Name of Policy: **Sharps Policy ‘Guidance for Clinical Healthcare Workers’**  
Protecting staff and patients against infection with blood borne viruses and management of sharps injuries

**Effective From:** 18/01/2018

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This policy supersedes all previous issues
### Version control

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Appendix 1
Information for Staff: Viral Hazards in Healthcare Settings

Appendix 2
Possible scenarios where a patient may be infected with a blood borne virus by an employee

Appendix 3
Ward / departmental guidance following a sharps injury
Contact points and sources of information

Any queries about the guidance given in this document which reflects recent Department of Health recommendations should be directed to the Occupational Health Nurses; Consultant Microbiologist or Infection Prevention and Control Team (IPCT). Exposure incidents not covered in this document should be reported directly to the clinical medical microbiologist (contact via QE switchboard on a 24-hour basis).

- Members of the public who have sustained sharps injuries sometimes report caches of needles lying in public places Gateshead Council Street Care and Cleaning will arrange for these to be removed and can be contacted on 0191 433 7000.

- Biohazard labels are available from Pathology Stores and can be ordered with pathology requisitions.

- Occupational Health Department Working hours Monday -Thursday 08.30 -1700; Friday 08.30-16.30 Closed bank holidays ext 5494 If dialling from outside GHFT prefix with 445.

- Gateshead Sexual Health Services 0191 283 1586.
1 Introduction

Sharps injuries and other exposures to blood in the health care setting are unnecessarily common at present. Many, especially those that involve third parties and particularly ancillary staff result from a failure to follow recommended procedures, and from the careless disposal of waste. Although the risk of acquiring a BBV through occupational exposure is low the consequences can be serious. Exposure to known or suspected BBV infected material is always stressful, and for some extremely so.

The Trust have a duty under the Health and Safety at Work Act (HASAWA), 1974, to ensure, so far as is reasonably practicable, the health, safety and welfare of their employees and anyone who may affected by their undertaking. They have a further duty under the Control of Substances Hazardous to Health (COSHH) Regulations, 1999, to ensure that suitable and sufficient risk assessments are in place that reduces the risk of acquiring Blood Borne Viruses (BBVs) to the lowest reasonable level. The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 place a duty on the Trust to avoid the unnecessary use of medical sharps, or use safer sharps incorporating protective mechanisms. The regulations also place a duty on employees to report sharp incidents, and place a duty on the Trust to record and investigate incidents.

Employees should take all reasonable steps to ensure that careless or deliberate misuse of or disposal of sharps do not place themselves or others at risk of injury as this may result in disciplinary action.

There will remain occasions when exposure occurs despite careful attention to correct procedures. Hence it is important that all exposure incidents are reported so that procedures can be reviewed in order that consideration can be given as to how recurrence might be prevented.

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 policy has been appropriately assessed.

2. Policy scope

This policy applies to all employees of GHFT, all students, visiting health professionals, locum and agency staff as well as patients and visitors. It details the Trust’s arrangements for the management of Infection Prevention and Control (IPC) activity, including the development and review of policies and procedures.

3. Aim

All staff has a responsibility to adhere to Trust policy and ensure that appropriate measures are taken to reduce the risk of infection. The measures outlined in this document aim to prevent anyone who may be present in the healthcare setting whether this be staff, patients, visitors or relatives from preventable exposure to Blood Borne Viruses (BBVs). The policy also outlines the action to be taken in the event of a sharps injury occurring.
4. Duties – roles and responsibilities

4.1 Chief Executive/Trust Board

The Chief Executive Officer (CEO) has ultimate responsibility for ensuring that effective systems and processes are in place to minimise the risk of infection to patients, staff and visitors.

Trust Board The Trust Board has a responsibility to ensure that the risk of infection to patients, staff and visitors is minimised to its lowest potential and therefore supports the full implementation of this policy. The Trust Board has overall responsibility for ensuring that adequate resources are provided for IPC and for monitoring the impact of the policies of the Trust and its management. The Board receives assurance regarding the effectiveness of IPC policies and practice through the monthly HCAI board reports and annual report presented by the Director of Infection Prevention and Control (DIPC) and reports from the Quality Governance Committee.

The Joint Directors of Infection Prevention and Control (DIPC) - The Director of Nursing & Midwifery and Quality (DN) and the Medical Director (MD) - The DN in conjunction with the MD as joint DIPC has delegated responsibility and oversight for ensuring effective systems and processes are in place to minimise the risk of infection across the Trust.

Consultant Microbiologist - will give advice against this policy and liaise directly with Public Health England (PHE) ensuring that all staff have access to this policy via the Trust Intranet and ensure that it is updated every two years or in line with current national guidance.

IPC Doctor (IPCD) - is responsible for supporting the joint DIPCs, Head of IPC and the IPC team by providing guidance and advice on matters relating to clinically relevant microbiological issues e.g. clinical IPC activity, antimicrobial prescribing, laboratory issues, surveillance and epidemiology. The IPCD liaises with the joint DIPCs and Head of IPC on key operational issues as required.

Head of Infection Prevention and Control - Provides expert IPC leadership, advice and support to the joint DIPCs providing management and leadership of the IPC Team. Produce an Annual Programme for IPC incorporating national infection control objectives, guidance legislation and policy.

The Infection and Prevention Control Team – works closely supporting multidisciplinary clinical teams/staff in ensuring the risks of HCAI are minimised across acute and community services. The IPC team provide specialist advice, expertise, education and training on matters relating to the identification, prevention and management of infection within the Trust to provide assurance for patient and staff safety.

The Infection Prevention and Control Committee - is responsible for the ratification of Trust wide infection prevention and control policies, procedures, and guidance, providing advice and support on the implementation of policies and monitoring the progress of the annual infection control programme.

Business Unit Associate Directors, Heads of Service and Service Line Managers - are responsible for

- Ensuring all staff are aware of relevant HCAI policies; are up to date with attendance of Trust’s Mandatory Training Programme, acting on non-compliance/attendance.
• Ensuring that there are effective IPC processes in place in accordance with the Trust’s IPC strategy and annual programme and that the appropriate level of local management action is initiated and completed as required.
• Ensure IPC is discussed at appropriate forums/meetings as on-going development, review and monitoring of Business Unit planning.
• Ensuring that Root Cause Analysis (RCA), and/or Post Infection Reviews (PIRs) are completed by senior medical and nursing staff and attend Serious Incident Meetings as required. Responsible for disseminating lessons learned to all levels of staff in their Business Unit.
• Ensuring that IPC is a mandatory item on all management team briefings/meetings.
• Reporting via performance and clinical practice and standards reviews on the Directorate IPC management performance in addition to new and emerging risks, major changes of priority on existing risks and key actions.
• Ensuring where necessary, that business unit HCAI risks are reported on the risk register with developed action plans to monitor, review and resolve the identified risk as necessary
• Ensuring that a programme is in place for carrying out risk assessment of procedures in order to prevent or control exposure to substances hazardous to health and that a written record of such risk assessment is part of any written policy relating to activities within their area of responsibility.
• Following a sharps injury ensuring that risk assessments (including COSHH risk assessment) are reviewed.

