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Welsh Assembly Government

## **Infection Prevention Model Policy/Procedure 4**

### **Occupational Exposure Management, including needlestick ( or “sharps”) injuries, Policy and Procedure**

(An element of Standard Infection Control Precautions)

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**Date of Ratification:** 10<sup>th</sup> September 2009 by Welsh Healthcare Associated Infections Sub-Group (WHAISG), Welsh Assembly Government

**Date of Issue:** 6<sup>th</sup> October 2009.

**Date of Review:** October 2012.

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## 1.0 Executive Summary/Key Points.

- Occupational exposure management, including needlestick (or “sharps”) injury, is one of the nine elements of Standard Infection Control Precautions (SICPs), which should be applied in all healthcare settings.
- All staff have a responsibility to ensure safe practices to avoid needlestick (or “sharps”) injuries, and know how to manage such injuries, in themselves and others, should they occur.
- All staff must receive training on the principles of Standard Infection Control Precautions (SICPs) and in managing occupational exposures including needlestick (or “sharps”) injury.
- Staff undertaking Exposure Prone Procedures (EPP) must have undergone required health checks.
- Any incident where occupational exposure has occurred must be dealt with according to local policy and reported in line with local incident reporting procedures.
- All employers and staff must ensure that occupational immunisations and clearance checks are up to date (e.g. hepatitis B immunization). All staff must know whether they have responded to hepatitis B vaccination or not. All non-responders to hepatitis B vaccination **must** be made aware of this and counseled accordingly.
- Staff must wear appropriate personal protective equipment (e.g. gloves, aprons, gowns, eye/facial protection) when handling sharps or at other times when exposure to blood, other body fluids, excretions, secretions, non-intact skin or contaminated wound dressings might occur.
- The use of sharps should be eliminated as far as possible.
- Sharps containers should conform to UN3291 and BS 7320 standards, be used correctly according to manufacturers instructions, have labels completed accurately and be disposed of sealed as per local clinical waste policy.
- Safe working practices and procedures must be used to prevent exposure incidents from occurring during the delivery of care.
- Consider the use of needlestick- prevention devices (safer needle devices) where there are clear indications that they will provide safe systems of working for healthcare practitioners.
- All organisations must have a local policy which defines responsibilities and actions to be taken in the event of a worker having occupational exposure including needlestick (or “sharps”) injury.

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- The injury must be **rapidly** assessed and it must be established whether or not a significant injury has occurred i.e. for an injury to be considered significant, both the **type of injury** and the **body fluid involved** must be **high-risk**.
- The injured person should be assessed and treated as a priority, **within one hour of injury if possible**.
- A timely risk assessment must be carried out on the source patient to establish whether they have a bloodborne virus (BBV) or are known to be at high risk of infection with a BBV.
- Consent should be sought from the source patient to take and test their blood for hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).
- The injured person **must not** carry out source patient risk assessment and **must not** seek consent for the testing of the source patient's blood. This is the responsibility of the Clinical Manager/Senior Doctor/GP covering the area where the source patient is located.
- An assessment must be made for the need for HIV post exposure prophylaxis (PEP). Remember therapy should be started as soon as possible following injury, ideally within one hour.
- An assessment must be made of the need for hepatitis B vaccination +/- hepatitis B Immunoglobulin.
- An assessment must be made of the need for hepatitis C follow-up.
- Consent should be obtained to take blood from the injured person for storage (all significant injuries).
- If necessary, referral for specialist counseling / support should be made available to the injured person.
- A process should be in place to ensure that all appropriate follow-up appointments are arranged for the injured person.
- All incidents (including "near misses") must be reported and investigated as per local Incident policy and protocol.
- Investigations should identify any preventative strategies that should be implemented, taking specialist advice as required.

