The Newcastle upon Tyne Hospitals NHS Foundation Trust

Policy for the prevention and management of Needlestick Injuries and Blood Borne Virus Exposures

Version No :	7.0
Effective from	10th July 2012
Expiry Date:	31st March 2015
Date Ratified:	20th April 2012
Ratified by:	IPCC

1. Introduction

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

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

2. Policy Scope

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

3 Aim of Policy

This policy is intended to ensure all sharps/needles are risk assessed and where reasonably practicable replaced by a safety device in order to reduce the risk of exposure to blood borne viruses and transmission of these infections following needlestick or other exposures.

4. Duties (Roles and Responsibilities)

All employees have a responsibility to follow policies and procedures and ensure they are trained in the use of all devices, and use them safely to reduce the risk of injury to themselves, their patients, colleagues or members of the public.

All directorate managers must ensure safe systems of work are in place, staff have received training in the use of any sharps, and a safety device risk assessment has been undertaken.

Please see appendix E for roles and responsibilities for immediate management of a needlestick injury.

5. Definitions

There are no particular definitions requiring explanation.

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

6.1 Important Principles

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

6.2 Prevention of Blood and Body fluid Exposures

All directorate managers will ensure there has been an assessment of risk performed in all ward/department areas, and will seek to eliminate risk as far as reasonably practicable.

Safety Device Risk Assessment

Risk by amount of blood exposure per device	Critical		IV catheter	Blood collection	
	Serious		IM injection	Lancet	
	Medium	Acupuncture	Blood Splashes		Surgical Devices
	Low	No patient contact		Heparin Injection	Insulin Injection
	Frequency of NSI in Health care settings				

Required preventative actions:

Use of Safety Devices essential, vaccination against Hepatitis B, information and training for staff mandatory
Use of Safety Devices required, vaccination against Hepatitis B, information and training for staff mandatory
Training for staff mandatory. Eliminate use of sharps if alternative available.

EBN Toolkit (2011)

6.3 Prevention of Needlestick/sharp Injuries

All staff who undertake work which requires them to use sharps should:

6.3.1. Always ensure the correct device has been selected for the task, and ensure as far as practicable that a sharp with a safety device is selected for use

6.3.2 Always ensure that a sharpsafe or sharpsmart box is available to dispose of any sharp at the point of use or at the patients bedside. Never start a procedure without having a facility available to dispose of sharps

6.3.3 Never re-sheath needles. This practice is nationally banned

6.3.4 Never allow sharps boxes to become more than two thirds full

6.3.5 It is the responsibility of the senior person on duty to ensure that sharps boxes are checked and changed when two thirds full

6.3.6 Never shake the sharps box contents down. Sharps can fly out of the box causing injury

6.3.7 Always place sharps boxes well away from public access areas at a suitable height, e.g. work surface level or waist level. Never place on the bottom shelf of a trolley or on the floor

6.3.8 Always concentrate on the task in hand and do not allow yourself to be sidetracked

6.3.9 Never leave a used needle or blade unattended. Always dispose of your equipment safely, before undertaking another task

6.3.10 If you find a sharp/needle in an inappropriate place, always take extra care. Pick up the sharp with forceps, or gently scoop into a dustpan using a brush and place into the nearest Sharps box Report the incident to your Manager

6.3.11 Ensure that needles/sharps do not adhere to gauze, cotton wool swabs, drapes etc, during aseptic/sterile procedures on the ward or in theatre. For example, never put theatre drapes onto a used scrub

trolley as sharps can adhere to drapes from disposafe pads. If used sharps cannot be disposed of immediately into a sharps bin during a clinical procedure on the ward, use a galipot or container to keep them safe until they can be disposed of correctly

6.3.12 If handed a sharp instrument, e.g. scissors, scalpel, never take the sharp end first, use a receiver to take the instrument

6.3.13 When patients are self-medicating insulin or checking their own glucose levels, they must be supplied with their own Sharpsafe box so they can dispose of sharps directly after use at their bedside. Patients who are self medicating insulin or using sharps of any description must be educated and instructed as to the importance of the correct disposal of sharps by the nurse who is responsible for their care

6.3.14 Additional care must be given to the use, closure and safe disposal of Disgarda- pads.

6.4 Reporting and Management of Needlestick Injuries

6.4.1 The recipient of the Needlestick injury should contact Occupational Health immediately between 8am and 5pm or A&E RVI/EAU FRH outside of these hours for immediate advice and follow up. All incidents occurring outside of 8am and 5pm must be reported to Occupational Health by the recipient as soon as possible. All donor blood tests for BBV should be followed up urgently by occupational health in hours or the senior physician who took the blood from the patient out of hours. The recipient must be informed of the results of any blood tests.