**Matrons/Ward Clinical Managers**, in addition to contributing to the responsibilities as outlined above, have responsibility for:

**Are responsible for:**

• Providing visible strong leadership for IPC and driving a culture of cleanliness in clinical areas and participating in regular monitoring of standards.
• Ensure staff attendance at mandatory training and act on non-attendances.
• Ensure clinical staff have access to, and read, infection prevention and control policies.
• Promote the standard principles of infection prevention and control, awareness and responsibilities amongst employees, service users, contractors and partners to ensure that patients and visitors are managed safely.
• Ensure ward quality measure audits are performed and any non-compliance are acted upon and documented in an action plan.
• Ensure infection prevention and control link practitioners are identified and attend link practitioner meetings ensuring that there is promotion and engagement in the clinical environment.
• Leads on rapid reviews, RCA, PIR and Serious Incident Review Meetings as required, to promote learning and practice improvement
• Ensuring staff are released to attend OHD / A+E following a sharps injury
• Ensuring risk assessment is carried out and arranging for urgent blood borne virus testing (with consent) of donor patient as Appendix 3.
• Reviewing processes and procedures of ward / department to reduce risk of sharps injuries
• Ensure that sharps incidents are recorded on Datix and investigated, and the outcome of the investigation is added to the Datix report.
**Occupational Health Department (OHD)**

Are responsible for:

- Co-ordinating delivery of education and training programmes, including sharps awareness campaigns.
- Production of annual report on prevention and management of sharps injuries for Trust Health and Safety and Infection Prevention and Control Committees.
- Leading on implementation of safer sharps and systems to reduce sharps injuries.
- Liaising with Health and Safety Advisor if post exposure testing results mean that an incident becomes RIDDOR reportable.
- Ensuring appropriate management of sharps injuries sustained by Trust employees, visiting health professionals, agency / locum staff and students.
- Providing information on their intranet site on background information / statistics, guidance for staff on how to report sharps injuries, process to follow in the event of sharps injuries, how sharps injuries will be managed, access to post exposure counselling, prevention of sharps injuries and hepatitis B Immunisation.
- Ensuring posters are located throughout the Trust in an attempt to promote awareness of sharps injury prevention and providing information to staff on sharps injuries and current/future developments.

**All Trust Staff (including employees, visiting health professionals, agency/locum staff and students) have a responsibility to adhere to Trust policy and ensure that appropriate measures are taken to reduce risks associated with infection.**

All Trust staff have a responsibility to ensure they:

- All staff has a responsibility to support a culture of promoting best practice adhering to IPC standards as required within their job role and ensuring review included as part of their annual appraisal process.
- All employees will be personally accountable for their action and are responsible for ensuring compliance with trust IPC policies.
- Employees must understand their legal duty to take reasonable care of their health, safety and security and that of other persons who may be affected by their actions and for reporting untoward incidents and areas of concern.
- Healthcare workers are responsible for identifying infectious conditions and circumstances that may lead to outbreaks of infection that require specific controls to protect themselves, their patients or others.
- They are responsible for notifying the IPC Team of such circumstances and it is the responsibility of healthcare workers to ensure that they utilise safe working practices as outlined in IPC policies.
- Any breach in IPC Policies or Practice will place staff, patients and visitors at risk and subsequently the completion of a Datix submission will be required.
- Participation in mandatory IPC education and training programmes as outlined in the Trust’s Mandatory Training Policy.
- Challenging any poor practice within IPC and/or highlighting this to senior members of their team or members of the IPC team where necessary.
- Read policy and understand individual responsibilities.
- Attend induction and annual mandatory training.
• Raise awareness of arrangements which enable safe handling of contaminated materials and safe sharps practice with colleagues, patients and visitors
• Must keep themselves informed of newer and safer methods of working. Familiarise themselves with risk assessment methods.
• Report all medical sharps incidents.

5. Definitions

Percutaneous exposure: needlestick or other contaminated sharp object injury or bite that causes bleeding or other visible skin puncture

Mucocutaneous exposure: contamination of non-intact skin, conjunctiva or mucous membrane

“Significant” exposure: a percutaneous or mucocutaneous exposure to any of the body fluids or tissues listed below

• Blood (highest infection risk)
• Blood-stained fluids
• CSF
• Pleural/pericardial/peritoneal/synovial fluid
• Amniotic fluid
• Vaginal secretions & semen
• Breast milk
• Saliva in association with dentistry only (likely to be contaminated with blood, even when not obviously so)
• Unfixed human tissues and organs
• Exudate or other tissue fluids from burns or skin lesions

The risk of acquiring blood-borne viruses is MINIMAL following exposure to urine, faeces, saliva (other than in association with dentistry) sputum, tears, sweat and vomit: these exposures will, therefore, NOT normally be regarded as significant exposures (as far as these guidelines, which deal with blood borne viruses, are concerned). Other bacterial or viral infections can obviously occur following these exposures and the site should be thoroughly washed with soap and water unless this is a splash to the eyes or other mucous membrane when water only should be used.

Sharps injury: a significant percutaneous or mucocutaneous injury

Source person /patient: the person whose blood or body fluids have caused the exposure accident

Window period infection: a 3 month period where a person has only recently become infected with HIV. Antibodies have not normally reached a level at which they may be detected by blood test but the person may be infectious with HIV

Recipient: the person who suffered the exposure
Manager: the person who is in charge of the ward/department when the employee (recipient) has had the injury

Designated Health Care Worker: the person who will follow guidance on Occupational Health Intranet site and carry out risk assessments of source patients and in undertaking pre-test discussions and arrange for testing the source patient for HIV, HBV (hepatitis B virus) and HCV (hepatitis C virus).

PEP (Post Exposure Prophylaxis): drugs which may be given to a recipient following a “significant” exposure after all risk factors have been considered to reduce the risk of them developing HIV or Hepatitis B infection.

6 Management of Sharps Injuries

The steps to be taken in the immediate management and follow up of both staff and patients following exposure to body fluids are outlined below.

6.1 Risks of transmission of BBVs (See also Appendix 3)

Not all patients infected with BBVs have had their infections diagnosed. It is therefore important that all blood and body fluids are regarded as potentially infectious and HCWs should follow standard precautions scrupulously in all circumstances to avoid contact with them. Refer to Infection Control policies IC02 Personal Protective Equipment and IC03 Standard Precautions for the Prevention & Control of Infection

http://pandora/docs/policies/DOCUMENTS%20POLICIES/Forms/Infection%20Control.aspx

A number of infections can be acquired following a “significant” exposure with any BBV, but the main concerns are about 3 viruses: hepatitis B virus, hepatitis C virus and HIV (the virus which causes AIDS). The overall risk is small because not all source patients are infected and, even when they are, not all “significant” exposures result in infection of the recipient. However, because these infections can be severe, preventative strategies are justified.

The risk following percutaneous exposure is higher than that following mucocutaneous exposure. The risk following a percutaneous exposure from a known infected source patient, appears to be as follows:-

- hepatitis B: virtually no risk for immunised staff who have responded to vaccination, the risk for unimmunised staff or non-responders ranges from between 2% to 40%, depending on the infectivity of the patient.
- hepatitis C: estimates of risk range from 3% to 10%, depending on the infectivity of the patient.
- HIV virus: estimated risk about 0.2-0.3%, it is believed that the risk is higher if the source has an acute seroconversion illness or end-stage AIDS (as opposed to asymptomatic disease) and if the injury is deep, the device was visibly blood stained or was a hollow needle placed directly in vein or artery of the source patient. Starting a prophylactic course of anti-retroviral agents, within 72 hours (ideally within 1 hour) of the exposure-taking place can reduce the risk.
6.2 Inoculation injury to relatives and visitors – action to take

In the event of a sharps injury or exposure to blood/body fluid to a relative or visitor, the ward /department staff should;

- Carry out first aid at or near the scene as outlined below in 6.3
- Advise the individual to attend the A & E Department
- Complete a Datix report
- If the source person is a member of staff they are to attend the Occupational Health Department (OHD) (or A+E if OHD closed) so that a risk assessment can be completed and any necessary action taken.

