
Prevention and management of needlestick (sharps) injuries and contamination incidents Policy

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| | |
|---|---|
| Purpose of Agreement | This policy provides a clear, evidence-based framework to ensure safe practice when sharps are used, thereby minimising injuries caused by contaminated sharps . It provides guidance to ensure that when inoculation or contamination incidents do occur; the incident is promptly risk assessed and the healthcare worker is offered appropriate treatment to reduce the risk of infection and counselling support to reduce distress. |
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| 3 | 1.1.15 | G.Ward | Policy group | |
| 3 | 1.6.16 | G.Ward | Policy group | Changes due to safer sharps legislation |
| 4 | May 2018 | G.Ward | Policy group | Policy refresh |

SUMMARY OF POLICY

QUICK REFERENCE GUIDE

For quick reference the guide below is a summary of actions required. This does not negate the need for the people involved in the process to be aware of and to follow the detail of this policy.

1. Wherever possible the use of Sharps should be avoided and safer Sharps Devices used where available. Sharps injuries and contamination incidents should be prevented wherever possible by appropriate use and implementation of Standard Precautions such as good hand hygiene; appropriate use of personal protective equipment (e.g. gloves) and safe handling and disposal of needles and other sharp instruments. The HSE regulations, the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, outline the following: the need to avoid the unnecessary use of sharps; use safer sharps which incorporate protection mechanisms; prevent recapping of needles; place secure containers and instructions for safe disposal of medical sharps close to the work area.
2. After a Needlestick injury (NSI) / other type of sharps injury or contamination incident there is a risk of transmission of Blood Borne Viruses (BBV) from affected patients to health care workers (HCW) (and vice versa to a lesser extent) and the incidents must therefore be managed correctly. The viruses include hepatitis B, hepatitis C and Human Immunodeficiency Virus (HIV).
3. After a NSI / sharps injury or contamination incident: allow the puncture site to bleed; wash the wound / exposed area with soap and water; in the case of a splash to the eyes, irrigate eyes with sterile water (before and after contact lens removal); report the incident to the Occupational Health Department (OH) on 07775 800 333 Or 0300 123 3392 or, if out-of-hours, to the local Emergency Department (ED). Inform manager and report via adverse incident reporting system.
4. All NSI / sharps injuries and contamination incidents reported to OH or ED will be fully assessed and managed as set out below and in the full policy. This will include a risk assessment of the incident, blood sample for long term storage from the recipient and arrangement of BBV virus screen from the source patient. ED will inform OH of out-of-hours incidents the next working day and affected HCW should also contact OH the next working day to arrange follow up.
5. If the source patient is known to be HIV positive or at high risk of HIV, the recipient must be assessed for the provision of HIV Post Exposure Prophylaxis (PEP). If the NSI / sharps injury is 'high risk' (deep injury; visible blood on the device causing injury) and the source is HIV positive or at high risk of HIV, PEP will be prescribed. This will be done by ED for out-of-hours incidents or the local Sexual Health clinic in 'office- hours' (after referral by OH). PEP follow- up is by Sexual Health.
6. If HIV PEP is required, timing is crucial and ideally it should be started within 1 hour of the incident (but can be given up to 48-72 hours), and this should be considered as a 'medical emergency'. Overall, however, the risk of acquiring HIV infection following occupational exposure to HIV-infected blood is low (approximately 1 in 300).
7. If the source patient is a carrier of hepatitis B, the recipient must receive a booster dose of hepatitis B vaccine or, if unvaccinated, must commence an accelerated course of hepatitis B vaccine and be considered for hepatitis B immunoglobulin (after discussion with Consultant Virologist).
8. There is a requirement for OH to liaise with Health and Safety Manager to report cases with a BBV positive source patient to the Health and Safety Executive (HSE) via Reporting Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and to Public Health England.