6.4.2 Potential exposure incidents should be reported on the Trust's Datix Incident/Accident reporting system. Donor details should be recorded on the Risk Assessment Form (Appendix C).

6.4.3 A risk assessment of all incidents (type of injury and donor risk factors) should be carried out (using appendix C) by the most senior clinician available at the time and faxed to the Occupational Health Department. The risk assessment should not be carried out by the individual who has sustained the injury.

6.4.4 For source patients of unknown serological status, urgent serological testing for BBV infection with informed consent should be the norm. When patients are incapable of giving consent, responsibility for testing must be undertaken by the senior physician and in accordance with the Mental Capacity Act and GMC guidance. See 6.6.3 Bloods should be phoned through then sent to FRH Microbiology Laboratories urgently, bloods being sent from the RVI or NGH should be sent on the hopper using a transport tube available from Leazes reception RVI, or if done out of hours via hospital taxi.

6.5 Post-Exposure Procedures (PEP) (See Appendices B & C for Summaries)

6.5.1 Following any exposure:

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

6.5.2 Staff MUST report the injury/contamination to the nurse in charge of the clinical area or their supervisor/manager and they, during normal working hours report without delay to the Occupational Health Department. The on-call for Infectious Diseases can be contacted for advice on risk assessment, counselling and need for PEP and must be contacted if the risk is high or involves a known positive patient.

6.5.3 Managers must ensure staff attend the Occupational Health Department (in office hours) A&E RVI & EAU FRH as soon as possible after the incident to enable appropriate follow up care is given.

6.5.4 The responsibilities for action following incidents are summarised in appendix E.

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

6.5.6 Patient's or visitor's exposures should be notified to the manager of the clinical area and then the Infectious Diseases on call via switchboard. Their management will follow the policy as detailed for staff. Incidents involving exposure of patients or visitors should be notified with consent to their GP.

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

6.6 Testing and Counselling

6.6.1 Testing of the source patient for blood borne viruses should be the norm, the patient must be consented for testing. Consent given should be recorded within the patient's notes and on the laboratory request form; tests will not be performed if patient consent is not confirmed on the laboratory consent form.

To arrange for testing of the donor specimen for BBV contact Freeman Hospital Microbiology Serology Department during office hours and the on-call biomedical scientist out of hours. Forms should indicate that a needlestick incident is involved and that consent has been obtained. Timely delivery to the laboratory should be arranged. Test results should be available ideally within 8 hours and not more than 24 hours after bloods is taken. Testing will normally be done up until 8pm or first thing the following morning. If urgent testing required after this it should be discussed via the virologist on-call.

6.6.2 A risk assessment of the source patient concerning possible indicators of BBV infections including risk factors, previous tests and suggestive medical history will be undertaken (see appendix C). All source patients will be counselled and informed consent for testing for HBV, HCV and HIV obtained. In hours this should ordinarily be done by the senior clinical staff on the source patient's ward/unit (but not by the recipient of the injury) with support as necessary from Occupational Health and/or the Infectious Diseases on-call. (Appendix E).

6.6.3 Section 1(1)(f) of the Human Tissue Act 2004 allows "relevant material" (which is defined as anything containing cells and would therefore include tissue, whole blood and other body fluids) to be used to obtain scientific or medical information about a person which may affect another person "if done with appropriate consent".

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

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

In the event of a Needlestick occurring from an unconscious patient Infectious Diseases should be contacted to discuss PEP and further action.

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

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

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

6.7 Post Exposure Prophylaxis

6.7.1 HIV infection

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

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

Plus

Two Kaletra film-coated tablets (200mg lopinavir and 50mg ritonavir) twice a day.

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

6.7.1.3 PEP should not be offered following exposures to low risk materials (e.g. urine, vomit, saliva, faeces) unless they are visibly bloodstained.

6.7.1.4 Where the HIV status of the source patient is unknown, assessment of possible infectivity will be necessary. This may depend on information from the history, the examination and the results of previous investigations of the patient. Testing the source patient for HIV antibody should be the norm but will usually entail obtaining informed consent from the patient (see section 5). If the source patient is strongly suspected to be infected with HIV, the health care worker should take PEP until consent has been obtained and the test result is known.

6.7.1.5 If the patient is unable to give consent, or refuses to, but is strongly suspected to be infected with HIV, the health care worker should take PEP, if appropriate, until consent has been obtained and the test result is known (see section 4.2). If there are delays in obtaining test results, if the donor patient has significant risks, the HCW should take PEP until definitive information is available, if necessary by testing without consent. This should be a consultant decision.

6.7.1.6 Advice on whether to recommend PEP can be obtained from the doctor on call for Infectious Diseases (contact via Trust switchboard).

