm. The patient must be consented for testing. Consent given should be recorded within the patient's notes and on the laboratory request form.

To arrange for testing of the source specimen contact Freeman Hospital Microbiology Serology Department during office hours and the on-call biomedical scientist out of hours up until 8pm. Forms should indicate that a needlestick incident is involved and that consent has been obtained. Bloods should be sent to FRH Microbiology Laboratories urgently, bloods being sent from the RVI or NGH should be sent on the Hopper Bus using a transport tube available from Leazes reception RVI, or if to be transported out of hours by hospital taxi. Test results should be available ideally within 8 hours and not more than 24 hours after blood is taken. If urgent testing is required after 8pm this should be discussed via the virologist on-call, otherwise it will be carried out first thing the following morning.

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

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

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

In the event of a needlestick/sharps injury occurring from an unconscious source patient Infectious Diseases should be contacted to discuss PEP and further action on a case-by-case basis with GMC guidance on testing in the unconscious patient taken into account.

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

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

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

## 6.7 Post Exposure Prophylaxis (PEP)

### 6.7.1 HIV infection

- 6.7.1.1 The following regime is now recommended for PEP starter packs:

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

Plus

Raltegravir 400mg bd

PEP should be given with appropriate advice on risks and PEP information sheet (Appendix G)

- 6.7.1.2 Advice about PEP in non-healthcare settings or following other types of exposure, e.g. significant needlestick injury in the community with known high risk source, can be obtained from the doctor on call for Infectious Diseases or, for children, the doctor on call for Paediatric Infectious Diseases (contact via switchboard). In the case of sexual assault the GUM department should be contacted to ensure appropriate care is given (see BASHH guidance <http://www.bashh.org/guidelines>). PEP is rarely necessary if the source of the needle is not known.

- 6.7.1.3 PEP should not be offered following exposures to low risk materials (e.g. urine, vomit, saliva, faeces) unless they are visibly blood-stained.
- 6.7.1.4 Where the HIV status of the source patient is unknown, assessment of possible infectivity will be necessary. This may depend on information from the history, the examination and the results of previous investigations of the patient. Testing the source patient for HIV antibody should be the norm but will usually entail obtaining informed consent from the patient. If the source patient is strongly suspected to be infected with HIV, the health care worker should take PEP until consent has been obtained and the test result is known.
- 6.7.1.5 If the patient is unable to give consent, or refuses to, but is strongly suspected to be infected with HIV, the health care worker should take PEP, if appropriate, until consent has been obtained and the test result is known (see section 4.2). If there are delays in obtaining test results, if the donor patient has significant risks, the HCW should take PEP until definitive information is available. This should be a consultant decision in discussion with Infectious Diseases.
- 6.7.1.6 Advice on whether to recommend PEP can be obtained from the doctor on call for Infectious Diseases (contact via Trust switchboard).
- 6.7.1.7 PEP is most likely to be effective when initiated as soon as possible (within hours, and certainly within 48-72 hours of exposure) and continued for 28 days. PEP is generally not recommended beyond 72 hours post-exposure and should only be initiated on the recommendation of an Infectious Disease Consultant.
- 6.7.1.8 PEP starter packs are available on Ward 19 at RVI, A&E RVI and EAS FRH
- 6.7.1.9 In certain circumstances the choice of drugs may require modification, e.g. depending on the medical history of the member of staff; depending on whether they are taking any other medication; where the virus may have developed resistance to the recommended drugs (i.e. know HIV positive patient); or if the member of staff is pregnant. In ALL circumstances, expert advice should be obtained immediately before starting PEP, from the Infectious Diseases Team.

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

## 6.7.2 Hepatitis B Infection

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

6.7.2.2 If the source patient is unidentifiable or unavailable for testing, including most needlestick injuries in the community, manage as an unknown source exposure (see latest version of 'Hepatitis B' chapter of 'Green Book' – see References). It is seldom appropriate to test discarded needles and syringes; they should generally be safely disposed of instead. Serological and clinical follow up (including other BBV) should be undertaken.