Contact details for local ED department:

Southampton General:

Switchboard-02380 777222

A&E direct- 02381 206220

Winchester:

Switchboard-01962 863535

A&E direct-01962 824950

Queen Alexandra Portsmouth:

Switchboard-023 92286000

A&E direct-023 92286380

Basingstoke:

Switchboard- 01256 473202

A&E direct-01256 314700

Frimley Park

Switchboard-01276 604604

A&E direct-01276 604110/01276 526123

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1. INTRODUCTION & PURPOSE

- 1.1 Prevention of sharps injuries and contamination incidents is extremely important. Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV) can be transmitted by percutaneous injury e.g. where the skin is cut or penetrated by needles or other sharp objects (a Needlestick / 'sharps' injury); or mucocutaneous injury (splash to mucous membranes or broken skin) from patients to health care workers (and vice versa to a lesser extent). Therefore, Needlestick / sharps injuries and contamination incidents must be managed correctly as set out in this policy. Transmission of these Blood Borne Viruses (BBV) occurs from blood, visibly blood-stained body fluids, Cerebra Spinal Fluid, peritoneal, pleural and amniotic fluids.
- 1.2 This policy has been developed to inform the Trust's employees of the correct way to manage NSI / sharps injuries and contamination incidents within the organisation and, by doing so, to improve the safety and wellbeing of both staff and patients. It is also important to emphasize that prevention of these injuries by safe handling and disposal of sharps and the use of other relevant infection control procedures, such as safer sharps, appropriate hand hygiene and use of personal protective equipment, is extremely important.

2. SCOPE & DEFINITIONS

- 2.1 This policy applies to all employees (including apprentices) who hold a contract of employment or engagement (including secondees, volunteers) within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, Agency workers, and other workers who are assigned to Solent NHS Trust.
- 2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.
- 2.3 DEFINITIONS :**
- 2.3.1 **'sharp'** is any object, which can puncture the skin and may be contaminated by blood or body fluids. This might include the following: hypodermic needles, suture needles, scalpel blades, pieces of bone, teeth splinters, glass ampoules, and pathological specimens
- 2.3.2 **NSI:** Needlestick injury or injury from a 'sharps' source.
- 2.3.3 **Blood Borne Virus (BBV):** a virus which is carried in the blood of an infected individual and which can be transmitted to another person exposed to the individual's blood.
- 2.3.4 **HBV:** Hepatitis B Virus
- 2.3.5 **HCV:** Hepatitis C Virus
- 2.3.6 **HIV:** Human Immunodeficiency Virus
- 2.3.7 **HIV PEP (Post Exposure Prophylaxis):** HIV treatment medication given after a NSI / sharps injury from a known or high risk HIV positive source patient to reduce the risk of seroconversion.
- 2.3.8 **OHW** Occupational Health and Wellbeing Service.
- 2.3.9 **HSE:** Health and Safety Executive
- 2.3.10 **RIDDOR:** Reporting Injury, Disease, Dangerous Occurrence Regulations.

3. MANAGING NEEDLESTICK (SHARPS) INJURIES AND CONTAMINATION INCIDENTS

3.1 SAFE SHARPS PRACTICE

- 3.1.2 The use of sharps should be avoided where possible. When their use is essential, particular care is required in handling and disposal.
- 3.1.3 Solent NHS Trust requires all staff to use safety engineered hypodermic needles, butterflies, lancets, insulin needles, insulin pen needles, subcutaneous butterflies, and cannula as standard (appendix D).
- 3.1.4 If staff identify a procedure where the safer device recommended is not appropriate they must liaise with Infection Prevention or Health and Safety to discuss further. Only once all safer alternatives have been considered and a risk assessment undertaken will the service be given permission through H&S to return to using a non-safer device. Injuries resulting from use of non-safer devices where this procedure has not been followed will be considered a breach of this policy.
- 3.1.5 Should staff identify a procedure where safety would be enhanced by using a Safety engineered device i.e. safer scalpels they should liaise with Infection Prevention team.