6.3 Immediate action to be taken – following exposure to staff member, patient or relative

Following a sharps injury:

- Wash off splashes on skin with soap and running water.
- Allow area to bleed if the skin has been broken.
- Cover any wounds with waterproof dressing.
- Wash out splashes in the eye (preferably using eyewash, from a fresh eye wash bottle or alternatively running tap water), rinse out splashes in nose or mouth with copious amounts of tap water.
- Complete DATIX report

**Action - insignificant exposure:**

- Manager to reassure recipient
- Recipient to consider Hepatitis B vaccination or booster if at continuing risk of exposure – if employee to contact OHD for this. If patient or visitor to contact their GP

**Action - significant exposures:**

Employees must report immediately to OHD (or A+E) if closed where the following action will be taken. Patients who are recipients of sharps injury should be managed by their clinical team and visitors who are recipients will be managed by A+E in line with the following:

- Adequate information, counselling and psychological support will be provided (or arranged) to the recipient who has reported exposure and an explanation of the potential risk of BBV infection will be given. This should include encouragement to provide a baseline sample (clotted blood) for storage and follow up samples for testing as appropriate for HIV, HBV or HCV infection and advice about treatment.
- Pre-test discussion should reflect the importance of any test procedure and the implications of results. Discussion after the tests should provide the necessary support.
- All baseline samples will be stored in microbiology for 2 years from the date of injury. This may be tested in the future if the recipient experiences any symptoms suggestive of infection acquired from the incident.
• Hepatitis B immunisation status of recipient will be established. If the person is a sero non convertor (i.e. has not gained immunity to hepatitis b following vaccination) then a first dose of hepatitis b immunoglobulin may be required within 48 hours of the incident.
• Tetanus status will be checked and antibiotic prophylaxis/treatment will be considered especially if injury is a bite or particularly dirty wound.

6.3.1 Urgent action in to be taken by employee and manager in wards and departments if an EMPLOYEE is the RECIPIENT of a significant sharps injury

• First aid measures as above
• Employee to immediately telephone Occupational Health Department (OHD) between the hours of 08.30 – 17.00, Mon – Thurs, 08.30 – 16.30 Fri (closed bank holidays). On 0191 445 5494. If OHD is closed the recipient must report to A+E department and wait there until seen. At the earliest opportunity the recipient must contact OHD once open to arrange any necessary follow up and appropriate recording of incident.
• Manager to urgently organise risk assessment of source patient and to ensure source approached for consent for BBV testing (HIV antibodies, Hepatitis B Surface antigen, Hepatitis B core antibody and Hepatitis C antibodies) and to inform OHD or A+E of the outcome of the risk assessment, the source patient’s details and to advise if blood has been sent for urgent testing (microbiologist to be contacted to arrange this).
• Manager to consider whether the source patient has also possibly been a recipient of a sharps injury – possible scenarios when this may have occurred are listed in Appendix 2. If this has happened OHD or A+E (if OHD closed) must be informed to enable to staff member to be assessed as a ‘source patient’ as well as a recipient of an injury. If the staff member tests positive for infection the patient should notified of an intra-operative exposure without revealing which member of the clinical team is infected and the patient managed as a recipient of a sharps injury by the clinical team responsible for their care with involvement/advice from the Infectious Diseases Unit at Newcastle if needed. If the health care worker tests negative for blood-borne viruses, there is no need to inform the patient about the incident as this would avoid causing the patient unnecessary anxiety. A written record of the incident and test results should, however, be entered in the health care worker’s occupational health notes. A separate Datix form should be completed and the number of this recorded in the patient’s notes. In order to maintain confidentiality for the staff member, OHD or A+E will in the event of a positive result for BBV infection advise the consultant or registrar responsible for the patient that a sharps injury has occurred and that the patient has been exposed to a BBV (which ever is identified) without identifying the staff member so that any post exposure prophylaxis of referral to relevant specialist can be arranged. If A+E have assessed the employee, OHD will be informed of this to enable them to follow up the staff member and the employee must contact OHD once open. OHD will maintain details of such incidents to link the employee to the Datix form.
• Manager to review risk assessments (including COSHH) following event and ensure incident is investigated
• OHD will review the circumstances of the incident and procedures in use, in conjunction with the Supervisor/Manager.
• OHD will arrange follow-up counselling, support of staff member and post exposure testing as per OHD protocols
NB The confidentiality of the source patient must be maintained and any risk factors or blood results that are identified as a part of the risk assessment are not to be discussed with anyone other than the parties involved in managing this incident.

Occupational Health Department and A+E will work closely together to ensure that incidents are managed appropriately when the injury has occurred outside of OHD opening hours or when follow up is needed by A+E. This will mean that copies of Occupational Health notes and A+E records relating to the incident will be shared at these times between the two departments.

6.4 Action to be taken by designated health care worker following a significant injury

As a designated health care worker you may be requested by a line manager or Occupational Health Department/ Accident and Emergency to carry out a risk assessment on one of your patients if they are the source patient involved in a ‘sharps injury. It is expected that this will be dealt with urgently and ideally within 1 hour of the incident. N.B. if you are the person who has suffered the injury, you should NOT also act as the designated health care worker; this must be carried out by another suitable person.

The following action should be taken:

- Explain to source patient that a sharps injury has occurred without divulging the name of the recipient, the purpose of the discussion and that the outcome of the discussion any related blood results will be shared with the OHD and possibly A+E.
- Complete the BBV assessment checklist in Appendix 3
- IF BBV status (HIV, Hepatitis B and Hepatitis C infectivity) unknown then ask patient for consent to test their blood for these infections. Current GMC guidance does not support the taking of blood for testing or testing of blood samples already taken without consent.
- Carry out appropriate pre test discussion as per appendix 3
- If source patient agrees to testing then contact microbiologist to arrange urgent testing for
  - HIV antibodies
  - Hepatitis B Surface antigen
  - Hepatitis B core antibodies
  - Hepatitis C antibodies
- Inform OHD (or A+E if out of hours) of outcome of risk assessment and whether urgent blood tests have been arranged.
- If risk assessment and / or consent for bloods cannot be obtained (e.g. if patient is unconscious or does not have the mental ability to undertake this then this information must also be relayed to OHD / A+E.
- Once blood results are known then the source patient must be informed of them immediately and if positive, post test counselling and referral to the relevant specialist must be arranged urgently. If negative then consider the possibility of window period infection and discuss risk factors and reduction of risk behaviours with patient.
6.5 Post exposure HIV chemoprophylaxis

Chemoprophylaxis (PEP) should be recommended or offered following a “significant” exposure, where the risk assessment deems it to be necessary. Commencement of PEP should not be delayed whilst waiting for test results if the risk assessment indicates this may be needed. It may be recommended if a window period infection for the source patient is being considered or following a significant exposure to blood or body fluid from a patient or source known to be infected or considered to be high risk of HIV infection when the test result is not known or can not be obtained. Its use is unlikely to be justified following an unknown source incident. PEP may be advised if window period infection is being considered.

