Policy:

NPCS 005 Infection Prevention & Control Standard Precautions - Prevention of Sharps Injuries & Prevention of Exposure to Blood & Body Fluids

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Policy Version and advice on document history, availability and storage
This is version 2 of this policy and supersedes version 1 (March 2013).

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version (V1) should be destroyed and if a hard copy is required, it should be replaced with this version.

Contents

1. Introduction:

Providers of health and social care in England are required to provide services that are safe, effective, caring, responsive and well-led. Providing services in this way meets the regulations and fundamental standards required by registration with the Care Quality Commission (CQC).

Providing these services requires policies that will help to prevent and control infections, including policies for

- standard infection prevention and control precautions (abbreviated throughout this document to „Standard Precautions‟)
- safe handling and disposal of sharps
- prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries
- management of occupational exposure to BBVs and post-exposure prophylaxis.

This document describes the Sheffield Health & Social Care Trust (SHSC) policy for each of these areas.

Contact with blood/body fluid may happen to clinical staff and non-clinical staff and by those handling contaminated waste, linen and including sharps. This type of contact has a potential to spread infection to staff and for clinical staff to spread infection between patients. Simple precautions used correctly and consistently will limit the risks of healthcare-associated infection for patients, while protecting health care workers (HCWs) from infection with disease-causing micro-organisms, including blood borne viruses.

The guidance in this policy will enable staff employed by (SHSC) to minimise the risks of:

a) spread of infection between patients through appropriate use of protective clothing;

b) unprotected exposure of staff to blood/body fluids

c) sharps injuries and describes the procedure to follow for a staff member occupationally exposed to blood borne viruses e.g. through sharps injury.

2. Scope:

The scope of this policy is to ensure staff members employed by SHSC are aware of the correct precautions to be taken when a) contact with blood/body fluid is anticipated and b) when handling and disposing of sharps; these are known as Standard Precautions. The policy has a preventive focus and will enable staff within SHSC to apply Standard Precautions effectively. Applying Standard Precautions effectively ensures that:

- personal protective equipment (PPE), most commonly disposable gloves and aprons, is worn for procedures where contact with blood/body fluid is anticipated
- PPE is removed after use with one patient and is not worn to provide care for other patients
- hands are cleaned effectively after removal of PPE and before contact with the next patient
- sharps are handled and disposed of safely. Together these minimise the likelihood of a) spread of healthcare-associated infection; b) unprotected exposure of staff to blood/body fluid; and c) sharps injury occurring.

The policy will also describe the procedure to follow if preventive measures fail and a staff member has an unprotected exposure of the mouth, nose, eyes or non-intact skin to blood/body fluid or sustains a sharps injury.

This policy does not cover exposure to sharps injuries contaminated with medicines, for this please seek advice from the Pharmacy Department.

3. Definitions

Patient – is used throughout this policy to refer to any individual to whom we, the Trust, provide care. It is interchangeable with the term service user, resident, client and where appropriate tenant.

In this policy the term "**blood/body fluid exposure incident**" is used to cover **all** the following:

- incidents where the mucous membranes of the mouth, nose or eyes, or broken skin (e.g. abrasions, cuts, eczema) have been contaminated by blood/body fluid. These exposures are also known as **mucocutaneous** exposures.
- Sharps injuries, where the skin has been visibly punctured by a needle or another sharp object contaminated with blood or other body fluid. These exposures are also known as **percutaneous** exposures and include human and animal bites.

The term **blood/body fluid** is used to mean

- Blood or material visibly contaminated with blood

- Body fluids which may pose a risk of transmission of blood borne viruses if significant occupational exposure occurs

- Body fluids which may pose a risk of transmission of healthcare associated infection (HCAI) between patients and for staff if Standard Precautions are not applied effectively.

Blood-borne viruses (BBVs) are viruses which are transmitted in blood/blood stained body fluids which may cause disease in other people. The most common BBVs are Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV).

Sharps include syringes, needles, scalpels, administration sets, razor blades, broken glass, including bone and tooth or any other sharp implement with the potential to cause a penetrating injury if not handled in a safe manner

Safety Devices are devices that incorporate a built in safety feature which is intended to reduce the risk of a sharps injury

Transmission is the passing of a disease or infection from an infected individual to a previously uninfected individual.

Hepatitis B "e" antigen is a viral protein associated with Hepatitis B virus (HBV) infections. It is used as a marker of ability to spread the virus to other people (infectivity).

4. Purpose

The purpose and objectives of this policy is:

- To prevent staff exposure to blood/body fluids within SHSC and minimise transmission of healthcare associated infection (HCAI) including blood borne viruses
- To prevent sharps injuries within SHSC and minimise transmission of blood borne viruses
- To ensure all staff are aware of safer sharps practice
- To ensure staff are aware of and adhere to the guidance issued in the prevention of sharps injuries policy and the actions to be taken following an exposure
- To ensure the appropriate Infection Prevention interventions and procedures are employed when dealing with staff/patients who have sustained a sharps injury.

5 Duties

The Trust Board, via the Chief Executive will:

- Ensure there are effective and adequately resourced arrangements for complying with and is accountable for ensuring that suitable arrangements are in place for managing the Infection Prevention and Control Standard Precautions, Prevention of Sharps Injuries and Prevention of Exposure to Blood and Body Fluids within the Trust.
- Identify a board level lead for Infection Prevention and Control.
- Ensure that the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled by appropriate and competent persons as defined by DH, (2008).

Director of Infection Prevention and Control (DIPC):

The DIPC reports directly to the Chief Executive and the Trust Board. The DIPC duties are

- Corporate responsibility for IPC throughout the Trust
- To promote IPC considerations in other operational and development decisions of the Trust Board
- Overseeing local control of IPC policies and standard operating procedures, guidance & protocols and their implementation in conjunction with the IPC team.
- Challenging inappropriate clinical practice as well as antibiotic prescribing decisions.