3.2 SAFE USE OF SHARPS BINS

- 3.2.1 Sharps must only be disposed of in designated sharps bins that meet the requirements and in accordance with HTM 07-01 Safe Management of Healthcare Waste (DH,2013) provides a framework for good practice to all producers of healthcare waste on the development and management arrangements for the safe, economic disposal of healthcare waste.
- 3.2.2 Use appropriate designated sharps bins for specific types of waste e.g. yellow sharps bin with yellow lid, or yellow sharps bin with purple lid
- 3.2.3 Always assemble sharps bins correctly.

3.3 MANAGEMENT OF ALL NSI (SHARPS) INJURIES/CONTAMINATION INCIDENTS

3.3.1 Immediate Action

First Aid: see *Poster Guidance*.

3.3.2 Trust Reporting Procedure (NSI or contamination incident).

- 3.3.2.1 Inform manager/person in charge and ensure Adverse Event form is completed and sent to the Health & Safety Team.
- 3.3.2.2 It is vital that staff report incidents immediately to OHW and out of hours to the local ED, so that a local risk assessment can be made. See *Poster Guidance*.
- 3.3.2.3 OHW is required to report cases with a BBV positive source patient to Health and Safety Executive (HSE) via Reporting Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and to Public Health England.

3.4 Attend OHW/ local Emergency Department (ED)

- 3.4.1 A risk assessment of the injury and exposure will be undertaken.

- 3.4.2 OH / ED will arrange for a sample of the recipient's blood to be stored (red-top bottle - 'Long term storage' should be requested on the pathology form).
- 3.4.3 **See Appendix B - algorithm for assessment of Hepatitis B prophylaxis following a reported exposure.**
- 3.4.4 OH / ED will ask the clinical team caring for the source patient to obtain blood for HBV, HCV and HIV testing and storage. This blood sample should not be taken by the recipient. Appropriate consent must be obtained. In urgent, high risk cases the microbiology laboratory will be informed by OH / ED and arrangements made for urgent testing.
- 3.4.5 In high risk incidents HIV Post Exposure Prophylaxis (PEP) may be required and the initial prescription will be provided by ED for out-of-hours incidents and by the Sexual Health department for incidents in 'office-hours' (after referral by OH). PEP should be started within 1 hour of the incident, although it can be given within 72 hours.
- 3.4.6 OH will complete exposure incident form with the staff member.
- 3.4.7 They will arrange appropriate blood testing and follow up in the weeks following the incident :
 - 3.4.7.1 Known HIV infected source patient: HIV test for recipient at 6, 12 and 24 weeks
 - 3.4.7.2 Known HCV infected source patient: HCV RNA test for recipient at 6 and 12 weeks. In addition, anti-HCV test at 12 and 24 weeks.
 - 3.4.7.3 Known positive HBV source patient: test non-immune recipients from 6 weeks (HBsAg test).
 - 3.4.7.4 Unknown source patient: test recipient for HIV at 12 weeks and anti-HCV at 12 and 24 weeks
 - 3.4.7.5 Known negative high-risk source patient e.g. i.v drug user: consider possible 'window period' of seroconversion and test recipient for HIV at 12 weeks and anti-HCV at 24 weeks
- 3.4.8 HIV PEP follow-up is in Sexual Health