## 2.0 Introduction

In order to avoid occupational exposure to potentially infectious agents, particularly those microorganisms that may be found in blood and other body fluids, precautions are essential while providing care. It must always be assumed that every person encountered could be carrying potentially harmful microorganisms that might be transmitted and cause harm to others. Therefore precautions to prevent exposure to these and subsequent harm in others receiving or providing care must be taken as standard. Occupational exposure management, including needlestick (or “sharps”) injury, is one of the nine elements of Standard Infection Control Precautions (SICPs), which should be applied in all healthcare settings.

Needlestick (or “sharps”) injuries are one of the most common types of injury to be reported to Occupational Health Services by healthcare staff. The greatest occupational risk of transmission of a Blood Borne Virus (BBV) is through parenteral exposure e.g. a needlestick injury, particularly hollow bore needles. Risks also exist from splashes of blood/body fluids/excretions/secretions (except sweat), particularly to mucous membranes; however, this risk is considered to be smaller. There is currently no evidence that BBVs can be transmitted through intact skin, inhalation or through the faecal-oral route. However precautions are important to protect all who may be exposed, particularly when treatment for certain BBVs is not readily available. The risks of occupationally acquiring other infections are not as clearly documented; however Standard Infection Control Precautions (SICPs) should help to prevent exposure to other infectious agents. Everyone has an important part to play in improving safety for patients/clients and staff. Undertaking SICPs are crucial elements in ensuring everyone’s safety.

For the purposes of this policy, the **definition of a needlestick (or sharp)** includes items such as needles, sharp-edged instruments, broken glassware, any other item that may be contaminated with blood or body fluids and may cause laceration or puncture wounds, such as razors, sharp tissues, spicules of bone and teeth.

### 3.0 Responsibilities

#### 3.1 Managers/Clinical Directors must:

- Ensure that all staff have had instruction/education on the principles of SICPs and in the management of occupational exposures including needlestick (or “sharps”) injury. (Self-injecting patients will be required to have received specific training on the safe management of sharps).
- Ensure that an up-to-date evidence-based occupational exposure (including needlestick injury) policy is easily available to all staff.
- Ensure that adequate resources are in place to allow recommended infection prevention and control measures such as occupational exposure management to be implemented.
- Undertake a risk assessment to optimise patient/client and staff safety, consulting expert infection prevention and control guidance if/as required.
- Support staff in any corrective action or interventions if an incident occurs that may have resulted in an exposure or injury.
- As part of the local Incident Reporting process, all incidents should be investigated, and any learning points shared with staff to help prevent recurrences.
- Ensure staff undertaking Exposure Prone Procedures (EPP) have undergone required health checks.
- Where staff health records are not held and managed by an Occupational Health Department, managers should ensure that staff records of health checks undertaken are kept, and updated as required. **However, these should not contain the results of any tests undertaken.**
- Ensure any staff with health concerns, or who have become ill due to occupational exposure, are referred to the relevant agency e.g., General Practitioner or Occupational Health.
- Provide needlestick prevention devices (safer needle devices) that have been fully evaluated and assessed as practical.

#### 3.2 All staff (who provide direct care or have a responsibility in a health or social care setting including a patient/client’s own home) must:

- Apply the principles of SICPs, and ensure all other staff/agencies apply the principles of SICPs.

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- Attend induction, mandatory and update infection prevention and control education sessions, including those on occupational exposure management (including needlestick injuries).
- Understand what to do in the event of themselves or others working with them sustaining a needlestick injury/occupational exposure to blood/body fluids.
- Report to line managers any deficits in relation to knowledge of occupational exposure management/SICPs, facilities/equipment or incidents that may have resulted in exposure or injury.
- Ensure that all requested occupational health checks/clearance requirements are fulfilled prior/during employment e.g. hepatitis B immunisation.
- Know whether or not they are a responder to hepatitis B immunization.
- Report any illness as a result of occupational exposure to their line manager.
- Consider the elements of SICPs such as occupational exposure management as an objective within staff continuing professional development, ensuring continuous updating of knowledge and skills.
- Handle and dispose of “sharps” safely and according to local policy.
- Use needlestick prevention devices (safer needle devices) following local policy/risk assessment.