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

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

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

6.7.2.6 Known non-responders to the vaccine, (hepatitis B surface antibody (anti-HBs) level < 10 IU/L) following a booster dose of HB vaccine, will require hepatitis B

immunoglobulin (HBIG), after significant exposures from unknown or HbsAg positive sources. This can be obtained by contacting a clinical virologist (extension 21104 9-5pm and via switchboard out-of-hours). A further dose of HBIG is required 4 weeks after exposure.

6.7.2.7 Following exposures to HBsAg positive sources, staff with no history of HB vaccine and staff who have received only one dose of vaccine will require HBIG. This can be obtained by contacting a clinical virologist (extension 21104 9-5pm and via switchboard out-of-hours).

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

### 6.7.3 Hepatitis C

6.7.3.1 Following significant exposures (see Appendix F) the source patient should be tested with consent for Hepatitis C (HCV) antibody. Patients who are HCV antibody positive should also be tested for HCV RNA.

6.7.3.2 Any needlestick injury involving a patient who is HCV positive should be discussed with the ID on-call and follow up of the recipient arranged with ID.

## 6.8 Follow up Action

6.8.1 All health care workers occupationally exposed to HIV, HCV or HBV should be offered follow up counselling, post-exposure testing and medical evaluation whether or not they have received PEP.

6.8.2 Healthcare workers employed in roles classified as involving exposure prone procedures (EPP) should attend all follow up appointments and have post-exposure testing performed within the Occupational Health Department.

6.8.3 Occupational exposures to patients who are known to have a BBV infection will be reported by Occupational Health in confidence to the PHE Communicable Disease Surveillance Centre (CDSC). Occupational Health will also notify the trust Risk Manager of the Datix number for all such incidents to initiate follow up, and reporting via RIDDOR where appropriate.

- 6.8.4 Any acute illness compatible with a diagnosis of a BBV infection that occurs during the follow up period should be reported to the Occupational Health Department or Department of Infectious Diseases and appropriate diagnostic tests performed.
- 6.8.5 All high risk injuries, recipients put on PEP, recipients requiring HBIG or rapid HB vaccination or with exposure to HCV RNA positive material should be followed up by Infectious Diseases who will liaise closely with the Occupational Health Department
- 6.8.6 Any occupationally acquired BBV infection should be reported to CDSC.

## **7 Education & Training**

7.1 All staff will receive annual education & training via induction and online training in:

- The risks associated with blood and body fluid exposures.
- The correct use of medical devices incorporating sharps engineering mechanisms (safer sharps devices).
- The importance of immunisation and how to access Occupational Health services
- The reporting, response and monitoring procedures and their importance.

7.2 Standard Precautions

7.2.1 Blood or body fluid from any individual must be regarded as potentially hazardous.

7.2.2 Ensure that all cuts or lesions are covered with a waterproof dressing whilst on duty.

7.2.3 Hands must be washed before and after carrying out procedures

7.2.4 Disposable gloves must be worn if exposure to blood or body fluids is anticipated, including mopping up spillages.

7.2.5 Where splashing or spraying of bodily fluids/blood or COSHH substances may occur always wear PPE, e.g. full face visor, goggles and face mask, disposable gloves, disposable apron, fluid repellent gown as required upon risk assessment for each individual situation, as per the Trust's Control of Substances Hazardous to Health policy and Personal Protective Equipment policies

7.2.6 Compliance with relevant Trust policies relating to the cleaning of non-disposable instruments.

## 8 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

## 9 Monitoring compliance with the policy

Standard / process / issue	Monitoring and audit			
	Method	By	Committee	Frequency
Training	Monitor and report on the completion of mandatory training	Training department	Heads of Nursing	Monthly
Reporting	Datix Incident & OH Rep Data	H & S & OH	Health and Safety Committee	Quarterly
Reporting	Analysis of inoculation incidents (including those reported to RIDDOR)	Lead Nurse Manager for Occupational Health	Health and Safety Committee	Quarterly

## 10 Consultation

The policy has been circulated to

- H&S,
- Clinical Gov and Risk,
- OH Team
- ID Team
- Head of Nursing
- CPG
- IPC team

## 11 Implementation

The policy will be placed upon the intranet and listed as NEW, staff will be informed of the policy on induction to the Trust. The policy will be circulated to Directorate Managers/Matrons/Clinical Lead/Managers to ensure local implementation.