3.5 Guidelines for obtaining source patient's blood in NSI / sharps injuries and contamination incidents:

- 3.5.1 If the source patient's risk of BBV carriage is high, consider liaising with Sexual Health / ED before testing. If the source patient's risk of BBV carriage is low, proceed to blood testing.
- 3.5.2 Ask source patients with capacity for consent to be tested for HBV, HCV & HIV in order to comply with Department of Health recommendations. This consent is verbal and ideally must not be taken by the NSI / sharps injury recipient, but by a colleague or other member of staff in the clinical area.
- 3.5.3 Inform the patient that a NSI / sharps injury has taken place and that specific BBV such as HBV, HCV and HIV can be transmitted after such an incident. Enquire as to whether there is any possibility of carriage or exposure to these viruses in the past.
- 3.5.4 Inform the source patient that results will be made available to OHW / ED and recipient of NSI.
- 3.5.5 If a positive result is obtained from a source patient repeat the test for confirmation. If it is a true positive result, liaise with Sexual Health for advice on further management in the case of HIV or with a Consultant Virologist in the case of hepatitis B or C.
- 3.5.6 In the case of a deceased patient, it is appropriate to seek consent from a relative. Where the patient is expected to regain capacity before a decision on testing is needed, testing should not take place until consent has been obtained.
- 3.5.7 Where a patient is not expected to regain capacity before a decision on testing needs to be made, consider following a process based on British Medical Association guidance (2016) summarised below:
 - 3.5.7.1 Determine whether the patient has a valid and applicable advance decision to refuse treatment (ADRT) or whether there is anyone with legal authority to make the decision (eg an attorney with the relevant decision making authority or a court-appointed deputy).
 - 3.5.7.2 If there is no ADRT or individual with legal authority, make a decision by assessing whether

testing is in the best interests of the patient:

- 3.5.7.3 Follow a structured decision-making process, including seeking views from the patient (if conscious) and consulting a range of parties including relatives and those caring for the patient or an independent mental capacity advocate (IMCA) if the patient has no-one else to represent them.
- 3.5.7.4 If it is decided that testing is in the best interests of the patient and the patient's representative confirms that the patient would be expected to consent to the test if they had capacity, proceed with the test.
- 3.5.7.5 If the patient regains capacity, inform them that the test has been undertaken and give them sufficient information to make an informed decision about whether to receive the results of the test and whether information about the test should be included in their medical record.

3.6 POST EXPOSURE PROPHYLAXIS (PEP)

- 3.6.1 The Department of Health (DoH) recommends PEP for healthcare workers who have had a significant occupational exposure to blood or other potentially infectious material from a patient or other source known to be HIV infected or considered to be at high risk of infection. A significant exposure is defined as:

- Percutaneous injury (e.g. from needles, instruments, significant bites which break the skin)
- Exposure of broken skin (e.g. eczema, cuts, abrasions)
- Exposure of mucous membranes, including the eye

HIV post-exposure prophylaxis (Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS. (September 2008)):

3.6.2 The DH does NOT recommend PEP:

- After an exposure through any route with low risk materials e.g. saliva, urine, faeces or vomit unless visibly bloodstained (e.g. saliva associated with dentistry)
- If a risk assessment has concluded that HIV infection of the source is highly unlikely
- Where the source is known to be HIV-negative
- If the source is known to have an undetectable viral load (<200 copies HIV RNA/mL). However,
- PEP should be offered to those who are anxious about the risk of infection.
- Where a risk assessment suggests that HIV infection of the source is a potential risk, a request will be made to test the source for HIV. However, it may not always be possible, or appropriate, to perform a test. In this case it will be up to you to decide whether to continue treatment after further discussion with the treating clinician. You will need to balance the relative risk of transmission against the possibility of side effects of the medication.
- If you decide not to start treatment you can still discuss with the Clinician at a later date, although commencing PEP is generally not recommended beyond 72 hours post exposure.
- **If the source of injury/exposure is unknown:**
In the majority of cases where the source of the exposure is completely unknown, the risk of HIV is so low that PEP should not be recommended. If you would still prefer to take treatment then you should discuss this with the prescribing doctor. You can always stop treatment at a later date after further discussion with the clinician.