### **3.3 Infection Prevention and Control staff must:**

- Provide education for staff and management on this policy.
- Act as a resource for guidance and support when advice on occupational exposure management is required.
- Provide advice on individual risk assessments for patient/client with known or suspected infections.
- Provide advice on the requirements and suitability of needlestick precaution devices (safer needle devices).

***(The source of Infection Prevention and Control advice and support should be identified by all healthcare providers)***

### **3.4 Incident reporting**

Any incident where occupational exposure has occurred must be dealt according to local policy and reported in line with local incident reporting procedures. It is essential that all actions are taken in a **timely manner** when dealing with these incidents.

#### **4.0 Avoiding occupational exposure to blood, body fluids and needlestick injuries**

##### **4.1 General good practice advice**

- All staff must ensure that occupational immunisations and clearance checks are up to date (e.g. hepatitis B immunization) and must know whether they have responded to hepatitis B vaccination or not. All non-responders to hepatitis B vaccination must be made aware of this and counseled accordingly.
- Cuts and abrasions should be covered with a waterproof dressing before providing care.
- Staff with skin conditions should seek advice from Occupational Health or their GP to minimise their risk of infection through open skin lesions.
- Wear gloves when handling sharps or at other times when exposure to blood, other body fluids, excretions, secretions, non-intact skin or contaminated wound dressings might occur (see **Personal Protective Equipment Policy**).
- Wear other personal protective equipment as necessary to avoid exposure, e.g. aprons, masks, goggles/visors (see **Personal Protective Equipment Policy**).
- Do not wear open footwear.
- Use devices to protect against exposure during mouth-to-mouth resuscitation, e.g. pocket masks.
- Blood or other body fluids that have spilled or have contaminated items should be cleaned up immediately and appropriately.
- Dispose of clinical waste immediately according to local policy.

##### **4.2 Good sharps practice**

- The use of sharps should be eliminated as far as possible.
- If essential to use sharps, gather approved containers for the disposal of sharps, blood or other bodily fluids before beginning an activity.
- Sharps should not be passed directly hand to hand, and handling should be kept to a minimum and carried out with care.
- Needles must not be recapped, bent, broken or disassembled after use.
- Never try to manipulate/remove a needle/other sharp from its holding implement with your hands. Use needle/blade removal devices where necessary, i.e. where single-use disposable blade devices are not available. These devices should not require a two-handed needle removal procedure as this is known to increase the likelihood of injury occurring.

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- Used sharps must be discarded into a sharps container (conforming to UN3291 and BS 7320 standards).
- Approved sharps containers should be assembled correctly and should never be over-filled, i.e. above the manufacturers' fill line on the box/more than  $\frac{3}{4}$  full.
- All sharps bins should be positioned out of reach of children at a height that enables safe disposal by all members of staff. They should be secured to avoid spillage.
- These containers should be appropriately sealed in accordance with manufacturers' instructions once full, and should be disposed of according to local clinical waste disposal policy.
- Items should never be removed from sharps containers. The temporary closure mechanism on sharps containers should be used in between use for safety.
- The label on the sharps containers must be completed when starting to use the container and again once sealed, to facilitate tracing if required.
- The safe carriage of sharp items is also essential, e.g. if sharps containers are being used by district nurses then they must be secured safely when being transported, for example, in the boot of their car.
- Consider the use of needlestick- prevention devices (safer needle devices) where there are clear indications that they will provide safe systems of working for healthcare practitioners. Rigorous evaluation of these devices should be conducted before use to determine their effectiveness, acceptability to practitioners, impact on patient care and cost benefit prior to widespread introduction.
- Where patients/clients are involved in the practice of injecting, e.g. insulin dependent diabetics, they must be taught how to dispose of sharps safely to avoid others, including those providing care, sustaining injuries.
- Specific procedures to reduce sharps injuries during surgical/invasive procedures should also be adopted. These should be found in local policies.
- Any exposure incident that occurs must be reported and managed appropriately (see **section 6.0** below "**Actions in the event of an occupational exposure including needlestick or similar injury**").