- Assessing the impact of all existing and new policies and plans on infection and make recommendations for change.
- Have the authority to set & challenge standards of cleanliness
- Be a full member of the IPC Team and antimicrobial stewardship committee and regularly attend infection control committee meetings
- Being an integral member of the organisation‟s clinical governance and patient safety teams and structures.
- Produce & present an annual report on the state of IPC in the Trust & release it publicly.
- Produce & present quarterly reports and an assurance framework to the Trust Board on the organisations performance in relation to IPC
- Provide leadership to the IPC team & IPC programme in order to ensure a high profile for IPC throughout the organisation.

Director of Care Standards:

- Clinical, operational and corporate staff understanding and enacting their responsibilities in meeting regulatory care requirements and standards across all Trust health and social care services.
- Compliance in practice with relevant legislative requirements including: the Mental Health Act; Mental Capacity Act; Care Act; Safeguarding Adults and Children; Infection Prevention and Control; and Health and Safety requirements.
- Compliance with local commissioners‟ contractual requirements.
- Effective learning from complaints, incidents and serious incidents.
- Improvements in care / services / quality through the judicious use of the outcomes of inspection, scrutiny, clinical audit, internal audit, use of benchmarking data, incidents, serious incidents, complaints, performance / peer review and from service user / patient and staff experience/ feedback.
- Application of effective quality improvement methodology that brings benefit.
- Effective utilisation of staff and service user experience / feedback to improve care / and people‟s experience of giving / receiving care.
- Application of research and development in improving practice.
- Use of technology and innovation to enhance the effectiveness, efficiency, safety and accessibility of services.
- Professionally qualified staff being fully registered and / or accredited (revalidation) to practice and duly comply with their respective Codes of Professional Practice.
- Effective clinical governance: that services are safe, responsive, effective, well led and caring.

The Medical Director is accountable for the Risk and Healthcare Governance Department.

The Director of Human Resources is accountable for the Occupational Health Service contract; which is currently supplied to SHSC via a Service Level Agreement (SLA) from Sheffield Teaching Hospitals.

Consultant Microbiologist:

- Provides relevant expert advice on a daily basis & supports the IPC Team.
- Advises & supports outbreak control and management as necessary
- Contributes to the review and update of policies and standard operating procedures, guidance or protocols including antimicrobial prescribing policy.
- Involvement in service specification including building and engineering works and purchase of medical or therapeutic devices/equipment.

Medical Devices Safety Officer:
The Clinical Risk & Investigations Lead is the Trusts nominated Medical Device Safety Officer (MDSO) with the MHRA. The key purpose of this role is to promote reporting & learning and safe use of medical devices across the organisation and be the main expert resource in this practice area.

Senior Nurse Infection Prevention & Control Lead:
Supports the DIPC and Deputy DIPC and is responsible for:

- Acting as a specialist resource for all health care workers, service users and relatives providing advice on the prevention and control of infection
- Strategic lead of educating staff on matters relating to IPC
- Identifying infection hazards and ensuring measures are taken to reduce those risks
- Monitoring IPC decontamination procedures
- Developing, implementing and monitoring the effectiveness of IPC policies and standard operating procedures, guidance & protocols.
- Managing outbreaks of infection and collecting/analysing mandatory & voluntary surveillance data
- Monitoring, identification and investigation of preventable infection
- Maintaining partnership working with other IPC specialists
- Maintaining an effective Link Worker Forum group
- Production of an annual work programme for IPC and quarterly reports of progress towards objectives set in the programme
- Assessing the risk of infection and advising on allocation of resources or actions required to reduce the risk
- Providing timely information to staff on effective control of infection measures
- Producing an annual report & quarterly reports on behalf of the DIPC
- Reporting relevant healthcare associated infections to the Public Health England (PHE) as directed by the Department of Health
- Provide specialist advice on new build projects and renovation, linen & waste within the Trust
- Facilitates an annual audit programme in regards to IPC

Clinical & Service Directors/Assistants, Heads of Service, Ward Managers, Managers, Team Leaders
Have responsibility for local performance management with regard to IPC and are responsible for:

- Implementation of this policy and the Trust IPC policy and standard operating procedures ensuring that advice & recommendations given by IPC team is followed
- Establishing a cleanliness culture across their areas of responsibility ensuring the Environmental Domestic Cleaning Schedule is followed.
- Ensure every area has a written Departmental Cleaning schedule detailing the reusable equipment & devices which require decontamination between patient use
- Challenging poor practice and bring to the attention of the IPC team & Infection Control committee situations were significant risks have been identified and where local control measures are considered to be potentially inadequate.
- Individual management teams will be responsible for ensuring that staff attend IPC core mandatory & mandatory update training and adhere to Trust IPC policies and procedures.

- Identifying individual staff members to act as a local resource for IPC within each area (Link Workers).
- Facilitating feedback of information related to surveillance data
- Fully engage with the IPC audit process by developing and taking ownership of action plans to address areas of practice where improvement is required
- Ensuring IPC is a standing agenda item on all locally held governance meetings

All Staff, Contractors, Agency, Apprentices, Secondees, Volunteers

- Have a duty to adhere to infection control policies and associated guidelines. This responsibility to be explicit in all job descriptions and included as part of the annual appraisal system and personal development plans as appropriate. All staff are obliged to:
- Undertake IPC training relevant to their role
- Maintain effective implementation of IPC policies in their area of work
- Report infection control incidents and risks to their line manager, raise incidents via the Risk Department and contacting the IPC Team as necessary.