4. ROLES & RESPONSIBILITIES

- 4.1 **Clinical Managers / Heads of Department** have a responsibility to ensure that all staff within their department involved in NSI / sharps injuries or contamination incidents are managed appropriately and that preventive measures are in place.
- 4.2 **Line Managers** are responsible for ensuring that NSI / sharps injures and contamination incidents are managed appropriately as set out in this policy and that preventive measures are put in place.
- 4.3 **All staff** must co-operate with the Trust and line management on prevention and correct management of NSI / sharps injuries and contamination incidents as set out in this policy.
- 4.4 **Occupational Health, Safety and Wellbeing Service** will ensure NSI / sharps injuries and contamination incidents are managed appropriately as set out in the process section of this policy and that advice on implementation of preventive measures is provided.
- 4.5 **Emergency Department (ED)** is responsible for the management of NSI / sharps injuries out-of-hours and for the initial administration of HIV PEP where indicated out-of-hours.
- 4.6 **Health and Safety Committee** is responsible for receiving the results of audits of NSI / sharps injuries and contamination incidents and recommending any appropriate action to reduce any identified risks.

5. TRAINING

- 5.1 Training needed to implement the policy and any ongoing training is provided by the IPCT as identified by a 'training needs analysis'. All training undertaken must be recorded on the Organisational Learning Module (OLM) of the Electronic Staff Record (ESR) taken from signing in sheets.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

- 6.1 The outcome of the assessment **see Appendix A** was there was no negative impact.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

- 7.1 OHW will undertake an annual audit (in accordance with local audit) of the management of needlestick /contamination incidents in the last 12 months. A summary of compliance will be recorded. Any subsequent issues/findings resulting from the audit may be included in staff training and a review of this Policy /SOP will be considered.
- 7.2 Non-compliance incidents relating to this policy will be reported to the Health & Safety Sub Committee

8. REVIEW

- 8.1 This Policy may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 REFERENCES

- 9.1.1 Health and Safety (Sharp Instruments in Healthcare) regulations 2013 .Guidance for employers and employees.
- 9.1.2 Control of Substances Hazardous to Health (COSHH) Regulations (2002)
- 9.1.3 Health & Social Care Act (DH, 2008) Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
- 9.1.4 DH (2013) Immunisation of healthcare and laboratory staff, in: Immunisation against infectious disease (the 'Green Book'), Chapter 12,
- 9.1.5 NHS Employer-Managing the risk of sharps injuries framework (2015)
- 9.1.6 HIV Post- Exposure Prophylaxis. Guidelines from the UK Chief Medical Officers Expert Advisory Group on AIDS (2008)
- 9.1.7 Portsmouth Hospitals NHS Trust Needlestick /Sharps Injury & Contamination Incidents: Prevention & Management (May 17).

9.2 LINKS TO RELATED SOLENT NHS TRUST DOCUMENTS

| | |
|--|--|
| <ul style="list-style-type: none">• Decontamination Policy• Health & Safety Policy• First Aid At Work Policy• Data Protection Caldicott & confidentiality Policy• Serious Incidents requiring Investigation Policy• Reporting Adverse Incidents Policy• Infection and Prevention Control Standard Precautions Policy | <ul style="list-style-type: none">• Hand Hygiene Policy• Aseptic Technique Policy• Healthcare Worker screening and Immunisation Policy• Sickness Absence Policy• Waste Management Policy |
|--|--|


10. GLOSSARY

10.1 See Definitions 2.3

| Step 1 – Scoping; identify the policies aims | Answer |
|---|--|
| 1. What are the main aims and objectives of the document? | To ensure safe practice when sharps are used, thereby minimising injuries caused by contaminated sharps. To ensure that when inoculation or contamination incidents do occur; the (24/7) the incident is promptly risk assessed and the healthcare worker/patient is offered appropriate treatment to reduce the risk of infection and counselling support to reduce distress. |
| 2. Who will be affected by it? | All employees/patients and service users |
| 3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve? | <p>Department of Health guidance (PHE- Integrated management of HCW and Blood borne virus Oct 2017).</p> <p>Safe management of Healthcare waste (HTM 07-01,DH 2013)</p> <p>Health and Safety (Sharp instruments in Healthcare) Regulations 2013.</p> <p>Health & Safety at Work Act 1974</p> <p>Control of Substances Hazardous to Health Regulations 2002</p> <p>National guidance from various sources including NHS Employers Framework</p> |
| 4. What information do you already have on the equality impact of this document? | Assumption that this will potentially impact on a diverse group of service users |
| 5. Are there demographic changes or trends locally to be considered? | Not aware of any high risk areas within the Trust which would increase incidence of injury. |
| 6. What other information do you need? | None |

