



THE STATE HOSPITAL BOARD FOR SCOTLAND

OPERATIONAL GUIDANCE ON IMMEDIATE ACTION FOLLOWING BLOOD AND BODY FLUID EXPOSURE (STAFF AND PATIENTS)

Policy Reference Number	IC16	Issue: 5
Lead Author	Senior Nurse for Infection Control	
Contributing Authors	SALUS Occupational Health & Safety	
	NHSL (ID consultant)	
	The State Hospital Infection Control Committee	
Advisory Group	The State Hospital Infection Control Committee	
Approval Group	Policy Approval Group	
Implementation Date	8 December 2021	
Next Review Date	8 December 2023	
Accountable Executive Director	Director of Nursing, AHPs and Operations	

The date for review detailed on the front of all State Hospital policies/ procedures/ guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/ procedure/ guidance at any time due to organisational/legal changes.

Staff are advised to always check that they are using the correct version of any policy/ procedure/ guidance rather than referring to locally held copies.

The most up to date version of all State Hospital policies/ procedures/ guidance can be found on the intranet: <http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx>

REVIEW SUMMARY SHEET

No changes required to policy (evidence base checked)

Changes required to policy (evidence base checked)

Summary of changes within policy: No factual changes only reformatting.

Contents	Page
1. Guidance on Safe Working Practices	4
2. Roles & Responsibilities	4
3. Risk Assessment	4
4. Precautions	4
5. Exposure Prone Procedures (EPP) Dental procedures within The State Hospital)	5
6. Employees Responsibility for Hepatitis B Immunisation	5
7. Management of Exposure Incidents	6
7.1 First Aid	
7.2 Risk assessment	
8. Equality and Diversity	7
9. Stakeholder Engagement	8
10. Communication, Implementation, Monitoring and Review of Policy	8
Appendices	
1. Guidelines for safe use and disposal of sharps	9
2. Best Practice: Management of occupational exposure incidents	11
3. Assessment of Risk Factors from Source Person	12
4. Exposure Risk	13
5. Risk from Source Patient	14
6. Risk Matrix	15
7. Summary Flowchart for BBV Exposure for Healthcare Workers (HCW)	16
8. Guidance for Occupational Health and Safety Service responding to initial telephone contact	17

1. GUIDANCE ON SAFE WORKING PRACTICES

The State Hospital guidance on management of blood and body fluid exposures supports [The National Infection Prevention and Control Manual](#), Chapter 1 - Standard Infection Control Precautions section 10. Any concerns about the implementation of this guidance should be discussed with the Occupational Health and Safety Service (OHSS) or The State Hospital Infection Control Committee.

All health care workers have an obligation not to put patients at risk and also to promote the safety of themselves and their colleagues.

2. ROLES AND RESPONSIBILITIES

The Senior Nurse for Infection Control / Director of Nursing/AHP and Operations have overarching responsibility for all Infection Control issues at The State Hospital.

The Occupational Health Advisor / Physician have responsibility for the management of any staff following exposure to blood / body fluids.

The Senior Nurse for Infection Control will provide advice and assistance (in the first instance) in the management of sharps injury or significant exposure to blood or body fluids.

To prevent transmission of blood borne viruses (BBVs), the appropriate level of precautions to be taken is determined by the extent of possible exposure to blood and certain body fluids, and not because of knowledge or speculation about the infectious status of the patient.

3. RISK ASSESSMENT

It is not possible to set out absolute rules for when and how care should be provided. The requirement for particular precautions must be assessed in each individual circumstance related to activity. Thorough assessment of risk from known or potential sources of harm is a requirement under health and safety and environmental legislation, in terms of the Duty of Care obligations.

The State Hospital must know where sharps are being used, what risk might be involved in using them and consider whether there might be safer alternatives based on potential risk and harm to staff. They must also be aware of the type of sharp being used and for what procedure.

Written information on the Safe Uses and Disposal of Sharps can be viewed in appendix 1.

4. PRECAUTIONS

Infection control measures to prevent transmission of infection (including BBVs) in the health care setting **should be normal practice**. Protective measures should be implemented according to risk assessment.

In respect of potential exposure to BBVs, tasks can be categorised according to the risk of contact to blood, for example:

- Contact with blood probable and potential for uncontrolled bleeding or spattering
- Contact with blood possible but spattering unlikely.
- Low probability of personal contact with blood.

Examples of tasks which may involve exposure to blood most common within the State Hospital

Category	Examples	Protective Measures
Contact with blood possible but spattering unlikely.	When cleaning contaminated equipment. Handling open specimen containers containing blood or body fluids. Venepuncture / insertion of intravenous cannula	*Disposable gloves and plastic apron (or other appropriate protective clothing as per risk assessment) should be worn. Face masks and protective eyewear should be available. Routine use of disposable gloves for venepuncture is recommended.
Low probability of contact with blood.	Administration of intramuscular, intradermal or subcutaneous injections.	Gloves should be available and worn in accordance with risk assessment Selection and use of safer guarded hypodermic needles when appropriate
Low probability of contact with saliva (excluding dentistry)	Spitting	Good oral hygiene

*Disposable gloves should have appropriate BBV barrier properties.