## 12 References

- Immunisations against infectious disease – “The Green Book” Hepatitis B latest guidance, available at: <https://www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18> [last accessed 4th June 2015].
- Human Tissue Act 2004
- GMC, Confidentiality: Supplementary Guidance – Disclosing Information about Serious Communicable Diseases (2009) – [ww.gmc-uk.org](http://www.gmc-uk.org)
- The European framework on Prevention of Sharps injuries in Hospital and Healthcare Sector 2010/32/EU
- Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

- The National Institute for Health and Clinical Excellence (2012) Infection. Prevention and control of healthcare associated infections in primary and community care <https://www.nice.org.uk/guidance/cg139> [last accessed 4th June 2015].
- Loveday HP et al (2013) epic 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated infections in NHS Hospitals in England. Journal of Hospital Infection. [http://www.his.org.uk/files/3113/8693/4808/epic3\\_National\\_Evidence-Based\\_Guidelines\\_for\\_Preventing\\_HCAI\\_in\\_NHSE.pdf](http://www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf) [last accessed 4th June 2015]

### **13 Associated Documents**

- [Control of Substances Hazardous to Health Policy](#)
- [Hand Hygiene Policy](#)
- [Personal Protective Equipment Policy](#)
- [Standard Precautions Policy](#)

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## GUIDANCE FOR THE PREVENTION OF SHARPS INJURIES AND EYE/SKIN-SPLASHES

The Newcastle upon Tyne Hospitals NHS Foundation Trust

### Avoiding Sharps Injuries in Practise

- **If there is the potential to sustain a contaminated sharp injury, suitable clinical safety devices should be considered to reduce the risk.**
- All clinical staff must undertake Sharps Prevention Training and wards/departments must provide suitable clinical safety devices as outlined in the Trust Safety Devices Inventory.
- When using clinical sharps at the patients bedside or in a clinical setting always take have a suitable sharps box to dispose of the sharp immediately after use
- During clinical procedures the operator in charge has a responsibility to ensure the safe keeping, use, storage and safe disposal of all sharps and associated equipment
- If a separate plastic receiver is required to transport sharps during a clinical procedure always ensure the sharp is disposed of at the point of use/bedside into a suitable sharps box. (Following use, the receiver should be cleaned in accordance with Trust policy)
- When using any sharps equipment, always concentrate on the task in hand and do not allow yourself to be distracted. Maintain visual contact with sharps in use at all times
- Never leave a used sharp unattended, always dispose of equipment immediately and safely before undertaking another task
- Never re-sheath Needles, this practise is nationally banned
- Take care clearing up following a procedure, be aware of sharps hidden under gauze or equipment that could cause an injury.
- If you are using Butterfly devices for the infusion of subcutaneous analgesia always be aware of the potential of a sharp injury should the device becomes detached from the patients infusion site and maybe lying in the bed or in patients clothing
- Always consider the use of a safety canulla as first choice. When cannulating, give extra care to the safe removal and disposal of the canulla introducer
- When using butterfly type devices care should be to ensure that the needle does not pivot/curl on the plastic tubing and cause an injury.
- If handed a sharp instrument eg. scissors, scalpel, never take the sharp end and where ever possible always use a receiver to take and give sharp instruments and equipment
- If you find a sharp in an inappropriate place, take extra care. Pick up the sharp with forceps, or gently sweep into a dustpan using a brush and place into the nearest Sharpsbox box. Report the incident to your manager and complete a Datix incident form.
- Staff should cover any cuts or abrasions they have with an occlusive dressing.