| Step 2 - Assessing the Impact; consider the data and research | Yes | No | Answer (Evidence) |
|---|------------|-----------|--|
| 1. Could the document unlawfully discriminate against any group? | | x | This policy applies to all and is consistent with current DH policy. |
| 2. Can any group benefit or be excluded? | x | | Of potential safety benefits to all staff and patient / service users in prevention of injuries and treatment to prevent infections. |
| 3. Can any group be denied fair & equal access to or treatment as a result of this document? | | x | This policy applies to all and is consistent with current DH policy/Health & Safety Policy |
| 4. Can this actively promote good relations with and between different groups? | x | | As all staff/patients/service users are treated the same. |
| 5. Have you carried out any consultation internally/externally with relevant individual groups? | x | | Internally with Occupational Health & Wellbeing Team/ IPC team/GU (Sexual Health) team. |
| 6. Have you used a variety of different methods of consultation/involvement | | | As above. |
| <u>Mental Capacity Act implications</u> | | | |
| 7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information) | | x | This policy applies to staff and part of the aim is to protect service users. |

APPENDIX B:



Steps to take should a sharps or contamination injury occurs

(Sharps, bites, cuts, scratches or splashes of blood or body fluids)

The information needs to be shared widely with clinical staff and the poster displayed in an appropriate clinical area e.g. treatment room/office. Please be aware that there is information on the poster which is sensitive and therefore displaying the poster in areas directly accessible to patients/visitors is not appropriate.

ACTION: If a sharps or contamination incident occurs.

1. First Aid

- Allow wound to bleed, ideally by holding it under running water, (do not squeeze or suck the wound).
- Wash wound thoroughly with soap and water (do not scrub area). Dry and cover with waterproof dressing.
- Irrigate eyes: With copious water (before and after removing contact lenses)

4. Further Action

- Staff who went to Emergency Department should contact Occupational Health on the next working day for follow up.
- Complete Incident form; when incident relates to a positive source, managers should contact the Risk Health & Safety team to report under RIDDOR.

If source/donor patient positive for blood borne virus: consider using condoms during sexual intercourse until follow up is clear, as it cannot be guaranteed there are no risks.

2. Immediate Action ☎

- REPORT INCIDENT to your manager and Occupational Health immediately telephone: Occupational Health Hotline 07775 800 333 or OH main reception 0300 123 3392.

3. Out Of Hours

- When Occupational Health is closed: (evenings, weekends and bank holidays). Staff should go to their local Emergency Department.
- If staff member has no transport they should go by a taxi (the Trust will reimburse the fare with receipt).

Information Needed

- Patients name or origin of source.
- Date of Birth, address.
- GP/consultant treatment and diagnosis if known.

Action

Incidents where there is high risk of BBV: Managers can assist by telephoning through these details and state incident is Medical Emergency likely to require Post Exposure Prophylaxis.

Quick Guide: To help with the initial assessment (Blood Borne Viruses)

Is the source or patient/client known or unknown?