The Infection Control Committee:

- Receiving a quarterly report from the Senior Nurse to include outbreaks of infection MRSA and Clostridium difficile data
- Monitor Trust compliance with externally set targets i.e. CCG Quality Account
- Monitoring progress against the rolling IPC programme
- Receive, review and endorse the annual IPC report
- Considers national guidelines and their subsequent impact upon the Trust
- Review and endorse Trust policies and standard operating procedures for the prevention and control of infection and monitor implementation ensuring that such policies reflect legislation and published professional guidance including best practice.
- Ensuring that there is an annual programme of Audit in relation to IPC
- Discusses, amend and endorse plans for the management of outbreaks in the Trust
- Advise on the most effective use of resources
- Disseminating information and advice on prevention and control of infection to all Directorates and the Trust Board as appropriate.
- Promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection.

Health & Safety Committee

The Committee‟s role is to promote co-operation between the Trust and its employees, instigating, developing and carrying out measures to ensure the health, safety and welfare of employees and other people in connection with the Trust‟s activities.

The Risk & Governance Department

- monitor incidents of an exposure type
- share information and good practice
- support relevant investigations and reviews as required
- participate in specialist risk related groups as required
- provide advice to ensure compliance with statutory requirements

Occupational Health Service via SLA provided by Sheffield Teaching Hospitals (STH)

The Occupational Health Service provided by STH will have designated responsibility for the management of SHSC employees and others sustaining blood/body fluids exposure

incidents. The Clinical Director of the Occupational Health Service will have overall clinical responsibility for the service, but may delegate day to day responsibility for the management of these incidents to other medical and nursing staff within the Occupational Health Service Department.

Occupational Physicians managing staff potentially exposed to blood borne viruses will seek appropriate advice from other clinicians including virology, microbiology, infectious diseases, genitourinary medicine and public health medicine when necessary.

The Occupational Health Service provided by STH will advise managers and staff on the management of blood exposure incidents, including sharps injuries sustained at work and in cases where entitlement to NHS or industrial injuries benefits is under consideration as a consequence of these incidents.

Information, counselling and psychological support will be made available to any SHSC employee who reports an exposure with the potential to cause blood borne virus infection. This will include encouragement to provide a baseline sample for storage and follow up samples for testing as appropriate for HIV, HBV or HCV infection. Follow up samples are taken to exclude the possibility of transmission of these infections. Pre-test discussion will reflect the importance of any test procedure and the implications of the results. Discussion after the tests will provide the necessary support.

The designated Occupational Physicians will maintain awareness of the latest developments in post-exposure prophylaxis including the use of hepatitis B immunoglobulin and hepatitis B vaccine and the use of anti-retroviral drugs following occupational exposure to HIV infection.

The Occupational Health Service at STH will provide cover outside normal working hours to advise and treat SHSC staff who sustain significant occupational exposures.

The Occupational Health Service at STH will monitor the effectiveness of its patient management through clinical audit.

6 Process

SECTION A – PREVENTION

Preventing Incidents

The Infection Control Committee has a standing agenda item relating to the EU Directive on Sharps. This provides the committee the opportunity to discuss safety devices and adheres to the following principles as per EU Sharps Directive.

- Integrated and passive safety features, which are likely to have the greatest impact on preventing sharps injuries
- The integrated safety feature should be part of the basic design of the device – it cannot be removed and is not an accessory feature
- The device should provide a barrier between hands and needle after use
- The device should require worker‟s hands to remain behind the needle at all times
- The device should have safety features that cannot be deactivated and remain protective throughout disposal to protect downstream workers
- The device should be simple and self-evident to operate; in addition training will be provided where required to ensure effective use

- The device should be appropriate to the procedure to be undertaken and be chosen following risk assessment.

Standard Infection Prevention and Control Precautions

Standard Infection Prevention and Control Precautions (Standard Precautions) are a set of measures to be taken when a) contact with blood/body fluid is anticipated and b) when handling and disposing of sharps. Applying Standard Precautions effectively will limit the risks of healthcare-associated infection for patients, while protecting health care workers (HCWs) from infection with disease-causing micro-organisms, including blood borne viruses.

Standard Precautions <u>are not prompted by a diagnosis of infection</u>; they are precautions that must be applied at all times, by all staff and for all patients, regardless of diagnosis. Standard Precautions are:

- Cleaning hands at the point of care before and after patient contact and between procedures for the same patient
- Choice and use of personal protective equipment (PPE) to protect staff from exposure to blood/body fluids and prevent spread of infection between patients
- Preserving integrity of the skin as a barrier to infection
- Treating waste and linen contaminated with blood/body fluids as infected or offensive
- Treating all blood spillage as infected
- Handling and disposal of sharps to prevent sharps injuries

Other measures may be required **in addition to** Standard Precautions for the safe management of patients with certain infections - please refer to the Infection Prevention and Control Policy.

Hand Hygiene

Hands should be cleaned before and after all procedures. If skin is contaminated with blood or body fluids, wash off immediately with soap and water. Alcohol hand rub can be used on clean hands for hand hygiene between patient contact tasks; for full details see the Hand Hygiene section in the Infection Prevention & Control Policy.

Use of Personal Protective Equipment

- When carrying out clinical procedures **it is essential** that each task is assessed for the healthcare worker‟s risk of exposure to blood/body fluids.
- The level of precautions taken will be determined by the risk of exposure to blood and body fluids and not by any perceived „risk factors‟ in the patient. In other words, **risk assess the procedure and not the patient**.
- Gloves must be worn for direct contact with blood or body fluid and for direct contact with non-intact skin or mucous membranes.
- Gloves should be discarded after each procedure and between different procedures for the same patient.
- Plastic aprons should be worn whenever contamination of clothing with blood or body fluids is anticipated.
- Full-body fluid-repellent gowns must be worn where there is a risk of extensive splashing of blood or body fluids on to the skin or clothing of healthcare workers.