The procedure when offering chemoprophylaxis should be as follows:

- Whenever possible, the HIV chemoprophylaxis should be started within 1 hour from the exposure and will normally be continued for 28 days. PEP is generally not recommended beyond 72 hours post-exposure. There may be circumstances where it is appropriate that the exposed worker is offered the initial doses immediately, pending fuller discussion and risk assessment as soon as practicable.
- The Occupational Health Department or A&E, will if necessary liaise with the Infectious Diseases Unit or Public Health England to seek advice on whether PEP is needed.
- An HIV chemoprophylaxis information pack will be available in A & E who will be responsible for issuing this and obtaining consent to use of PEP from the recipient and for providing them with information both about the limited efficacy and the potential for side effects.
- The exposed worker will be given an opportunity to read the drug information pack and to discuss the limited efficacy and the potential for side effects of the drugs. The exposed worker will have to decide whether he/she intends to accept the offer/recommendation.
- On acceptance of the HIV chemoprophylaxis it will be necessary to read and sign a consent form for treatment.
- Pregnancy does not preclude HIV chemoprophylaxis but it should be noted there is limited information about the use of these drugs in pregnancy (Urgent pregnancy tests can be arranged).
- Staff who are referred to and followed up by the Infectious Diseases Unit should provide or allow feedback to be given to the OHD. Where the employee is involved in the provision of Exposure Prone Procedures it will be necessary to allow the Infectious Diseases Unit to provide feedback on any infection that has developed as a result or to allow OHD to carry out any necessary blood tests to ensure they are not infected with HIV, Hepatitis B or Hepatitis C which could place patients at risk. Staff should refer to PP45 Occupational Health Policy.
- If the exposed workers incident occurs on a weekend or bank holiday and it is deemed appropriate to prescribe HIV prophylaxis in A and E then sufficient HIV chemoprophylaxis should be prescribed to cover until the next working day. The exposed worker should be seen by the on call Infectious Disease Consultant in Newcastle as soon as possible.
- Employment issues related to staff health and well-being will be managed by the OHD.

6.6 Post exposure immunoprophylaxis for hepatitis B

Post-exposure prophylactic measures will follow the Department of Health (Immunisation against infectious disease) recommendations and may include hepatitis B vaccination course or booster or
the administration of human immunoglobulin. Staff who have been informed they are a sero non convertor to hepatitis B vaccines must not delay in reporting the incident and must inform OHD or A+E that they are a sero non convertor. If immunoglobulin is required the first dose should be administered within 48 hours of the incident (a second dose may be required 1 month later). Hepatitis B prophylaxis should be considered for sexual and other close contacts of any exposed member of staff found to be hepatitis B surface antigen positive. Human immunoglobulin is available from the Public Health England Laboratory in Newcastle upon Tyne Hospitals Foundation Trust.

6.7 Post exposure prophylaxis for hepatitis C virus (HCV)

The available data does not support the use of immunoglobulin or alpha-interferon for prophylaxis against HCV. Whenever possible the source person should be tested for HCV antibody, and those with HCV antibody should subsequently be tested for HCV RNA PCR (using fresh EDTA blood), the risk is much reduced if HCV RNA is not detectable. The HCV RNA PCR should also be considered for some HCV antibody negative patients who fall in one of two categories: immunocompromised patients (including those on dialysis) and those with features suggestive of acute hepatitis.

6.8 Follow up action

Information should be made available to any recipient who reports a potential risk of blood borne virus infection and may include advice about testing for hepatitis B, hepatitis C and or HIV infection, advice about treatment or prophylaxis, any changes to work practices that may be required and the arrangement of counselling if needed.

6.8.1 Follow up for HIV

Staff who have had significant exposures to HIV infection should be offered an HIV antibody test 12 weeks post-exposure or post completion of PEP and should avoid further possible transmission (protected sexual intercourse, avoidance of pregnancy, blood, organ and semen donation). Longer follow-up with additional testing may be indicated in complex cases, for example if the exposed worker is immunocompromised, experiences an illness compatible with an acute retroviral syndrome (regardless of the interval since exposure) or where the source patient is dually infected. In the case of HIV and hepatitis C co infection, delayed seroconversion for HIV (documented at 7 months post sexual exposure) has been reported.

Post Exposure Prophylaxis (PEP) drug toxicity monitoring should include a full blood count U&Es and LFTs at baseline and 2 weeks after starting prophylaxis.

If toxicity is noted dose reduction, or drug substitution should be considered, in consultation with one of the Consultants in Infectious Diseases – via the Newcastle Hospitals switchboard.

Occupational exposures to patients who are known to be HIV positive should be reported in confidence to Public Health England (PHE) by the OHD.

If a health care worker presents having recently been exposed to HIV non-occupationally, a risk assessment should be conducted of the actual exposure. PEP may be indicated if the worker presents within 72 hours of the exposure event. The risk of seroconversion may be substantially higher from a non-occupational exposure.
Where the exposure, or most recent in a series of exposures, is within the last 3 months, the worker may be in the window period for seroconversion. If he/she performs exposure-prone procedures, modifying their practice during the follow-up period will be considered by the OHSD.

6.8.2 Follow up for hepatitis B

Where necessary, follow up visits should be arranged for further doses of Hepatitis B vaccine and blood test to check immunity. Non-responders or staff who are not immune should be counselled, and with their consent, tested for hepatitis B surface antigen and hepatitis B core antibody 6 weeks, 12 weeks and 6 months post exposure. For employees this will be provided by OHD. For other recipients they should be advised to contact their GP.

6.8.3 Follow up for hepatitis C

Staff who have had significant exposures to hepatitis C infection should be offered hepatitis C testing at 6 weeks, 3 months and 6 months post exposure. Provided that risks of hepatitis B and or HIV infection have been excluded it is not necessary to advise staff to have only protected sexual intercourse during the follow up period or to discontinue breast feeding or to avoid pregnancy. Testing will be recommended as follows:

<table>
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<th>Time after exposure</th>
<th>Recommended tests.</th>
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<tr>
<td>0 (baseline at the time of the exposure)</td>
<td>None: store at –20°C or below for at least 2 years</td>
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<tr>
<td>6 weeks</td>
<td>HCV RNA (PCR)</td>
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<tr>
<td>12 weeks</td>
<td>HCV RNA (PCR), HCV antibodies</td>
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<tr>
<td>24 weeks</td>
<td>HCV antibodies</td>
</tr>
</tbody>
</table>

If hepatitis C antibody is detected in a follow up specimen from a member of staff, their initial post exposure sample should also be tested.

Any person found to be infected with Hepatitis C should be referred to a Consultant Gastroenterologist for further assessment and possible treatment.

Any illness compatible with a diagnosis of acute hepatitis in any exposed member of staff in the six months after an exposure incident should be reported to the Occupational Health Physician and a referral made to a Gastroenterologist for appropriate diagnostic tests and management.

Any occupationally acquired hepatitis B or hepatitis C infection should be reported to Public Health England (PHE) and to the HSE under RIDDOR requirements.

6.9 Work practices during follow up

Pending serological follow up after occupational exposure to blood borne viruses a Healthcare Worker (HCW) need not avoid performing exposure prone procedures (EPPs) This is because the risk of the HCW having become occupationally infected, combined with the even smaller risk that the infection then being transmitted to a patient during an EPPs of such small order not to merit a restriction. Advice should be given about safer sex and avoiding blood donation during the follow up period. However in the event of the HCW seroconverting during follow up and having established blood borne virus infection, continued performance of EPPs must be reassessed in line with current guidance.
7 Arrangements which enable Safe Handling of Contaminated Material and Safe Sharps Practice

7.1 Precautions against exposure to BBV infection

7.1.1 Assessment of risk

Staff carrying out clinical procedures should at all times observe written policies produced by their employer, who in turn should observe the Control of Substances Hazardous to Health (COSHH) Regulations 1994. COSHH requires employers to undertake their own risk assessment and to bring into effect measures necessary to protect workers and others who may be exposed, as far as is reasonably practicable, against these risks.