1. **Unknown risk:** risk assessment should determine the likelihood that medical device/source was higher risk of contamination with BBV e.g. was the medical device was from a ward with patients known to be infected with hepatitis B or hepatitis C or HIV.
2. **Known higher risk:** the source patient/client is infected with hepatitis B, hepatitis C or HIV. How long is it since they were screened and levels of antigen measured as this may affect their risk?
3. When source/patient is NOT known to carry any of these infections, risks may also be increased in the following:

Hepatitis B: The risk may be increased when the source/patient is one of the following:

- Injecting drug user
- Individual who may be at risk of hepatitis B through unsafe sexual activity (e.g. unprotected vaginal or anal intercourse).
- Individual who is having unprotected sex with hepatitis B positive partner or partner who put themselves at risk because of their sexual behaviour.
- People with hepatitis B infected mothers.
- People from Africa, the middle and Far East, south east Asia and southern and eastern Europe.

Hepatitis C: The risk may be increased when the source/patient is one of the following:

- Received unscreened blood or untreated plasma products in the UK prior to September 1991 (blood) and 1985 (plasma products) or has received blood/plasma products from country where blood is not tested for hepatitis C virus.
- An Injecting Drug User who has shared equipment
- A health care worker or has been a patient in invasive medical, surgical, dental or midwifery procedures in parts of the world where infection control procedures may have been inadequate or with populations with a prevalence of hepatitis C infection (e.g. Egypt).

HIV: The risk may be increased when the source/patient is one of the following:

- Individual who has been living in an area of the world with a high prevalence of HIV e.g. Africa (South/East/Central Africa), Central Asia and eastern Europe.
- Individual who may be at risk through unprotected/unsafe sex or have partners who and participate in unsafe sexual behaviour. Risk is increased in those from high prevalence areas
- Injecting drug user.
- Blood transfusion before Oct 1985 in UK.
- Mother HIV positive.
- Blood transfusion abroad; where blood is not screened.

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APPENDIX C:

Table 18.5 HBV prophylaxis for reported exposure incidents

| HBV status of person exposed | Significant exposure | | | Non-significant exposure | |
|--|---|---|--|--|---------------------------------|
| | HBsAg positive source | Unknown source | HBsAg negative source | Continued risk | No further risk |
| ≤ 1 dose HB vaccine pre-exposure | Accelerated course of HB vaccine* HBIG × 1 | Accelerated course of HB vaccine* | Initiate course of HB vaccine | Initiate course of HB vaccine | No HBV prophylaxis. Reassure |
| ≥ 2 doses HB vaccine pre-exposure (anti-HBs not known) | One dose of HB vaccine followed by second dose one month later | One dose of HB vaccine | Finish course of HB vaccine | Finish course of HB vaccine | No HBV prophylaxis. Reassure |
| Known responder to HB vaccine (anti-HBs > 10mIU/ml) | Consider booster dose of HB vaccine | Consider booster dose of HB vaccine | Consider booster dose of HB vaccine | Consider booster dose of HB vaccine | No HBV prophylaxis. Reassure |
| Known non-responder to HB vaccine (anti-HBs < 10mIU/ml 2-4 months post-immunisation) | HBIG × 1 Consider booster dose of HB vaccine A second dose of HBIG should be given at one month | HBIG × 1 Consider booster dose of HB vaccine A second dose of HBIG should be given at one month | No HBIG Consider booster dose of HB vaccine | No HBIG Consider booster dose of HB vaccine | No prophylaxis. Reassure |

*An accelerated course of vaccine consists of doses spaced at zero, one and two months.
A booster dose may be given at 12 months to those at continuing risk of exposure to HBV.
Source: PHLS Hepatitis Subcommittee (1992).

APPENDIX D

SOLENT NHS TRUST APPROVED SAFER SHARPS DEVICES

Phlebotomy use:

Use of standard hypodermic is not approved.

BD Eclipse™ Blood Collection Needle to use with vacutainer



Green 21G 32mm KFK217

Black 22G 32mm KFK216

Adaptor KFK037

Phlebotomy use:

Use of standard hypodermic is not approved.

BD Vacutainer Safety-Lok Blood Collection set – short duration use.