## 5.0 Management of occupational exposures including needlestick (or “sharps”) injuries

Due to the risks of bloodborne diseases caused by hepatitis B virus (HBV), human immunodeficiency virus (HIV), hepatitis C virus (HCV), and other agents, it is necessary for all health care workers (HCWs) to take precautions to protect themselves from contact with blood and other high-risk body fluids. In particular, HCWs should take action to prevent needlestick and the other similar injuries. Needlestick injuries cause considerable concern and uncertainty among those injured and their families.

- For HBV there is effective vaccination and there is also post-exposure prophylaxis (vaccination +/- immunoglobulin) for those who are not vaccinated. Post-exposure Hepatitis B immune globulin can be given to the small minority of HCWs who fail to respond to the hepatitis B vaccine
- For HIV there is no vaccine however, there is post-exposure prophylaxis (PEP) – immediate action is required.
- For HCV there is no vaccine or post-exposure prophylaxis available. There is effective treatment, so it is important that those exposed are followed-up so that treatment can be initiated if they become infected.

Testing source patients for HBV, HCV and HIV is the most effective way of providing reassurance to those injured, because the vast majority of patients will not be infected. In practice, there has been some reluctance to seek patients' consent to be tested, yet patients have usually been found willing to co-operate if approached in a sensitive manner.

In the event of a needlestick or similar injury occurring, it is important for **all staff** to know:

- What action to take.
- Who has responsibility to ensure proper assessment.
- Where to go for treatment of the injury and follow-up.
- How to report the incident so that future injuries are reduced or avoided.

Many needlestick and similar injuries can be prevented if proper care is taken and appropriate prevention strategies are adopted by both individuals and healthcare institutions.

### 5.1 What do we mean by occupational exposure including needlestick (or “sharps”) injury?

By occupational exposure including needlestick (sharps) injury this guidance refers to the following injuries or exposures:

- percutaneous injury (from needles, instruments, bone fragments, human bites which break the skin);
- exposure of broken skin (abrasions, cuts, eczema, etc);
- exposure of mucous membranes including the eye, nose and mouth;

For an injury to be considered significant, both the **type of injury** and the **body fluid involved** must be **high-risk**.

High-Risk Injury	Low-Risk Injury
Percutaneous exposure e.g. needlestick or other sharps injury, human bite that breaks the skin Exposure on broken skin Mucous membrane exposure (e.g. eye, nose, mouth)	Splash on intact skin.

High-Risk Body Fluid	Low Risk Body Fluid (unless blood-stained)
Blood Low risk fluid if bloodstained Amniotic fluid Breast milk Pericardial fluid Peritoneal fluid	Pleural fluid CSF Saliva associated with dentistry Semen Synovial fluid Unfixed tissues or organs Vaginal Secretions Urine Vomit Saliva Faeces

## **5.2 What is the risk of infection following needlestick or similar injury?**

### **5.2.1 Following needlestick or similar injury from known positive source**

**Hepatitis B virus (HBV):** Health care workers who have received hepatitis B vaccine and have developed immunity (>10 IU/L of antibody to hepatitis B surface antigen - antiHBs) are at extremely low risk of infection. For the unvaccinated person, the risk from a single needlestick or cut exposure to HBV-infected blood ranges from 6-30% and depends on the viral load and hepatitis B e antigen (HBeAg) status of the source individual.

**Hepatitis C virus (HCV):** Based on limited studies, the average risk of infection after a needlestick or cut exposure to HCV-infected blood (i.e. HCV PCR +ve blood) is approximately 1.8%. The risk following a blood splash is unknown, but is believed to be very small. Source patients who are known to be past or current injecting drug addicts should be considered high-risk for HCV infection.