### Avoiding Eye and Skin Splashes

- Where splashing or spraying of bodily fluids/blood or COSHH substances may occur always wear suitable Personal Protective Equipment (PPE) eg. Full Face Visor, Goggles and Face Mask, Gloves, Protective Apron, Fluid Impermeable Gown as required for each individual situation.

### Safe and Effective use of Sharps Boxes

- All wards and depts. must have adequate supplies of Sharpsmart boxes on trolleys and Sharpsafe boxes on trays available so that sharps can be disposed of at the point of use
- It is the responsibility of senior person on duty to ensure that the Sharpsmart and Sharpsafe boxes are checked and replaced when full and correctly labelled for disposal. If a Sharpsmart or Sharpsafe box is found to be full it is the responsibility of the user to inform the senior person on duty, so that the box can be replaced.
- In Specific areas where none- standard sharps boxes are still in use never shake the contents of the box down, objects can fly out and cause injury
- Take care when disposing of sharps into a sharp box, be aware of needle re-bound and possible protruding sharps from around the box tray and hinges
- Patients who are self-medicating insulin/checking their own glucose levels, must be supplied with a Sharpsafe box so they can dispose of sharps directly after use. This type of patient must be educated and instructed as to the importance of safe and correct disposal by the nurse who is responsible for their care.
- When using a Sharpsafe box ensure that it is securely placed in the moulded tray provided, and that it is cleaned with universal sanitising wipes between patient use
- Always place Sharpsmart/Sharpsafe boxes at a suitable waste height or work surface level, away from public access. NB. Never place on the bottom shelf of a trolley, or on the floor.

### Avoiding Operating Theatre Sharps Injuries

- Always use a receiver to take and give sharps and instruments to avoid injury at the table
- Keep all Sharps within your vision at all times, maintain good lighting in your work area
- Don't get distracted or sidetracked from the procedure.
- Take regular breaks between cases and keep hydrated to assist concentration levels.
- Introduce and use Safety Devices if available
- Addition care must be given to the use, closure and safe disposal of Disgarda-pads

## Roles and Responsibilities

### 8am – 5 pm Weekdays

#### Recipient

1. Inform nurse in charge of clinical area
2. Report injury to Occupational Health
3. Complete incident form

#### Nurse in Charge

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

#### SHO/Registrar/Consultant based in clinical area

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

#### Occupational Health

1. Arrange immediate assessment in the OH Service
2. Follow up donor blood tests urgently
3. Plan follow up and/or shared care with ID where indicated by risk assessment

### 5pm – 8 am and weekends/bank holidays

#### Recipient

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

#### Nurse in charge of clinical area:

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

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

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

### **Registrar on-call**

1. Risk assessment of patient.
2. Consent donor for HIV/HBV and HCV antibody tests.
3. Take blood from donor of needlestick injury in red topped tube, send to Freeman Hospital Microbiology **urgently** marked needlestick injury donor.
4. Phone FRH Microbiology Department to ensure blood tests are performed urgently. Testing will normally be done up until 8pm or first thing the following morning. If urgent testing required after this it should be discussed via the virologist on-call.
5. If high risk needlestick injury or in any doubt contact ID physician on-call

**Safety Device Risk Assessment Matrix**

Risk by amount of blood exposure per device	Critical		Infusion Devices /IV catheter	Blood collection Devices	
	Serious		IM injection Devices	Lancets	
	Medium	Acupuncture	Blood Splashes  Spinal Injection Devices  Subcutaneous Injection Devices		Surgical Devices Dental Equipment
	Low	No patient contact		Heparin Insulin Tinzeparin Injection	Insulin Injection Devices
		Seldom	Sometimes	Often	Frequently
Frequency of NSI in health care settings					

Important note: There are specific health care settings and situations where the probability that patients will be carriers of blood-borne pathogens will be predicatably high. In all cases where this is likely, the risk classification should automatically be considered high (RED) regardless of the type of sharps device being used.