- Protective eyewear and a mask, or full face visors, must be worn during any procedure where there is a risk of blood or body fluid splashing into the face.
- Personal protective equipment should be removed in the following sequence to minimise the risk of cross/self-contamination:
    - gloves;
    - apron;
    - eye protection (when worn); and
    - mask/respirator (when worn).

Hand Hygiene must be performed following the removal of personal protective equipment.

Immunisation

Protection against Hepatitis B Virus (HBV)

The risk of infection with HBV in individuals who have not been vaccinated against HBV, following a sharps or splash injury from a HBV positive source patient, is in the region of 1 in 50, rising to 1 in 3 if the source patient is also “e” antigen positive (HPA, 2008)

Staff who are carrying out exposure prone procedures or working in an area where there is a risk of an inoculation injury should be vaccinated against Hepatitis B Virus.

The Occupational Health Service (OHS) provided by STH will follow the most clinically appropriate Hepatitis B vaccination in line with DH guidelines. This will comprise of 3 initial doses of vaccine and a blood test with annual and 5 yearly boosters. Vaccination schedules may be subject to change but will follow the latest national guidance.

The action needed in the immediate post exposure period to protect staff against Hepatitis B is dependent on the vaccination status of staff and (where known) the Hepatitis B surface antigen status of the source patient. This will be managed by the OHS.

For action following exposure from a source patient see Section B „Incident Management below.
Hepatitis B immunoglobulin can be used as prophylaxis following a needle stick injury involving a Hepatitis B positive patient. If Hepatitis B immunoglobulin is required this is available via OHS.

Broken Skin
Cuts and abrasions on the hands and the forearms should be covered with a waterproof dressing at all times. Staff with extensive exposed lesions such as eczema or psoriasis should refer themselves via their manager to the Occupational Health Service.

Clinical Waste and Linen
Waste contaminated with blood or body fluid should be discarded into infectious or offensive healthcare waste streams; ensuring that no fluid leaks out.

- Use leak-proof rigid plastic containers and pre-treatment (gelling) if appropriate.
- Linen is not to be discarded.
- Soiled (including heavily soiled) linen is to be returned to NGH Linen services in multiple dissolve-bags (alginate) where appropriate, or where areas process their own laundry; should also follow this advice.
- Ensure that handling of healthcare waste and linen complies with local policy.

Blood/Body Fluid Spillage

Initially spillages of blood/body fluids should be safely cleaned up using a Clinell Spill Kit. Follow the instructions carefully on the reverse of the packet. Some areas are still using previous old style kits which use disinfecting granules to soak up the fluid at a strength of (10,000 parts per million) sodium hypochlorite solution and scoop & scrapper method. Follow the instructions carefully on the kit.

Once the initial clean-up process of the organic matter has been safely carried out, the area can be cleaned as normal with Virusolve+ by Housekeeping staff (when on duty) or other departmental or nursing/support staff when Housekeeping staff are not on duty.

Further advice on the safe management of blood & body fluid spillages can be found in the relevant section in the Infection Prevention & Control Policy

Management of a sharps spillage

A sharps spillage can be defined as:

- One or more inappropriately discarded sharp/s
- An overfilled sharps container with protruding items which cannot be safely locked
- Sharps not in a sharps container e.g. jam jar, bag
- An accidental release of sharps in the work place

If used sharps are spilled from a sharps container, the following procedure should be followed with extreme caution:

- Cordon off the area. Where possible a staff member should stay with the spillage.
- Apply protective equipment – gauntlet gloves if available or heavy duty gloves
- Collect a new sharps container and take it with you to the scene; a larger size than the original container may be necessary depending on the circumstances in this particular instance.
- In the case of a single discarded sharp, if the sharp is fully visible, you may feel able to pick up the non-sharp end and safely discard into a new sharps container.
- If more than one sharp item, use a dust pan and brush or a rigid piece of straight edged cardboard or plastic to carefully gather up the spillage and discard in a new sharps bin.
- If a sharps container has been over-filled and cannot be closed, do not retrieve items from it, instead place it in a larger assembled container and safely lock.
- Depending if any type of fluid has been spilled from the container, the floor area will need to be cleaned as per the advice above re: spillage kits
- Remove protective equipment. If reusable, clean as per the manufacturers‟ guidance and store. Discard single-use disposable equipment in the appropriate waste stream.
- Perform hand hygiene using soap and water.
- Complete and submit an incident report form.

If the situation cannot be safely dealt with using the above procedure, please contact the Waste Lead or Health & Safety Lead for advice.

Where the public notify any member of staff of a sharp found in a public area on Trust property; the staff member should advise the public not to touch it. The staff member must inform their manager of the incident and follow the above procedure.