- Designated managers responsible for health and safety within wards/departments are responsible for ensuring that a programme is in place for carrying out risk assessment of procedures in order to prevent or control exposure to substances hazardous to health and that a written record of such risk assessment is kept.

- Staff must keep themselves informed of newer and safer methods of working, and consider the benefits of introducing new working practices and safety devices to reduce the likelihood of sharps injury. In line with legislation safety devices are in use where available within the Trust and new devices will be assessed when they are available to replace non safety systems. Working practices must take into account cost effectiveness and avoidance of adverse consequences to patients or other HCWs. Any cost effectiveness assessment should include costs of follow up and claims following sharps injuries. This work is led by the OHD but if alternative safer practices or devices are known to an employee they should bring this to the attention of OHD.

- The following body fluids should be handled with the same precautions as blood:
  - Blood-stained fluids
  - CSF
  - Pleural/pericardial/peritoneal/synovial fluid
  - Amniotic fluid
  - Vaginal secretions & semen
  - Breast milk
  - Saliva in association with dentistry only (likely to be contaminated with blood, even when not obviously so)
  - Unfixed human tissues and organs
  - Exudate or other tissue fluids from burns or skin lesions

7.2 General measures to reduce the risk of occupational exposure

Pre employment health screening should identify those with damaged skin eg fissured hand eczema, who may be at higher risk of occupationally acquired infection, and ensure that advice is given about minimising any occupational health risk to which they may be exposed. Staff who
develop skin lesions whilst in employment should avoid invasive procedures and are advised to attend the OHSD for further advice.

The following measures will help to minimise the risk of exposure to BBVs and are appropriate to all health settings:

• Cover existing wounds, skin lesions and all breaks in exposed skin with waterproof dressings
• Wash hands before and after contact with each patient, and before putting on and after removing gloves (see glove policy)
• Change gloves between patients
• During procedures that carry a risk of contact with infected bodily products or contaminated materials disposable gloves must be worn and clothing protected with a plastic apron. When procedures that carry a risk of splashes are performed masks and eye protection must be worn.
• Open foot wear should not be worn in situations where blood may be spilt, or where sharp instruments or needles are handled
• Take care in the handling of sharp instruments.
• Clear up spillage promptly, disinfect surfaces and follow safe procedures for the disposal of contaminated waste. Refer to Infection control policy IC9 Waste Disposal and Recycling Policy)

http://pandora/docs/policies/DOCUMENTS%20POLICIES/Forms/Infection%20Control.aspx

7.2.1 Venepuncture, labelling, transport and reception of specimens

• Gloves should be available for all HCWs who undertake venepuncture
• Wear gloves when contact with blood is anticipated.
• Inexperienced venepuncturists should become accustomed to the wearing of gloves from the beginning of their training, and should not be asked to take blood from patients known to be infected with BBVs until trained and considered competent.
• There are safety devices throughout the Trust for taking blood samples and these should be used as follows:
  • BD eclipse safety vacutainer needle – expected that this will be suitable for most patients and staff
  • BD push button safety butterfly with vacutainer holder attached – may be used when patients have fine veins where use of vacutainer needle may not be suitable or where use of butterfly is staff member’s preference.
  • BD push button safety butterfly – for use with patients who have weak or friable veins that may collapse under the pressure exerted by a vacutainer. Blood should then be transferred into the vacutainer bottle by use of a blood transfer device.
  • Label specimen bottle after introducing the specimen
  • The use of a needle and syringe to obtain blood sample is not acceptable practice. It not only increases the risk of a sharps injury but can impair the quality of the blood sample making it unsuitable for testing.
  • Specimens from patients with known or suspected BBV infection should be accompanied by relevant clinical details and be conspicuously labelled or marked “danger of infection” (labels can be obtained via weekly pathology requisitions or by phoning 4452307).
• They should then be dispatched to the laboratory in sealed transparent polythene bags in a secure container that maintains patient confidentiality and is capable of disinfection in the event of specimen leakage.
• If specimen spillage/leakage does occur during transportation the laboratory should be informed. Kits for dealing with specimen spillage are available via the head porter/laboratory reception and should only be used by staff who have received training in how to use them.

7.2.2 Spillage of body and other fluids

If these are observed in general circulation areas between the hours of 0730-2000hrs the domestic supervisor should be informed. After this time the incident should be reported to the nearest open ward/department and materials obtained to clear up the spill. Refer to IC15 Cleaning and Disinfection policy

http://pandora/docs/policies/DOCUMENTS%20POLICIES/Forms/Infection%20Control.aspx

7.2.3 Safe handling and disposal of sharps

• Always concentrate on the task in hand and do not allow yourself to be side tracked
• Never leave a used syringe or blade unattended
• Never re-sheath needles manually
• Always dispose of your equipment safely, before undertaking another task. Consider using a small sharps box when undertaking a procedure so that the sharp may be disposed of immediately at the point of use wherever possible.
• Discard disposable syringes and needles wherever possible as a single unit, into sharps containers
• Remove needles from syringes only when essential eg when using local anaesthetic syringes as in dentistry.
• Never send samples either in needles or with needles attached to the laboratory. When sending arterial blood samples remove needles and attach blind hubs to syringes
• Intravascular guidewires and glass slides must be disposed of as sharps
• Place all sharps in a sharps container immediately after use
• Sharps boxes must be kept in a secure place well away from public access, out of the reach of children and as near as is practicable to sites of use. Never place on the bottom shelf or on the floor.
• All managers must make arrangements to ensure that sharps boxes are available in adequate numbers and regularly checked so that they are not overfilled in accordance with manufacturer’s instructions. They should be never be shaken down as sharps can fly out causing injury, closed securely prior to disposal and replaced promptly. Refer to Infection control policy IC09 Waste Disposal and Recycling Policy).

http://pandora/docs/policies/DOCUMENTS%20POLICIES/Forms/Infection%20Control.aspx

• If you find a sharp/needle in an inappropriate place carefully pick it up with forceps or gently sweep into a dustpan using a brush and place in a sharps box. Tell your manager and fill in a DATIX form.
7.3 Measures to reduce risks during surgical procedures

7.3.1 Reducing the risk of percutaneous exposure: methods, procedures and Equipment

The following measures may reduce the risk of percutaneous exposure and should be considered where practicable:

- Have no more than one person working in an open wound/body cavity at any time (unless essential to the safe and successful outcome of an operation) See also Section 3.9.2 for advice regarding Exposure Prone Procedures.
- Use a hands free technique where the same sharp instrument is not touched by more than one person at the same time, avoid hand to hand passing of sharp instruments during an operation.
- Assure safer passage of necessary sharp needles and instruments via a neutral zone The neutral zone may be a tray, kidney basin or an identified area in the operative field.
- Ensure that scalpels and needles are not left exposed in the operative field, but always removed promptly by the scrub nurse having been deposited in the neutral zone by the operator or assistant.
- Use instruments rather than fingers for retraction, and for holding tissues whilst suturing.
- Use instruments to handle needles and to remove scalpel blades.
- Direct sharp needles and instruments away from own non dominant or assistant’s hand.
- Remove sharp suture needles before tying suture; tie suture with instruments rather than fingers.
- Eliminate any unnecessary use of sharp instruments and needles.
- Opt for alternative less invasive surgical procedures where practicable and effective.
- Avoid scalpel injuries where associated with assembly/disassembly by using scalpels which are either disposable, have retractable blades or which incorporate a blade release device.
- Avoid the use of sharp clips for surgical drapes, blunt clips are available as are disposable drapes incorporating self adhesive operating film.
- Consider double gloving with a larger pairs of gloves innermost for optimum comfort.