**HIV:** The average risk of HIV infection after a needlestick or cut exposure to HIV-infected blood is low, around 3 per 1000 injuries. The risk after exposure of the eye, nose or mouth to HIV-infected blood is estimated to be, on average less than 1 in 1000. It has been considered that there is no risk of HIV transmission where intact skin is exposed to HIV infected blood.

### **5.2.2 Risk following needlestick injury from an unknown source**

If it is not possible to identify the source patient for a particular needle, a risk assessment should be carried out to determine the likelihood that the needle may have been used on a patient with a BBV infection.

**5.2.3 Risk that source is HIV positive**

<b><u>Community Group</u></b>	<b><u>HIV Seroprevalence</u></b>	<b><u>Risk</u></b>
<b>1. Known HIV Positive people</b>	100%	High
<b>2. Homosexual Men</b>		
London/Manchester/Brighton	Up to 15%	High
Elsewhere in UK <sup>1</sup> including Wales	Up to 5%	Medium
<b>3. Heterosexuals<sup>2</sup></b>		
Sub Saharan Africa	Up to 39%	High
Caribbean	Up to 6%	Medium
Latin America	< 2.7%	Medium
South & SE Asia	< 2.7%	Medium
N Africa & Middle East	< 2.6%	Medium
UK	< 1%	Low
W Europe	< 1%	Low
E Europe and Central Asia	< 1%	Low
N America	< 0.6%	Low
Australia and New Zealand	0.1%	Low
<b>4. Intravenous Drug Users</b>		
S Europe	>50%	High
London	4.7%	Medium
E Europe	Variable	Medium/High
Elsewhere in UK (Wales)	0.23%	Low

<sup>1</sup> Robust seroprevalence data not currently available but estimates of 2.5-5% made

<sup>2</sup> World HIV seroprevalence estimates can be obtained from the WHO website on [HTTP://gamapservr.who.int/maplibrary/files/maps/HIVprevalenceglobal2006.prg](http://gamapservr.who.int/maplibrary/files/maps/HIVprevalenceglobal2006.prg).....

## **6.0 Actions in the event of an occupational exposure including needlestick or similar injury**

### **6.1 First aid**

Perform first aid to the exposed area immediately.

- **Skin/tissues**

Skin/tissues should be gently encouraged to bleed. Do not scrub or suck the area.

Then wash/irrigate with soap and warm running water. Do not use disinfectants or alcohol.

The area should then be covered using a waterproof dressing.

- **Eyes and mouth**

Eyes and mouth should be rinsed/irrigated with copious amounts of water. There are often eyes/mouth washout kits available in clinical areas.

If contact lenses are worn, irrigation should be performed before and after removing these. Do not replace the contact lens.

Do not swallow the water which has been used for mouth rinsing following mucocutaneous exposure.

### **6.2 Reporting the incident**

Report/document the incident as per local procedures **immediately**, e.g. to line managers/Occupational Health department/Accident and Emergency department/GP. **Urgency** is important in these situations as post exposure prophylaxis (PEP) for HIV or other treatments may be required (i.e. ideally PEP should be commenced within **1 hour** of the incident having taken place, but is not advised if exposure time exceeds 72 hours).

Near misses should also be clearly reported/documented.

Ensure that the item that caused the injury is disposed of safely into an approved sharps container to ensure that a further incident is avoided.

### **6.3 Responsibilities in the event of a needlestick or similar injury**

#### **6.3.1 The injured person**

When an incident occurs the injured person must ensure that:

- First aid is carried out .
- The incident is reported immediately to the supervisor/line manager/Head of Department, as defined in the local policy .
- They must attend A&E/Occupational Health Department/GP for assessment and management of the injury in a timely manner as defined in the local policy.
- An incident form is completed.

**NB:** The injured person **must not** carry out source patient risk assessment and **must not** seek consent for the testing of the source patient's blood.