6.7.1.7 PEP is most likely to be effective when initiated as soon as possible (within hours, and certainly within 48-72 hours of exposure) and continued for 28 days. PEP is generally not recommended beyond 72 hours post-exposure and should only be initiated on the recommendation of an Infectious Disease Consultant.

6.7.1.8 PEP starter packs are available on Ward 19 at RVI, A&E RVI and EAS FRH

6.7.1.9 In certain circumstances the choice of drugs may require modification, e.g. depending on the medical history of the member of staff; depending on whether they are taking any other medication; where the virus may have developed resistance to the recommended drugs; or if the member of staff is pregnant. In ALL circumstances, expert advice should be obtained immediately before starting PEP, from the Infectious Diseases Team.

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

6.7.2 Hepatitis B Infection

6.7.2.1 Following significant exposures (see section 2.2) the source patient should be tested urgently, with consent, for hepatitis B surface antigen. If the source patient refuses consent, manage as though exposure has been to an HBsAg positive source (see section 6.2.7). Serological and clinical follow up for other BBV should also be undertaken.

6.7.2.2 If the source patient is unidentifiable or unavailable for testing, including most needlestick injuries in the community, manage as an unknown source exposure (see section 6.2.4 and table, Appendix A). It is seldom appropriate to test discarded needles and syringes; they should generally be safely disposed of instead. Serological and clinical follow up (including other BBV) should be undertaken.

6.7.2.3 The exposed member of staff's hepatitis B (HB) vaccination status and anti-HBs results, should be established from existing records or through urgent testing and hepatitis B prophylaxis given according to HBsAg/Ab status of the source patient and the recipient (see table, page 12).

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

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

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

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

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

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

6.7.3 Hepatitis C

6.7.3.1 Following significant exposures (see section 3.2) the source patient should be tested with consent for hepatitis C antibody. Patients who are hepatitis C antibody positive should also be tested for HCV RNA.

6.7.3.2 Any Needlestick injury involving a patient who is HCV positive should be discussed with the ID On Call and follow up of the recipient arranged with ID.

6.8 Follow up Action

6.8.1 All health care workers occupationally exposed to HIV, HCV or HBV should have follow up counselling, post-exposure testing and medical evaluation whether or not they have received PEP. Healthcare workers employed in roles classified as EPP must attend all follow up appointments and have post-exposure testing performed within the Occupational Health Department.

6.8..2 Occupational exposures to patients who are known to have a BBV infection will be reported by Occupational Health in confidence to the HPA Communicable Disease Surveillance Centre (CDSC). Occupational Health will also notify the trust Risk Manager of the datex number for all such incidents to initiate follow up, and reporting via RIDDOR where appropriate.

6.8.3 Any acute illness compatible with a diagnosis of a BBV infection that occurs during the follow up period should be reported to the

Occupational Health Department or Department of Infectious Diseases and appropriate diagnostic tests performed.

6.8.4 All high risk injuries, recipients put on PEP, recipients requiring HBIgG or rapid hep B vaccination or with exposure to HCV RNA positive material should be followed up by Infectious Diseases who will liaise closely with the Occupational Health Department

6.8.5 Any occupationally acquired BBV infection should be reported to CDSC.

7 Training

7.1 All staff will receive annual training in:

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

7.2 General Precautions

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

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

7.2.3 Hands must be washed before and after carrying out procedures.

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

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

7.2.6 Great care is required when cleaning non-disposable instruments.

8 Equality and Diversity

Equality and Diversity has been considered. There are no issues within the implementation of this policy.

9 Monitory compliance with the policy

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

10 Consultation

The policy has been circulated to
- H&S,
- Clinical Gov and Risk,
- OH Team
- ID Team
- Head of Nursing
- CPG

11 Implementation

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

12 References

ENB Toolkit 2011

Immunisations against infectious disease – “The Green Book” updated edition 2006, Department of Health. Crown

Human Tissue Act 2004 - GMC

Authors: Barbara Goodfellow, Deputy Lead Nurse Manager, Occupational Health Service, Dr E Ong, Consultant Physician, Infectious Diseases, Dr A Price, Consultant Physician, Infectious Diseases