Where the public notify staff of sharps found on non-Trust property, e.g. parks, the local authority should be informed (Street Force), they can be contacted on 0114 273 4567

Safe Handling of Sharps

Wherever possible avoid the use of sharps. Sharps must always be handled carefully in accordance with the following principles:

- Needles should not be re-sheathed. If resheathing is required in exceptional circumstances an approved device must be used.
- Needles must never be bent or broken
- Never pass sharps from person to person
- Never walk around with sharps in your hand or pocket
- Always get help when using sharps with a confused or agitated patient
- Always use needle free devices where provided

Safe Disposal of Sharps

- Always dispose of sharps yourself, never delegate; “you use it, you bin it”
- Dispose of sharps at the point of use (take a sharps bin with you)
- Dispose of syringes and needles as a single unit (do not remove the needle first)
- All sharps must be disposed of in an appropriate sharps bin
- Always ensure sharps bins are assembled correctly (ensuring that the lid is secured properly, the label is completed)
- Ensure that sharps bins are placed in a suitable safe location (wall brackets & trays should be used as appropriate).
    - Sharps bins should never be placed on the floor.
    - Risk assessments should always be made for confused patients.
    - During use in domiciliary care settings, a flat, hard surface at a safe working height should be chosen out of the reach of children and pets to prevent accidental „tipping-over“.
- Ensure sharps bins are of an appropriate size for the clinical activity and are filled only to the fill line displayed
- Sharps bins should be available at the point of use of the sharp

- All sharps bins to be closed & locked securely when ¾ full or at the specified interval i.e. the manufacturers‟ fill line.

- Between uses the temporary closure device should be employed to prevent accidental spillage of sharps if the bin is knocked over

- Always carry the sharps bin by the handle if fitted with one, or using the tray provided; never place it against your body. In the domiciliary care setting sharp bins do not have handles, therefore staff must carry their bins in a safe manner e.g. in their kit bags with the temporary closing mechanism in use.

- Ensure sharps bins are locked in accordance with manufacturers‟ instructions and ensure they are labelled with point of origin. Do not place sharps containers in any type of infectious or offensive healthcare waste bags for disposal.

- Used sharps bins awaiting disposal must be stored in a locked, segregated designated cupboard or infectious healthcare waste storage bin away from public access.

- Under no circumstances must one sharps container‟s contents be decanted into another sharps container.

- Items must never be retrieved from sharps bins

Sharps Generated by Patients at Home

In general patients and visitors must not have access to sharps bins unless supervised by a member of staff. Patients must be advised on the safe disposal of sharps, for example when involved in their own care. This advice must also include where to safely store the bin (when not in use) away from children and pets.

It is recommended that such patients be prescribed a sharps bin by their GP and when full it should be returned to the practice for safe disposal or arrangements made with the local authority for collection and disposal.

The Environment Agency provides an exemption for GPs to accept their self-medicating sharps, this Non Waste Framework Directive exemption (NWFD 4) allows GPs to temporarily store waste at a collection point before recovering or disposing of the waste elsewhere. NWFD 4 does not need to be registered with the Environment Agency, for further details:

https://www.gov.uk/waste-exemption-nwfd-3-temporary-storage-at-a-collection-point

Safety Devices

Many sharps injuries can be avoided by adherence to the principles of safe practice. However it is recognised that some injuries are complete accidents. The use of safety devices makes it possible to reduce the risk of these injuries occurring.

Safety devices incorporate a built in safety feature which aim to reduce the risk of sharps injuries.

SECTION B – INCIDENT MANAGEMENT

What is meant by exposure?

Percutaneous injuries (e.g. from used needles, bites and other wounds from sharp items) carry the greatest risk for transmission of blood borne viruses in the healthcare setting (Yazdanpanah, 2005).

Mucocutaneous exposure (e.g. splashes into the mouth, eyes, splashes onto broken skin or existing cuts/ eczema etc) carries a lower risk of blood borne virus infection, approximately 1 in 1000 for HIV. There is currently no evidence on the risk of transmission of Hepatitis B or Hepatitis C from mucocutaneous exposure (Department of Health, 2008).

Exposure to low risk body fluids e.g. urine, vomit, faeces, sputum and saliva (except when associated with dental work) is not normally considered a risk unless visibly stained with blood. Though low risk for transmission of blood borne viruses, these fluids are important sources of other pathogenic microorganisms implicated in healthcare associated infections. Standard precautions described previously are important to prevent the spread of these organisms between patients and from patients to staff.

Exposure of intact skin to blood and body fluids has not been associated with blood borne virus transmission to staff.

Note - Occupational exposure to Blood Borne Viruses is extremely uncommon

Body fluids that may transmit blood borne viruses

Blood
Saliva
Cerebro-spinal fluid
Pericardial fluid
Peritoneal fluid
Synovial fluid
Exudate or tissue fluid from burns/wounds
Any other body fluid if visibly blood stained.
Vaginal fluid
Semen
Amniotic fluid
Human breast milk
Pleural fluid
Unfixed human tissues and organs

First Aid

Immediately following any exposure, staff should quickly:

- **For a wound**
  Encourage bleeding by gently squeezing the site
  Wash the wound in warm running water with soap. Dry and apply a waterproof dressing - never suck the injury

- **For a splash in the eye**
  Irrigate the eye copiously with water before and after removing contact lens if worn.

- **For splash in the mouth**
  Irrigate thoroughly with drinking water for at least five minutes, without swallowing this water.

Staff who sustain an occupational exposure should report the exposure promptly to their manager and seek urgent advice on further management and treatment from Occupational Health. An incident form must be completed.

Injuries with unused clean needles or sharps should be washed and covered with a waterproof plaster. There is no requirement to inform the Occupational Health Service but should still be reported as an incident and recorded.

Initial Risk Assessment

The initial risk assessment is based on the potential for viral transmission, i.e. the type of body fluid involved, the route (e.g. percutaneous/mucocutaneous) and the severity of exposure. For example, some occupational exposures after careful assessment may not be considered to be significant as they do not have potential for BBV transmission. An incident form should be completed and the incident recorded. If after the initial risk assessment, which will be undertaken by the Occupational Health Service, a significant exposure has occurred see the following sections and refer to the document highlighted below.

Please download the **Blood Exposure Incident Management Pack** from the Infection Control Page on the Trusts intranet, listed under downloads. The management pack is universally used city-wide regardless of employing organisation.