7.3.2 Reducing the risk of blood skin contact

- If glove puncture is suspected or recognised, rescrub if possible and re-glove as soon as safety permits.
- Change gloves regularly if performing, or assisting with a prolonged surgical procedure even if no glove puncture is suspected or recognised.
- Consider the need for protection of body, eyes and face.
- Use waterproof gowns, or wear a surgical gown with waterproof cuffs and a plastic apron underneath if blood contact is considered a risk.
- If legs or feet are likely to be contaminated ensure that impermeable gown/apron covers legs and wear suitable foot wear.
- Wear protective headwear and a surgical mask.
- Ensure that all blood is cleansed from a patients skin before the patient leaves theatre.
- Remove protective clothing including footwear on leaving theatre. Footwear should be adequately decontaminated after use. All staff must be made aware of the correct procedures for disposing of once only and reusable clothing.
7.3.3 Measures to reduce eye and other facial exposure

All procedures should be assessed for the likelihood of splashes in order that goggles/visors are worn, and eyewash should be available in case of accidental exposure.

7.4 Clinical care of patients known to have BBVs in hospital

7.4.1 Acute hepatitis

Patients with known or suspected acute Hepatitis should be cared for in cubicle accommodation under Standard Isolation conditions (See Isolation Policy Number 6).

7.4.2 Hepatitis B surface antigen positive patients, hepatitis C positive patients, chronic non A-non B infections

- Patients who are acutely ill/bleeding/undergoing surgery/incontinent should be cared for in single accommodation under Standard Isolation conditions.
- Patients who are adequately self-caring and who do not pose a threat of sudden massive bleeding DO NOT REQUIRE ISOLATION.
- They may be admitted to the open ward and allowed the same activity as other patients without restrictions regarding the use of bathroom facilities, crockery or cutlery.
- Precautions should be taken to segregate potentially personal toilet equipment such as safety razors and tooth brushes. Non-invasive investigations such as chest x-ray and ECG can be carried out without precautions.

7.4.3 HIV infection

- Patients with HIV infection who are admitted to hospital do not need to be isolated unless they have other transmissible infections that require isolation in their own right or have conditions such as profuse diarrhoea, incontinence, bleeding diathesis or altered behaviour due to psychiatric disorder or neurological involvement. Their clinical condition will often indicate a need for a cubicle accommodation and patients may wish this for reasons of confidentiality.
- Precautions are required when venesection and invasive procedures are carried out, preferably in a clinical side room.
- Patients who are self caring, have normal behaviour and pose no risk of bleeding or incontinence should be allowed full use of ward facilities and do not require special precautions with regard to toilet/bathroom facilities (other than to segregate safety razor and tooth brush), crockery and cutlery or linen.
- Patients who require isolation because of other transmissible infection (eg Salmonellosis, Tuberculosis) should be cared for under Isolation conditions appropriate to their infection Refer to Infection Control Policy IC06 Isolation policy.

7.4.4 Transmissible Spongiform Encephalopathies e.g. CJD, New Variant CJD and related conditions Refer to IC22 Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathy Policy

- In patients undergoing essential neuro and ophthalmic surgery who are suspected of having, or have Creutzfeldt-Jakob Disease (including new variant CJD), or Gerstman-Straussler-
Scheinker Syndrome disposable instruments should be used. If it is not possible to use non-disposable instruments, instruments used in procedures on these patients should be destroyed.

- In addition to taking other precautions outlined in this document eye protection should be worn when collecting biopsy and lumbar puncture samples from known, suspect or at risk patients. Samples should be marked with a “Biohazard label” (See 3.3). The laboratory and Consultant Microbiologist should be informed prior to specimen collection.

7.4.5 Procedure after death - Refer to IC08 Cadaver Policy

- Staff performing Last Offices should wear disposable plastic aprons and gloves.
- Patients dying of Hepatitis B, C, HIV and other transmissible infections need special precautions in the handling of the body, which should be sealed in an impervious plastic cadaver bag. These can be obtained on request from the mortuary staff. Identity labels should be attached to the ankle and wrist of the patient and to the outside of the bag.
- A biohazard label that does not specify the cause of death must be attached to the bag.
- Relatives and close friends wishing to view the body should do so, if possible, before the body is placed in a cadaver bag and before removal from the ward.
- The body must not be handled unnecessarily
- When for religious reasons an attendant is required to handle the body, infection risk should be explained (without revealing the diagnosis) and appropriate protective clothing provided.
- Attach "Notification of Death" or mortuary label to the outside of the bag.

Undertakers will be advised to supply a 'finished leakproof coffin' and advised that the patient has died of an Infectious disease and that "viral precautions' are required, without revealing the diagnosis. Embalming would not be advised.

7.4.6 Post mortem examination

Written policies in the mortuary outline precautions to be taken when undertaking PMs these are similar to those undertaking invasive procedures in living patients

7.5 Other measures to prevent BBV transmission

7.5.1 Hepatitis B immunisation

Immunisation is recommended for individuals who are at increased risk of hepatitis B because of their lifestyle, occupation or other factors such as close contact with a case or carrier (see below). In some groups the risk is similar for all, but in others it will be necessary for an individual assessment of risk to be made. This is particularly the case for those who may be at risk because of their occupation.

If the stated aim in this policy is to be achieved it is appropriate not only to immunise staff who have direct contact with patient’s blood or blood stained body fluids or with patient’s tissues, but also those staff who are at risk of injury from blood stained sharp instruments, contamination of surface lesions by patient’s blood or body fluids, or of being deliberately injured or bitten by patients. These statements also apply to student health care workers, locums, agency and other temporary staff.
Hence there is a need for all sharps injuries and other relevant incidents to be reliably reported.

### 7.5.2 Risk groups

Immunisation is currently recommended in the following groups (refer to immunisation against Infectious Disease DH 2013 for further details):

- Babies born to mothers who are chronic carriers of hepatitis B virus or who have had hepatitis B during pregnancy (may also require post exposure prophylaxis with Hepatitis B immunoglobulin)
- Parenteral drug misusers
- Individuals who change sexual partners frequently
- Close family contacts of a case or carrier
- Families adopting children from countries with a high prevalence of hepatitis B
- Haemophiliacs, those receiving regular blood transfusions or blood products, or those carers responsible for the administration of such products
- Patients with chronic renal failure
- Health care workers
- Staff and residents of residential accommodation for those with severe learning disabilities (mental handicap)
- Others in occupations where they may be exposed to greater risk
- Inmates of custodial institutions
- Those travelling to areas of high prevalence who intend to remain there for lengthy periods or who have other lifestyle factors that put them at risk

### 7.5.3 Immunisation of healthcare staff against hepatitis B

This policy should be read in conjunction with Infection Control Policy IC05 Staff Immunisation Policy and PP45 Occupational Health Policy.


### 7.6 Staff performing exposure prone procedures (EPP)

It is recognised that those whose work involves exposure prone procedures or renal dialysis are at risk of transmitting blood borne viruses to their patients. Exposure prone procedures (Advisory Group 1993) have been defined as “where there is a risk that injury to the worker may result in the exposure of the patient’s open tissue to the blood of the worker. These procedures include those where the worker’s gloved hands may be in contact with sharp instruments, needle tips and sharp tissues inside a patient’s open body cavity, wound or confined anatomical space where hands may not be visible all the time”.