**Risk Classification and Required preventative actions:**

Risk is not acceptable. Use of Safety Devices essential, vaccination against Hepatitis B, information and training for staff mandatory
Risk is not acceptable. Use of Safety Devices required, vaccination against Hepatitis B, information and training for staff mandatory
Standard precautions acceptable. Training for staff mandatory. Eliminate use of sharps if alternative available.

From EBN Toolkit for Implementation of European Directive on Prevention from Sharps Injuries (2013)

**Risk Assessment form**

Donor Patient Sticker

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

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

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

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

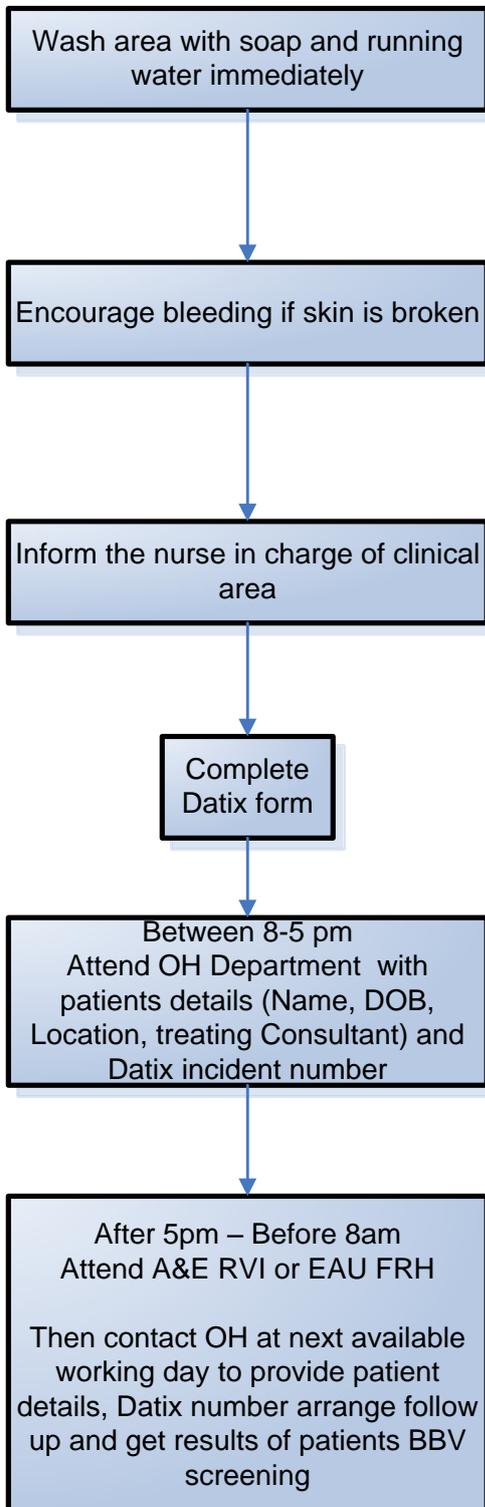
If NO/don't know to all questions: Await serology on donor patient.

.....

FOR OFFICE USE ONLY

Recipient of Injury\_\_\_\_\_

Contact Telephone number\_\_\_\_\_

**Guidance following a Needlestick Injury**

### Risks of Blood Borne virus (BBV) Infection

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

The risk of transmission of infection depends on:

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

The virus involved

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

The type of exposure/injury

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

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

Factors that may increase risk of occupationally acquired blood borne viruses are:

- percutaneous injury rather than mucous membrane or broken skin injury
- injury with a device which has been in a source patient's artery or vein
- exposure to blood rather than blood stained fluid, or other body fluid
- injury from hollow bore rather than solid bore needle
- injury from wide gauge rather than narrow gauge needle
- no protective equipment used (gloves, eye protection)
- first aid measures not implemented (washing & bleeding)
- active blood borne viral infection in source patient

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

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

#### Risk Factors in the Source Patient

Not all patients with BBV have had their infections diagnosed. Therefore all blood and body fluids and tissues are regarded as potentially infectious and staff should scrupulously avoid contact with them in all circumstances. Informed consent for testing of the source patient for HIV and HCV antibodies and HbsAg should be sought urgently (see Section 6.0). This consent should be obtained by someone other than the Needlestick recipient.