Post Exposure Procedures

Testing and Counselling

The occupational physician or nurse will need, where possible, to obtain information from or about the source patient concerning possible indicators of blood borne virus infection, including risk factors and results of previous tests for HIV and hepatitis, medical history suggestive of such infection and details of past and current antiviral therapy in patients known to be HIV infected.

The source patient will be asked to consent to testing for blood borne virus infections including HIV, HBV and HCV. This will entail pre-test discussion and obtaining fully informed consent. This will be the responsibility of the clinical team caring for the patient, including medical staff covering out of hours. If the source patient is approached in a sensitive manner, it is understood that consent to testing is rarely withheld.

Source Patient Testing

The source patient will be routinely asked to consent to testing for Hepatitis B, Hepatitis C and HIV.

Responsibility for obtaining the consent, arranging the blood tests with the laboratory and conveying the results of the test to the source patient will be the responsibility of the clinical team caring for that patient.

The staff member who sustained the exposure should not obtain the patient‟s consent for testing.

A source patient information sheet and standard consent form are provided in the Blood Exposure Incident Management Pack.

If the source patient requests more information which cannot be given adequately by the clinicians responsible for the patient‟s care, advice can be obtained from the consultant virologists via Sheffield Teaching Hospitals (STH) switchboard.

Source Patients unable to give consent

The provisions of the Mental Capacity Act 2005 will apply where there is doubt about the source patient‟s capacity to consent. Please refer to the Mental Capacity Act Policy.

If the source patient is unable to give consent, i.e. is unconscious, lacks capacity to consent or has died, the Consultant Occupational Physician or, if unavailable, a consultant in Genitourinary Medicine or Infectious Diseases should be consulted about the degree of risk and further management of the incident. These individuals can be contacted via the STH switchboard service.

Testing of source patient's pre-existing blood samples, for the purposes of BBV management in relation to blood exposures without consent, is not permissible.

Neonates

Where the source patient is a neonate, the risk assessment will need to be based on the mother‟s risk factors for blood borne viruses.

Where antenatal testing results are not available, and if staff have sustained a significant injury, the mother will need to be asked to provide a sample of her blood. The baby‟s blood will not be tested.

Children

Children (under 16) will be tested with the consent of the parent/guardian. The child may consent if deemed able to give informed consent.

Young Adults (16 – 18)

This age group can consent to source patient testing for themselves but it may be appropriate to involve the parent/guardian in the pre-test discussion, depending on the patient‟s wishes.

In patients over 16 years of age, the provisions of the Mental Capacity Act 2005 will apply where there is doubt about the patient‟s capacity to consent.

Management of Refused Consent

If the source patient refuses consent, no testing will be carried out, even on stored blood.

Refusal to consent to source patient testing will not affect the patient‟s subsequent care and does not constitute evidence of infection.

Duration of Consent

The source patient‟s consent to be tested will only apply for the specific incident for which it is obtained.

If the same patient is subsequently the source of another blood exposure, advice from the Occupational Physician or Consultant Virologist should be obtained on the need for further testing. If a further test is advised, consent will need to be obtained again.

Information to the Source Patient following testing; Record keeping

The results of screening for blood borne viruses will be given to the patient by the senior clinicians or registered GP responsible for their care. If the source patient has been found to be infected with a blood borne virus, appropriate counselling and support and referral for treatment as indicated will be arranged by the clinical team responsible for their care.

Where the source patient is a child, the senior clinician will give the information to the parents/guardians and the child if competent as appropriate.

The senior clinician, usually the consultant, or GP and the Occupational Physician will liaise carefully over disclosures of any positive source patient result to ensure that the source patient and the staff member are informed in an appropriate manner. For this reason, the laboratory results on the source patient will normally be given to the Occupational Health Service initially.

Where source patient results are positive for blood borne viruses, the Consultant Occupational Physician will liaise with the source patient‟s Consultant or GP to ensure that appropriate action is taken.

When informing the source patient of the results of the test, the clinician will ask whether or not the patient wishes the results to be recorded in their notes and whether or not they wish their GP to be informed. The reason for the test must be clearly stated in the notes and any subsequent correspondence, i.e. that it was following a blood exposure to staff.

All information relating to the source patient obtained by the Occupational Health Service will remain strictly confidential and will not be disclosed to any third party. When information has to be disclosed, e.g. in legal matters, only the hospital or NHS number will be disclosed.

Workplace Wellbeing Support

Following the event of exposure to fluids Workplace Wellbeing can offer a range of interventions to all affected staff. Reactions can vary according to many factors, the degree of distress or trauma experienced is not always proportional to the actual risk. It is important that managers offer timely and immediate follow up to the affected member of staff preferably face to face where possible. As part of a range of interventions following an incident such as these managers should ensure that their staff are offered psychological support.

Confidential individual support via self-referral to Workplace Wellbeing can be offered to support staff process some of these events. This can be done in range of ways, from information sharing e.g. personal reactions to trauma, individual support in pre-test scenarios, support where there is perceived conflict of interest between the Trust and staff member and emotional support, psychological therapy or more formal post-trauma interventions such as EMDR.

Workplace Wellbeing can also offer support to mangers via consultation and have several information sheets that can be helpful to support them in these situations e.g. Guidelines for Managers dealing with Staff after Traumatic incidents. WWB can also offer psycho-educational materials and group facilitation to teams to enable the working through of the psychological and emotional processes that might be associated with such an event as appropriate.

Post Exposure Prophylaxis

Hepatitis B

If staff have been exposed to HBV infected blood, post exposure prophylaxis will be considered in accordance with guidance from the Public Health Laboratory Services (PHLS) Hepatitis Sub-committee (Communicable Disease Report, Vol. 2, Review No. 9, August 1992)

Hepatitis C

At present no post-exposure prophylaxis is available for HCV. Follow up of staff will be in accordance with current national guidance.