Healthcare workers who will perform exposure-prone procedures will be screened for blood borne viruses by OHD in line with Department of Health guidance and will not be passed fit for these procedures until satisfactory status has been determined.
7.7 Decontamination and waste disposal

Many occupational exposures to BBVs, result from a failure to adhere to basic rules concerning decontamination, waste disposal etc. Hence portering staff and engineers will not remove either any equipment for repair/servicing unless a decontamination notice is attached or waste that is incorrectly bagged from wards/departments. Refer to:

- RM30 Policy for the Procurement, Management and Use of Medical Devices
- IC09 Waste Disposal and Recycling Policy
- IC10 Linen Service Policy

8. Education and Training

Training on sharps injuries (management and reduction) is required as part of Induction and mandatory training.

9. 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 the grounds or any protected characteristics (Equality Act 2010).

10. Monitoring the Effectiveness/Compliance with this Policy

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
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<tbody>
<tr>
<td></td>
<td>Method</td>
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<tr>
<td>Audit of Sharps Injuries</td>
<td>The OHD will undertake an annual audit of the management of a selection of sharps injuries minimum of 10 that have occurred within the previous 12 months including a mixture of cases managed by both OHD and A+E for compliance with this policy.</td>
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<th>By</th>
<th>Lead/Committee</th>
<th>Frequency</th>
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<td></td>
<td>OHD</td>
<td>OHD/IPCC</td>
<td>Annually</td>
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11. Consultation and Review

This policy is reviewed and approved by Infection Prevention and Control Committee to ensure that it continues to reflect current priorities.

12. Implementation of this Policy (including raising awareness)

This policy will be circulated by the Trust Secretary. An implementation process will complement any policies submitted for approval to the IPCC, as per policy OP27. This will ensure awareness of
roles and responsibilities, and training requirements are identified. Training and awareness raising will be provided by Infection Prevention and Control team and Occupational Health on sharps injuries.

13. References


Health and Safety Executive (201??) Advisory Committee on Dangerous Pathogens Protection against blood-borne infections in the workplace: HIV and Hepatitis.


JAMA 1996, 276;90-92
Centers for Disease Control and Prevention, Atlanta USA. Update: Provisional Public Health Service recommendations for chemoprophylaxis after occupational exposure to HIV.


Benenson A.S. 1995


14. Associated Documentation

IC02 Personal Protective Clothing in Clinical Practice
IC03 Standard Precautions for the Control of Infection
IC05 Immunisation Policy for Health Care Workers
IC06 Isolation Policy
IC09 Waste Disposal & Recycling Policy
IC10 Hospital Laundry Arrangements for Used and Fouled/Infected Linen
IC15 Cleaning and Disinfection Policy
IC22 Creutzfeldt-Jakob Disease (CJD) and any other Transmissible Spongiform Encephalopathy Policy
PP45 Occupational Health Policy
RM01 Management of Risk Strategy
RM04 Incident Reporting and Investigation
RM08 Management of Risk Strategy
RM30 Procurement, Management and Use of Medical Devices
Appendix 1

Information for Staff: Viral Hazards in Healthcare Settings

Human Immunodeficiency Virus (HIV) Hepatitis B(HBV) Hepatitis C(HCV)

HIV

Although HIV transmission may occur in health care settings most HIV transmission occurs:

- by unprotected penetrative sexual intercourse with an infected person (between men or between man and woman
- by inoculation of infected blood. At present in the UK this results mainly from drug mis-users sharing blood contaminated injecting equipment
- from an infected mother to her baby before or during birth or through breast feeding

Hepatitis B Virus (HBV)

Hepatitis B virus surface antigen (HbsAg) may be found in blood and virtually all the body fluids of patients with acute hepatitis B and carriers of the virus, but blood, semen and vaginal fluids are mainly implicated in the spread of HBV infection. Transmission usually occurs:

- by unprotected sexual intercourse
- by injecting drug mis-users sharing blood contaminated injecting equipment
- perinatally from an infected mother to her baby

Up to 90% of babies infected perinatally and around 5-10% of those infected as adults develop chronic carrier status. The persistence of the ‘e’ antigen correlates with a high level of viral replication and increased infectivity

The most important measure whereby HCWs can be protected against Hepatitis B is by immunisation, which should be offered to all HCWs including students and trainees, who have direct contact with patients’ blood or other potentially infectious body fluids or tissues. Immunisation is not, however, a substitute for good infection control practice, since it affords no protection against other BBVs.

Hepatitis C Virus (HCV)

HCV is the main cause of what was previously known as non-A non-B hepatitis. HCV is most frequently acquired by direct blood-to-blood contact and the commonest mode of transmission in the UK is by the sharing of injecting equipment by injecting drug mis-users. Both sexual and perinatal transmission can occur but in general these are less efficient modes of transmission.
Appendix 2

Possible scenarios where a patient may be infected with a blood borne virus by an employee

- During an exposure-prone procedure performed by a health care worker who does not know his/her HIV status;

- During a non-exposure-prone procedure performed by an HIV-infected health care worker (e.g. physical assault on the health care worker, spontaneous nosebleed);

- An instrument or needle contaminated with the blood of the health care worker being inadvertently introduced into the patient’s tissues. For example where a health care worker accidentally sticks themselves with a needle and then puts the needle in the patient without realising what has happened or as another known Trust example continues suturing without changing the needle

- In the unlikely event that an invasive device or product contaminated by use on one patient is accidentally reused on another patient

- Visible laceration occurring to a health care worker’s hand in circumstances where the patient’s open tissues or mucous membranes could be contaminated with the health care worker’s blood;

- Visible bleeding of a health care worker from any other site (e.g. nosebleed) leading to significant bleed-back into a patient’s open tissues or mucous membranes;
WARD / DEPARTMENTAL GUIDANCE FOLLOWING A SHARPS INJURY

Action to be taken by employee and person in charge of department in event of significant sharps injury

In the event of a sharps injury allow the injury to bleed freely. Do not suck the affected area. Wash the wound with soap and water. Do not scrub or use antiseptics or skin washes. Cover the wound with waterproof dressing.

In the event of a mucocutaneous injury e.g. splashes of blood stained body fluids into the eyes or mouth or onto skin lesions irrigate the affected area with water.

Report injury immediately to manager / person in charge and complete DATIX form

If source identified and significant injury line manager to organise assessment of risk presented by source and with consent to arrange urgent testing of source patient blood for HIV antibodies, Hepatitis B surface antigen, core antibody and Hepatitis C antibodies. It is expected that the risk assessment will be dealt with urgently and ideally within 1 hour after the injury. Results of risk assessment to be relayed to Occupational Health Department (OHD) / A+E immediately.

Manager and employee need to assess whether the source patient has also possibly been a recipient of a sharps injury – possible scenarios when this may have occurred are listed in Appendix 14. If this has happened OHD or A+E (if OHD closed) must be informed to enable to staff member to be assessed as a ‘source patient’ as well as a recipient of an injury. If the staff member tests positive for infection the patient should notified of an intra-operative exposure without revealing which member of the clinical team is infected and the patient managed as a recipient of a sharps injury by the clinical team responsible for their care with involvement / advice from the Infectious Diseases Unit if needed. If the health care worker tests negative for blood-borne viruses, there is no need to inform the patient about the incident and this would also avoid causing the patient unnecessary anxiety. A written record of the incident and test results should, however, be entered in the health care worker’s occupational health notes. Enter in patient’s notes / theatre records that this incident has occurred with DATIX reference.