Appendix A

Safety Device Risk Assessment

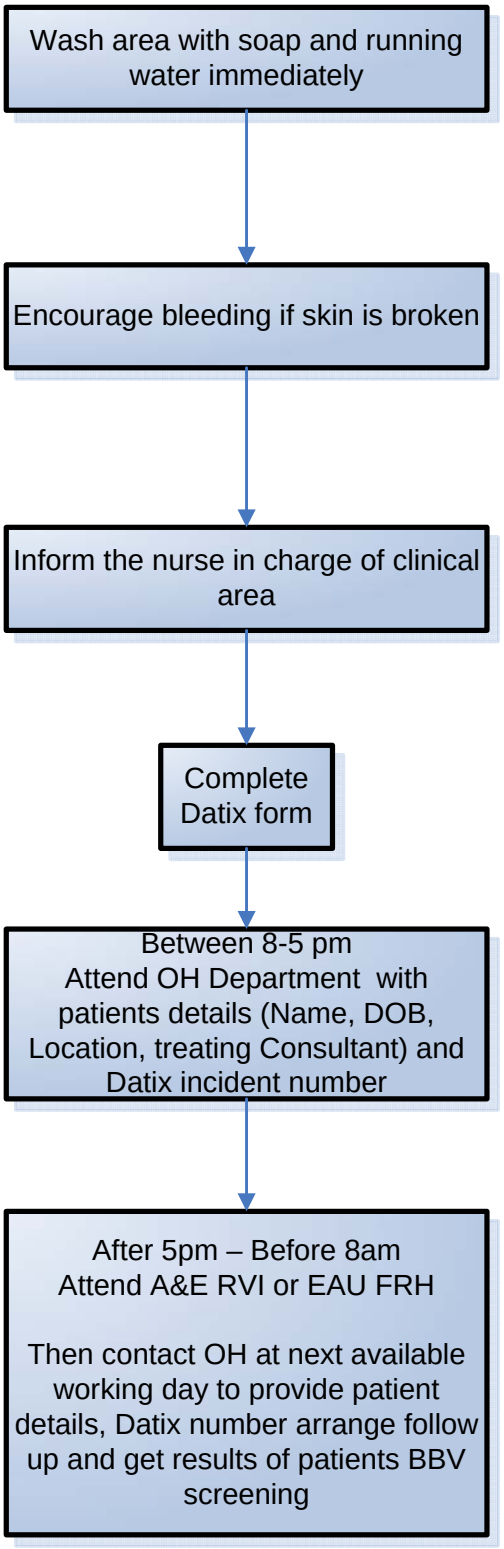
Risk by amount of blood exposure per device	Critical		IV catheter	Blood collection	
	Serious		IM injection	Lancet	
	Medium	Acupuncture	Blood Splashes		Surgical Devices
	Low	No patient contact		Heparin Injection	Insulin Injection
	Frequency of NSI in Health care settings				

Required preventative actions:

Use of Safety Devices essential, vaccination against Hepatitis B, information and training for staff mandatory
Use of Safety Devices required, vaccination against Hepatitis B, information and training for staff mandatory
Training for staff mandatory. Eliminate use of sharps if alternative available.

Appendix B

Guidance following a Needlestick Injury



Risk Assessment form

Donor Patient Sticker

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

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

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

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

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

……

FOR OFFICE USE ONLY

Recipient of Injury_____

Contact Telephone number_____

Risks of Blood Borne virus (BBV) Infection

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

The risk of transmission of infection depends on:

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

The virus involved

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

The type of exposure/injury

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

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

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

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

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

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

Risk Factors in the Source Patient

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

Appendix E

Roles and Responsibilities

8am - 5 pm weekdays

Recipient

1. Inform nurse in charge of clinical area

2. .Report injury to Occupational Health

3. Complete incident form

Nurse in Charge

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

SHO/Registrar/Consultant based in clinical area

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

5pm - 8 am and weekends/bank holidays

Recipient

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

Nurse in charge of clinical area:

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

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

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

Registrar on-call

1. Risk assessment of patient.
2. Consent donor for HIV/HBV and HCV antibody tests.

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

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

IMPACT ASSESSMENT – SCREENING FORM A

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

Policy Title:	**Policy for the prevention and management of Needlestick Injuries and Blood Borne Virus Exposure**	Policy Author:	Barbara Goodfellow, Deputy Occupational Health Nurse Manager
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)		
	• Race *	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender *	No	
	• Culture	No	
	• Religion or belief *	No	
	• Sexual orientation including lesbian, gay and bisexual people *	No	
	• Age *	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *	No	
	• Gender reassignment *	No	
	• Marriage and civil partnership *	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? *(If "yes", please answer sections 4(b) to 4(d)).*	N/A	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d)	Can we reduce the impact by taking different action?	N/A	

Comments:	**Action Plan due (or Not Applicable): N/A**

Name and Designation of Person responsible for completion of this form: Barbara Goodfellow, Deputy Occupational Health Nurse Manager Date: 20/4/2012

Names & Designations of those involved in the impact assessment screening process: IPCC

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

For advice on answering the above questions please contact Frances Blackburn, Head of Nursing, Freeman/Walkergate, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.