#### **6.3.2 The Supervisor /Line Manager/ Head of Department responsible for the injured person**

When an incident occurs the Supervisor /Line Manager/ Head of Department **responsible for the injured person** must:

- Ensure that first aid has been carried out.
- Ensure that the injured person attends A&E/Occupational Health Department/GP (as defined in the local policy) for assessment and management of the injury within 1 hour, if possible.
- Ensure that source patient risk assessment is carried out by liaising with the clinical Manager/Senior Doctor/GP covering the area where the source patient is located.
- Ensure that all steps in the local policy are taken and follow-up is completed.
- Ensure that the incident is reported as per local policy and protocol.
- Investigate the cause of the injury.
- Adopt any appropriate preventative strategies and liaise with the Infection Control Team as required.

#### **6.3.3 The Clinical Manager/Senior Doctor/GP covering the area where the source patient is located**

The Clinical Manager/Senior Doctor/GP **covering the area where the source patient is located** should:

- Locate the source patient if possible.

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- Arrange for a source patient risk assessment to be carried out **immediately** and for the source patient's informed consent to be sought for HBV, HCV and HIV testing.
  - The source patient risk assessment should be carried out by an experienced health care professional (e.g. senior nurse or doctor) from the clinical team caring for the patient (**not** the injured HCW).
- Inform the A&E/Occupational Health Department/GP (as defined in local policy) whether or not a source patient risk assessment has been arranged and provide them with contact details of the person carrying out the risk assessment.
- Inform the consultant / GP responsible for the source patient.

### 6.4 Management of the injured person

Local Policy will dictate who will manage the injured person in the event of an occupational exposure. This will depend on when during the day an exposure occurs, availability of occupational health, arrangements with local A&E departments etc. Whatever mechanisms are decided upon for local needs it is essential that the following are clearly addressed when managing the injured person.

- All staff are aware what to do in the event of an occupational exposure, including needlestick (or "sharps") injury.
- The correct first aid must be carried out.
- The injury must be rapidly assessed and it must be established whether or not a significant injury has occurred i.e. for an injury to be considered significant, both the **type of injury** and the **body fluid involved** must be **high-risk**.
- The injured person should be assessed and treated as a priority, **within one hour if possible**.
- A timely risk assessment must be carried out on the source patient to establish whether they have a BBV or are known to be at high risk of infection with a BBV. The use of source patient risk assessment forms, which have been agreed within an organisation, and contain the important questions to be answered allows standardisation of this risk assessment process.
- Consent should be sought from the source patient to take and test their blood for HBV, HCV and HIV. A mechanism must be in place to inform the source patient of their blood results, and deal with the medical implications of any positive results.
- An assessment must be made for the need for HIV PEP. Remember therapy should be started as soon as possible following injury, ideally within one hour. PEP should normally be continued for 4 weeks, and these HCWs require regular follow up.

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-The recommended schedule of serological investigations following occupational exposure to HIV is that, as a minimum, follow-up should be for at least 12 weeks after the HIV exposure event or, if PEP was taken, for at least 12 weeks from when PEP was stopped.

- An assessment must be made of the need for hepatitis B vaccination +/- hepatitis B Immunoglobulin (see table below).

### HBV Prophylaxis for reported significant injury

HBV Status of person exposed	HBsAg positive source	Unknown source	HbsAg negative source
<b>Known responder to HB vaccine (anti-HBs <math>\geq</math> 10 mIU/ml)</b>	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine
<b><math>\geq</math> 2 doses of HB vaccine given, or course completed but response unknown.</b>	Give one dose of HB vaccine followed by second dose one month later.	Give one dose HB vaccine.	Finish course of HB vaccine.
<b>Unvaccinated or only 1 dose of HB vaccine given.</b>	Accelerated course of HB vaccine <sup>†</sup> . HBIG X 1 in other arm.	Accelerated course of HB vaccine <sup>†</sup> .	Initiate or complete course of HB vaccine.
<b>Non responder to vaccine (anti-HBs &lt;10 mIU/ml)</b>	Consider booster dose of HB vaccine. Give HBIG X1 in other arm Repeat HBIG in 30 days	Consider booster dose of HB vaccine. Give HBIG X 1 in other arm. Repeat HBIG in 30 days	No HBIG Consider booster dose of HB vaccine