# Post Exposure Prophylaxis (PEP)

## What is important to remember?

- Keep all medicines out of the reach of children
- Store both drugs at room temperature
- Keep the drugs in their original container with the lid tightly closed
- Inform the doctor if you are taking any drug (prescribed by a doctor or bought yourself, including herbs)
- If you see a doctor including your GP you should let them know you are taking PEP
- If you buy any medicines from a pharmacy you should let the pharmacist know you are taking PEP.

**If problems contact ID outpatients on  
0191 2823106**

Code:

## Information for patients

### What is Post Exposure Prophylaxis (PEP)?

Post Exposure Prophylaxis is anti-HIV medication given to people who have been exposed to HIV infection, in order to reduce the risk of them becoming HIV positive. PEP may stop HIV infection if taken early after HIV has entered the body, but before the infection takes hold.

### When is PEP given?

The most common reason for giving PEP is that someone has had sex without a condom or a condom failed when having vaginal or anal sex with someone who is HIV positive or is suspected to be HIV positive or of unknown status. Other reasons for prescribing PEP include needle stick injury and following sexual assault.

### How soon should it be taken?

The quicker PEP is started the better, definitely within 72 hours of the risk, however the longer the wait the more likely it is not to work.

### Are the drugs the same as the ones taken by people with HIV?

Yes they are the same drugs that are taken by people with HIV infection, and the combination recommended is Truvada and Raltegravir but other combinations are sometimes used. Specifics of these medications can be discussed with the clinical staff.

### What is involved in taking PEP?

Blood tests are taken before you start medication to check your HIV status, liver and kidney function, blood sugar and cholesterol. These tests are repeated 2 weeks after starting and when you have finished the medication. Repeat HIV testing is done 3 months after completing the course of medication.

### How often and for how long would I need to take it?

The commonest combination consists of Truvada (1 tablet daily) and Raltegravir (1 tablet twice daily) and they need to be taken every day for four weeks (28 days).

### Are there any Side Effects?

Yes there can be with the most common side effects being sickness, diarrhea, fatigue, headaches, dizziness and rash. However it is unusual for them to be severe and if so can be treated with medication.

### What do I do after PEP has been given?

You will be given a starter pack of 3 to 5 days and also advice on what to do next. If not please contact your local GUM service for an appointment on the next working day. It is important to use condoms whilst taking PEP and until your blood test following treatment has returned negative for HIV.

**Equality Analysis Form A**

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

**PART 1**

1. **Assessment Date:**
2. **Name of policy / strategy / service:**
3. **Name and designation of Author:**
4. **Names & designations of those involved in the impact analysis screening process:**
5. **Is this a:** Policy  Strategy  Service   
**Is this:** New  Revised   
**Who is affected** Employees  Service Users  Wider Community
6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*  
**1 Aim of Policy**
7. **Does this policy, strategy, or service have any equality implications?** Yes  No

**If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:**

This is a policy looking at prevention of all staff and the management of an incidence should it occur. No scope for inequality.

**8. Summary of evidence related to protected characteristics**

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address ( <i>by whom, completion date and review date</i> )	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? ( <i>by whom, completion date and review date</i> )
Race / Ethnic origin (including gypsies and travellers)	N/A	N/A	N/A
Sex (male/ female)	N/A	N/A	N/A
Religion and Belief	N/A	N/A	N/A
Sexual orientation including lesbian, gay and bisexual people	N/A	N/A	N/A
Age	N/A	N/A	N/A
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	N/A	N/A	N/A
Gender Re-assignment	N/A	N/A	N/A
Marriage and Civil Partnership	N/A	N/A	N/A
Maternity / Pregnancy	N/A	N/A	N/A

**9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?**

N/A

**10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.**

Do you require further engagement?    Yes     No

**11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)**

No

## PART 2

**Name:**

Chris Wright

**Date of completion:**

01/07/2015

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)