Green 21G 19mm needle 178mm tubing KFK253

Green 21G 19mm needle 305mm tubing KFK056

Light blue 23G 19mm needle 178mm tubing KFK254

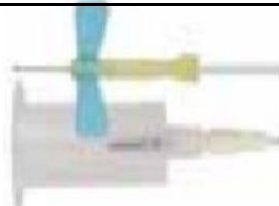
Light blue 23G 19mm needle 305mm tubing KFK058

Dark blue 25G 19mm needle 178mm tubing KFK336

Phlebotomy use:

Use of standard hypodermic is not approved.

BD Vacutainer Safety-Lok Blood Collection set with pre attached holders – short duration use.



Drawing up needle: To be used in place of standard hypodermic needles for drawing up. Filtered for glass ampoules and non-filtered for bung or plastic containers.

BD Blunt fill drawing up needles for plastic or rubber bung vials.

BD blunt filter needles for glass ampoules



Filtered 18G 1.2mm x 40mm FTR436
Non Filtered 18G 1.2mm x 40mm FTR437

Hypodermic needles: To be used in place of all standard hypodermic needles.

BD Eclipse hypodermic needle with Smartslip Technology



Orange 25G 0.5mm x 16mm FTR470
Blue 23G 0.6mm x 25mm FTR471
Green 21G 0.8mm x 40mm FTR 473

Lancets: To be used in place of all other types of lancet.

Green 21G 19mm needle 178mm tubing with adaptor KFK348
Green 21G 19mm needle 305mm tubing with adaptor KFK347
Light blue 23G 19mm needle 178mm tubing with adaptor FK350
Light blue 23G 19mm needle 305mm tubing with adaptor FK349

Unistik® single-use safety lancets by Owen Mumford

Unistik® 3 Gentle
Appreciate the finer point
Our NEW 30 gauge
single use lancing device



Comfort Purple 28G 1.8mm FTM054
Gentle pink 30G 1.5mm FTM339
Neonatal 18G 1.8mm FTM001
Larger quantities available on request

Insulin needles: To replace all standard insulin needles.

BD SafetyGlide Safety Insulin Syringe



0.5ml 30G 0.30mm x 8mm FWD085
0.5ml 29G 0.33mm x 1.7mm FWD057
Other sizes are available within this range

Cannulation: To replace all standard cannula.

BD Venflon Pro safety



Blue 22g FSP 639
Pink 20g FSP 796
Green 18g FSP 797
Grey 16g FSP 798
Orange 14g FSP 803

Subcutaneous Infusions: To replace metal needle devices intended to remain insitu.

BD Saf-T-Intima for subcutaneous infusion therapy



Yellow 24G 0.7 x 19mm FSP 3559 (single item)
Blue 22G 0.9 x 19mm FSP319

Subcutaneous Infusions: To replace metal needle devices intended to remain insitu.

BD Saf-T-Intima with Y adaptor for subcutaneous infusion therapy



Pink 20G 1.1mm x 25mm FSP329
Yellow 24G 0.7mm x 19mm FSP 324
Blue 22G 0.9mm x 19mm FSP325

BD AutoShield Duo Order via non-catalogue requisitioning route and choose Bunzl as the supplier using reference 329605

BD 5mm Safety Pen Needle for pro:

0,30mm (30G) x 5mm Box of 100.
Reference: 329605.
Drug Tariff Code: 360-5615
NHSSC code: FTR1083

S



Department Specific Items

2" needle for joint injections or where standard 40mm needle is not long enough.

SOL-CARE™ Safety Hypodermic Needle
Needle protection device for injection



For Special Care Dentistry only

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Cannula intravenous infusion set with integrated system and safety device 24g x 19mm polyurethane with Dual BD Q-Syte closed luer access split septum

- **MPC:** 383531
- **Unit of issue:** Each
- **Brand:** BD Nexiva
- **Supplier:** BECTON DICKINSON UK LTD