HIV

A separate policy on the provision of PEP for staff occupationally exposed to HIV supports this policy, and implements the requirements of “HIV post exposure prophylaxis: Guidance from the UK Chief Medical Officers Expert Advisory Group on AIDS” (2008).

Staff to Patient Exposure

These incidents are those where, in the course of clinical procedures, blood or body fluids from a member of staff contaminate a patient‟s tissues, usually where staff sustain a sharps injury and bleed into the patient, or more rarely, by “double needlestick” where staff stick themselves with a needle, which then enters the patient.

In this situation, there could be a risk of BBV infection to the patient if the staff member is infected and the patient may need to be given prophylaxis.

Staff who may be the source of an exposure to a patient must report the incident immediately to the Occupational Health Service, who will determine the risk of exposure to the patient and, where appropriate, obtain a blood sample from the staff member, with their consent, for testing. If the staff member is infected with blood borne viruses, the Consultant Occupational Physician will liaise with the consultant responsible for the patient‟s care to ensure that the patient is appropriately informed and counselled and given prophylactic treatment when indicated. Occupational Health will provide appointments, support and follow up to the staff member.

Detailed guidance on the management of incidents where a patient is exposed to the blood of an HIV infected HCW are contained in HIV Post-Exposure Prophylaxis: Guidance from the Chief Medical Officers‟ Expert Advisory Group on Aids, (Department of Health, 2008).

The identity of the “source” staff member will not be disclosed to the patient.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

If staff become infected with a blood borne virus as a result of a blood or body fluid exposure, this is reportable under RIDDOR as a disease. The Occupational Health Service will inform the Health & Safety Lead and the Medical Director should such a report be necessary.

7. Dissemination, storage and archiving (Control)

This policy will be available on the Trusts intranet site following the ratification process. It will be disseminated via the Infection Control Committee and the Infection Prevention & Control Link Worker Forum; and available to all staff.

Previous versions of this policy will be archived by the Corporate Governance Team. Individual staff are responsible for ensuring that they are accessing and adhering to the latest version of this policy; and delete any previous versions to prevent confusion.

8. Training and other resource implications

Preventing sharps injury and managing blood and body fluid exposures are incorporated into the Infection Prevention and Control Core and Update Mandatory session facilitated by the Training & Education Department; which are **mandatory** for staff employed by the Trust.

The Line Manager or Designated Supervisor/Team Leader should inform their staff about their personal Mandatory and Job Specific Training requirements during induction or when there is a significant change in role. The Line Manager/Designated Supervisor should consult the Training Needs Analysis for Infection Prevention and Control or contact the Training and Education Department for clarification.

The Line Manager/Designated Supervisor should book the employee onto any relevant training courses and confirm these arrangements with the employee. This process should be completed as part of induction and repeated when updates are due.

Staff should complete the specified training or notify their Line Manager or Designated Supervisor if they are unable to comply so that alternative training can be arranged.

9. Audit, monitoring and review

This policy will be monitored by the Infection Control Committee by monitoring & reporting incidents involving sharps; collated and reported by the Risk Management Team. The policy will be reviewed on a 3 yearly basis or as and when national guidance changes.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
How inoculation incidents are reported	Audit of incidents recorded on Safeguard system and OH data	Risk Department IPCT Team ICC H&S Committee	Quarterly	ICC and QAG	ICC H&S Committee	ICC/Board
Process for the management of an inoculation incident (including prophylaxis)	Audit of incidents recorded on Safeguard system and OH data	OH Department	Quarterly monitoring of Safeguard reports	Infection Control Committee/ Quality Assurance Group	Infection Control Committee	Infection Control Committee/Board
How the organisation trains staff, in line with the training needs analysis	HR & Workforce Education & Training Steering Group	Education & Training Department Education & Training Steering Group	Quarterly	HR & Workforce Education & Training Steering Group	HR & Workforce Education & Training Steering Group	HR & Workforce Education & Training Steering Group

10. Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	TBC once ratified.	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue.	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue.	

11. Links to other policies, standards and legislation (associated documents)

Risk Management Policy
Health and Safety Statement
COSHH Policy
Physical Health Policy
Incident Reporting and Investigation Policy
Waste Management Policy
Mandatory Training Policy
Consent to Examination or Treatment Policy
Mental Capacity Act Policy
Infection Prevention & Control Policy

External Documentation & Legal Frameworks
Prevention from Sharp Injuries in Hospital and Healthcare Sector Directive
Health & Social Care Act 2008 (2015)
Health and Safety at Work etc. Act 1974
Management of Health and Safety Regulations 1999
The Control of Substances Hazardous to Health Regulations 2002
The Personal Protective Equipment at Work Regulations 1992
Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (2014) Journal of Hospital Infection, Volume 86, Supplement 1 , Pages S1-S70

12. Contact details

Title	***Name***	***Phone***	***Email***
Occupational Health Department	Nurse on Duty	271 3360	
STH Switchboard RHH NGH	Telephonist	 271 1900 243 4343	
Health & Safety Lead	Charlie Stephenson		Charlie.stephenson@shsc.nhs.uk
Medical Devices Safety Officer	Vin Lewin		Vin.Lewin@shsc.nhs.uk
Infection Prevention & Control Lead Nurse	Katie Grayson		Katie.grayson@shsc.nhs.uk

13. References

Nil to record

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
1.0	Policy created	March 2013	New policy commissioned & approved
2.0	Full policy review	Jan 2017	Full review in all sections. New Trust policy template introduced & adopted. Comments included where appropriate during consultation phase prior to ratification.