*From: Immunisation against infectious disease, Department of Health, 2006*

<sup>†</sup>Accelerated course of vaccine consists of doses at zero, one and two months and fourth dose at 12 months. A very rapid course consisting of the first three doses given at 0, 7 and 21 days, with a fourth dose at 12 months, can also be used in adults where rapid protection is desirable and to maximise compliance; e.g. in those travelling to areas of high endemicity, IDUs and prisoners.

- An assessment must be made of the need for hepatitis C follow-up.

-If a significant injury has occurred and the source patient is known HCV positive or considered high-risk for HCV, then HCV PCR testing should be performed on the injured person at 6, 12 and 24 weeks with anti-HCV testing at 12 and 24 weeks. If they test positive for HCV, prompt referral should be made to a specialist HCV centre for early treatment.

- Consent should be obtained to take blood from the injured person for storage (all significant injuries).
- If necessary, referral for specialist counseling / support should be made available to the injured person.
- A process should be in place to ensure that all appropriate follow-up appointments are arranged for the injured person.

## **6.5 Unknown source**

If it is not possible to identify the source patient for a particular needle or sharp implement, a risk assessment should be carried out to determine the likelihood that the needle may have been used on a patient with a BBV infection. Are there patients known to be infected with a BBV in the clinical area concerned?

## **7.0 Management of patients exposed to the blood of a healthcare worker**

Circumstances that could allow the transmission of bloodborne viruses from HCW to patient include:

- Visible laceration occurring to a HCW's hand where the patient's open tissues or mucous membranes could be contaminated with the HCW's blood.
- Visible bleeding from a HCW from any other site (e.g. nosebleed) leading to significant bleed-back into a patient's open tissues or mucous membranes.
- An instrument or needle contaminated with the blood of the HCW is inadvertently introduced into the patient's tissues.

The injured worker should:

- Stop the procedure as soon as possible, wash and dress the wound and stem the bleeding.
- Clean and disinfect any contaminated areas.
- Report the incident to the clinical supervisor or line manager.

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- Ensure that, in accordance with local policy, the Occupational Health department, A&E department, Infection Control Officer or other nominated individuals are informed without delay.
- Complete an accident / incident form.

A risk assessment should then be carried out by a suitably trained and competent individual (**not** the injured HCW), to ascertain whether or not a significant exposure has occurred. If the incident is considered to be a significant exposure, involving bleed-back into the patient, a source HCW risk assessment should be carried out immediately and the injured HCW should routinely be asked to consent to testing for HIV, HBV and HCV.

If the HCW tests positive for any bloodborne virus, the patient should be notified of an intra-operative exposure without revealing which member of the clinical team is infected. Only in exceptional circumstances would a patient be given PEP for HIV in the absence of a positive blood test in the HCW (e.g. high risk of having been infected with HIV and refusal to undergo a test). National guidance indicates that it is unnecessary to tell the patient if the HCWs tests are all negative.

A written record of the incident and test results should be entered in the HCW's occupational health notes. Full advice on how to manage such exposures can be found in guidance issued by the Department of Health. This can be accessed on-line at <http://www.advisorybodies.doh.gov.uk/eaga/publications.htm>

### **8.0 References/literature review**

This policy/procedure is supported by a full review of literature with references.

**This work is based on the Model Infection Control Policies developed by Health Protection Scotland and on “What to do with. Needlesticks and similar injuries” by Cardiff and Vale NHS Trust/Velindre Trust/NPHS Microbiology Cardiff, with thanks.**