Employee to report without delay to OHD ideally taking completed source risk assessment

If OHD closed attend Accident and Emergency Department; ideally with completed donor risk assessment completed; inform Occupational Health and Safety Department of the incident when they are next open. A+E will triage the employee as a P3 which means they will aim to see the person within 1 hour. The staff member must stay in the A+E department until seen. If any follow up is needed out of hours e.g. to receive donor blood test results then ideally the staff member should visit A+E in person to discuss these. This will enable appropriate advice and support to be provided and to ensure that accurate handover of information occurs between A+E and OHD.
Action to be taken by Designated Health Care Worker following a significant injury

As a designated health care worker you may be requested by a line manager or Occupational Health / Accident and Emergency to carry out a risk assessment on one of your patients if they are the source patient involved in a ‘sharps injury. It is expected that this will be dealt with urgently and ideally within 1 hour of the incident. N.B. if you are the person who has suffered the injury, you should NOT also act as the designated health care worker; this must be carried out by another suitable person.

Explain to the source patient that a sharps injury has occurred (staff name should not be provided to ensure confidentiality), purpose of discussion and that outcome of assessment and blood results will be made known to Occupational Health Department and possibly A+E. Assess the source patient as follows.

- HIV, hepatitis B, hepatitis C status of patient negative (if has had previous testing) or unknown
- Source patient known to be HIV positive or to have hepatitis B, hepatitis C infection / carrier status. If HIV positive assess if patient has any drug resistance for this infection
- Complete a blood borne virus risk assessment
- Request consent to test the source patient’s blood for BBV’s (HIV, Hepatitis B, Hepatitis C). Provide / arrange for pre-test discussions / counselling, and obtain informed consent before blood is taken. Advise patient that the results will be made available in confidence to OHD and A+E if they are managing the incident
- If consent cannot be obtained, or is refused inform OHD or A&E and ensure the risk assessment form has been sent to whichever of these departments is managing the injury
- Immediately inform OHD or A&E (whichever of these 2 departments is managing the injury)
- Inform source patient of test results immediately and arrange any necessary treatment or referrals to appropriate specialist urgently. If results negative discuss any risk factors with patient and advise on risk reduction to avoid infection.
**Sharps injury donor patient risk assessment**

This form is to be completed for donor (source) patient when an employee has sustained a significant sharps injury. The risk assessment needs to be carried out urgently to enable any post exposure prophylaxis that may be needed to be given quickly. **ENSURE PATIENT IS ASSESSED BEFORE BEING DISCHARGED**

<table>
<thead>
<tr>
<th>Staff member who has sustained the injury/splash</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name</td>
<td></td>
</tr>
<tr>
<td>Patient date of birth</td>
<td></td>
</tr>
<tr>
<td>Patient hospital number</td>
<td></td>
</tr>
<tr>
<td>Ward, department patient on and extension number</td>
<td></td>
</tr>
<tr>
<td>If patient to be moved from above area please say where to</td>
<td></td>
</tr>
</tbody>
</table>

**About the donor patient**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient infected with HIV, AIDS, Hepatitis B or hepatitis C?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the patient engaged in unsafe sexual practices that may have increased their risk of developing blood borne virus infection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient or sexual partners from a “high risk” country? (Sub Saharan Africa South East Asia Latin America Caribbean)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there history of intravenous drug use and sharing needles?</td>
<td></td>
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</tr>
<tr>
<td>Has the patient any clinical features compatible with HIV seroconversion illness (monucleosis like febrile illness, fever with rash aseptic meningitis, encephalitis)?</td>
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</tr>
<tr>
<td>Has the patient persistent lymphadenopathy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the patient had any blood transfusions If yes state when and which part of world</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the patient a disease associated with AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient a haemophilia sufferer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the patient has tattoos or skin piercing performed? If yes identify when and if possible whether shop or parlour used clean equipment</td>
<td></td>
<td></td>
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<tr>
<td>Does the patient have a past history of hepatitis (B or C)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list any other relevant factors here or advise if risk assessment could not be carried out stating why
Blood tests to be requested (with patient consent)
If patient is unable to give informed consent, blood must not be tested

<table>
<thead>
<tr>
<th>Test</th>
<th>Obtained and sent for testing? Yes/no</th>
<th>Comments/ reason not tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.I.V. antibodies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B surface antigen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Co Antibody</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C antibodies</td>
<td></td>
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</tr>
</tbody>
</table>

Blood samples must be sent urgently to the laboratory and the microbiology lab informed that urgent testing for sharps injury is needed.

Occupational Health will pick up the results from ICE to manage the employee’s injury and it is the ward / departments responsibility to inform the patient of the results and to organise any referral that may be needed.

Your details

<table>
<thead>
<tr>
<th>Name of person completing this form</th>
<th>Job Title</th>
<th>Extension number or bleep number</th>
</tr>
</thead>
</table>

Please ensure that this form accompanies the employee (recipient) when attending the Occupational Health Department.

Alternatively the completed form can be sent as soon as possible to the Occupational Health Department(OHD) by email:-
OHD email address:-
ghnt.occupational.health@nhs.net

Please note if the employee is attending A/E then this this form needs to be completed and taken to A/E with the employee.
If the employee has attended A/E, then they must contact the OHD the next working day.
OHD contact number :-
0191 445 5494

A Datix must be submitted as soon as possible following the incident.

Sharps injury donor pt risk assessment form 30.08.2017 HA

SEQOHS Accredited Occupational Health Service since May 2014
DEFINITION OF "SIGNIFICANT" EXPOSURE

**percutaneous injury**
e.g. from needles, instruments, bone fragments, significant bites which break the skin

**mucocutaneous exposure**
exposure of broken skin (abrasions, cuts, eczema etc)
exposure of mucous membranes including the eye

**“significant” exposure**
a **percutaneous or mucocutaneous exposure** to any of the body fluids or tissues listed below:

- blood (highest infection risk)
- blood-stained fluids
- CSF
- pleural/pericardial/peritoneal/synovial fluid
- amniotic fluid
- vaginal secretions & semen
- breast milk
- unfixed tissues
- saliva in association with dentistry only (likely to be contaminated with blood, even when not obviously so)
- unfixed human tissues and organs
- Exudative or other tissue fluids from burns or skin lesions

The risk of acquiring blood-borne viruses is MINIMAL following exposure to urine, faeces, saliva, sputum, tears, sweat and vomit: these exposure will, therefore, NOT normally be regarded as significant exposures (as far as these guidelines, which deal with blood borne viruses, are concerned). Other bacterial or viral infections can obviously occur following these exposures.

GUIDANCE FOR TESTING THE SOURCE PATIENT

(Taken from HIV Post exposure Prophylaxis: Guidance from the UK Chief Medical Officer’s Expert Advisory Group on AIDS July 2008)

When a source patient is asked to agree to undergo HIV testing, careful pre-test discussion will be needed, as will informed consent, which should include disclosure of the source patient’s test result to the occupational health service and to the health care worker. This pre-test discussion can be provided by any appropriately trained and competent health care worker. Specialist pre-test discussion may sometimes be considered appropriate if the circumstances of the source patient are unusual or complex (e.g. source patient does not speak English, has mental health problems or a learning disability).

**Current GMC guidance** is: Decisions about testing the infection status of incapacitated patients, after a needle-stick or other injury to a healthcare worker, must take account of the current legal framework governing capacity issues and the use of human tissue. In England, Wales and Northern Ireland this area is covered by the Human Tissue Act 2004 and the Mental Capacity Act 2005 (E&W only). In Scotland this area is covered by the Adults with Incapacity (Scotland) Act 2000 and the Human Tissue (Scotland) Act 2006. As we understand it, current law does not permit testing the infection status of an incapacitated patient solely for the benefit of a healthcare worker involved in the patient’s care.