Appendix B – Dissemination Record (Example)

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
1.0	March 2013	March 2013	
2.0	TBC	TBC	

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

Infection Control Committee March 2017

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have „due regard" to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain „protected characteristics" and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don"t know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	Neutral The policy applies equally to all individuals		
DISABILITY	Neutral The policy applies equally to all individuals		
GENDER REASSIGNMENT	Neutral The policy applies equally to all individuals		
PREGNANCY AND MATERNITY	Neutral The policy applies equally to all individuals		
RACE	Neutral The policy applies equally to all individuals		

RELIGION OR BELIEF	Neutral The policy applies equally to all individuals		
SEX	Neutral The policy applies equally to all individuals		
SEXUAL ORIENTATION	Neutral The policy applies equally to all individuals		

Stage 4 – Policy Revision - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date) K Grayson January 2017

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person‟s Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. **Is your policy based on and in line with the current law (including case law) or policy?**

■ **Yes. No further action needed.**
☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. **On completion of flow diagram – is further action needed?**

☐ **No, no further action needed.**
☐ **Yes, go to question 3**

3. **Complete the table below to provide details of the actions required**

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose „Format Text Box" and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.

1.1 What is the policy/decision title? …….. 1

1.2 What is the objective of the policy/decision? ……..

1.3 Who will be affected by the policy/decision? ……..

Will the policy/decision engage anyone"s Convention rights? 2.1

NO → **Flowchart exit**

There is no need to continue with this checklist. However,

- Be alert to any possibility that your policy may discriminate against anyone in the exercise of a Convention right
- Legal advice may still be necessary – if in any doubt, contact your lawyer
- Things may change, and you may need to reassess the situation

YES

Will the policy/decision result in the restriction of a right?

NO → **Flowchart exit** (as above)

YES

Is the right an absolute right?

YES

NO

Is the right a limited right?

NO → **Flowchart exit** (as above)

YES

Will the right be limited only to the extent set out in the relevant Article of the Convention?

YES

1) Is there a legal basis for the restriction? AND
2) Does the restriction have a legitimate aim? AND
3) Is the restriction necessary in a democratic society? AND
4) Are you sure you are not using a sledgehammer to crack a nut?

NO

YES

Policy/decision ***is*** likely to be human rights compliant

BUT

Policy/decision is *not* likely to be human rights compliant please contact the Head of Patient Experience, Inclusion and Diversity.

Get legal advice

Regardless of the answers to these questions, once human rights are being interfered with in a restrictive manner you should obtain legal advice. You should always seek legal advice if your policy is likely to discriminate against anyone in the exercise of a convention right.

Access to legal advice MUST be authorised by the relevant Executive Director or Associate Director for policies (this will usually be the Chief Nurse). For further advice on access to legal advice, please contact the Complaints and Litigation Lead.

Appendix E – Development, Consultation and Verification

Version 2 – updated policy to reflect Trust‟s adoption of new policy template. This policy will be available via the Trust‟s intranet site.

This policy has been reviewed by the Senior Nurse – Infection Prevention and Control. Occupational Health Department at STH are contracted to provide an occupational health function to SHSC via an SLA. Their procedure for the management of exposure to blood/body fluids has not been formally reviewed since 2011 and document remains ratified as current best practice. The responsibility for renewal of this universal document for exposure management across the city of Sheffield remains that of the OH Department at STH.

This policy review has been sent out for consultation with all members of the Infection Control Committee and additional relevant colleagues from 31/01/17to 28/02/17. Comments were received back from:

- Nikki Littlewood – IPCN Sheffield CCG
- Gwyneth De Lacey Director, Psychological Services/Consultant Clinical Psychologist

All comments and corrections were accepted and included within the policy as and where relevant.

The policy has been circulated to all members of the Infection Control Committee and Health & Safety Committee for verification, comment/approval prior to being presented for ratification. The policy was verified on the 08/03/17 at the Infection Control Committee.

Appendix F –Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy template which can be downloaded on the intranet (also shown at Appendix G within the Policy).

1. Cover sheet ☐

All policies must have a cover sheet which includes:

- The Trust name and logo ☐
- The title of the policy (in large font size as detailed in the template) ☐
- Executive or Associate Director lead for the policy ☐
- The policy author and lead ☐
- The implementation lead (to receive feedback on the implementation) ☐
- Date of initial draft policy ☐
- Date of consultation ☐
- Date of verification ☐
- Date of ratification ☐
- Date of issue ☐
- Ratifying body ☐
- Date for review ☐
- Target audience ☐
- Document type ☐
- Document status ☐
- Keywords ☐
- Policy version and advice on availability and storage ☐

2. Contents page

3. Flowchart ☐

4. Introduction ☐

5. Scope ☐

6. Definitions ☐

7. Purpose ☐

8. Duties ☐

9. Process ☐

10. Dissemination, storage and archiving (control) ☐

11. Training and other resource implications ☐

12. Audit, monitoring and review ☐

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template						
Minimum Require-ment	Process for Monitoring	Responsible Individual / group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group up/ committee for action plan development	Responsible Individual/ group/ committee for action plan monitoring and implementation
Procedure in place to manage injuries	Policy review 3 yearly or if changes by OH	Infection Control Committee	3 yearly	Infection Control Committee	Infection control committee	Infection control committee

13. Implementation plan

14. Links to other policies (associated documents) ☐

15. Contact details ☐

16. References ☐

17. Version control and amendment log (Appendix A) ☐

18. Dissemination Record (Appendix B) ☐

19. Equality Impact Assessment Form (Appendix C) ☐

20. Human Rights Act Assessment Checklist (Appendix D) ☐

21. Policy development and consultation process (Appendix E) ☐

22. Policy Checklist (Appendix F) ☐