5. EXPOSURE PRONE PROCEDURES (EPP) (Dental procedures within the State Hospital)

- Exposure prone procedures are those where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. These procedures include those where the workers gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times
- If you know or suspect that you are infected with a blood-borne hepatitis virus or HIV and are involved in EPP (see below) you have an obligation to discontinue these and should consult a consultant in occupational medicine. In Lanarkshire this service is available from the OHSS.

6. EMPLOYEE RESPONSIBILITY FOR HEPATITIS B IMMUNISATION

A copy of the result of immunisation is routinely sent to each employee following hepatitis B virus (HBV) immunisation performed by OHSS.

It is the employee's responsibility to keep up to date with their immunisation schedule, keep their results safely and if possible to memorise his/her antibody level and the date last immunised or when recheck is due.

7. MANAGEMENT OF EXPOSURE INCIDENTS

7.1. First Aid

If any person sustains a significant injury or contamination involving exposure to blood or body fluids, **first aid treatment should be carried out immediately**. Report the injury to your line manager, ensuring that you indicate whether this is a significant injury. The same principals will apply to patient exposure incidents.

Take prompt first aid action (appendix 2)

7.2. Risk Assessment

The rapid management of the exposed person can make the difference between them becoming ill or remaining well. It is good practice to ask the patient if a blood sample can be taken for testing; however, this is unlikely in an emergency situation and therefore the following process should be adopted. This is a 3 step process.

Step 1

An **assessment of risk factors from source person** must be completed (**appendix 3**) by the Nurse in Charge. This will help identify date of last BBV test and if the patient has refused BBV testing it will give the opportunity for a rapid risk assessment to be completed.

This information should be taken by the staff member to University Hospital Wishaw (UHW) accident & emergency (A&E) department if the risk assessment identified high risk for BBV infection.

If the source person is unable to be interviewed check RiO or Vision for any evidence of BBV carriage or risk factors. If no risk factors exist, the source is classed as low risk.

NB. All incidents must be reported via DATIX. Any exposure deemed as high risk will require to be reported to the Health and Safety Executive under RIDDOR reporting regulations as a dangerous occurrence. In addition to the DATIX Risk management must be notified via email or in person.

Step 2

Assess the **Exposure Risk** and record same (**appendix 4**).

Step 3

Assess the **Level of Risk** (Risk from Source Patient **appendix 5**)

a) Follow up for incidents assessed as low risk

The injured HCW should arrange to attend OHSS as soon as possible post incident in order to have a blood sample taken for storage / follow up.

b) Follow up for incidents assessed as medium risk

The injured HCW needs to immediately contact A&E at UHW for advice on appropriate action.

Depending on advice from UHW A&E, the injured HCW should arrange to attend OHSS as soon as possible post incident in order to have a blood sample taken for storage / follow up

c) Follow up for incidents assessed as high risk

The injured HCW needs to attend A&E Department at UHW as soon as possible for further treatment, **ideally within 1 hour of the incident**, taking with them details of their Hepatitis B antibody status, if available from OHSS and the completed **assessment of risk factors from source person** form (appendix 3).

The HCW should make an appointment with OHSS as soon as possible after the event in order to gain support and receive any additional follow up.

For the risk matrix see appendix 6.

A summary flow chart for BBV exposure for health care workers (HCW) can be viewed in appendix 7.

Guidance for OHSS responding to initial telephone contact can be viewed in appendix 8.

NB. Follow up BBV bloods should be taken from the patient as soon as reasonably possible and sent to UHW laboratory. This should be taken as a matter of urgency i.e. taxi or security staff. Clinical staff must alert the laboratory and make them aware the sample has been taken and to be processed as a matter of urgency.

8. EQUALITY AND DIVERSITY

The State Hospitals Board (the Board) is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and / or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person-Centred Improvement Lead on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments are in place to enable staff to understand and comply with policies and procedures. This policy is included in the Infection Control Manual EQIA. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Patient pre-admission assessment processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. Dementia, Autism, Intellectual Disability, sensory impairment). Rapid access to interpretation / translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith / religion / beliefs, highlighting any adapted practice required to support individual need in this respect. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Carers / Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and / or other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy".

The volunteer recruitment and induction process supports volunteers to highlight any barriers to communication, physical disability or anything else which would prevent them from contributing meaningfully to patient care and / or engage in other aspects of the work of the Hospital relevant to

their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

9. STAKEHOLDER ENGAGEMENT

Key Stakeholders	Consulted (Y/N)
Patients	N
Staff	Y
TSH Board	Y
Carers	N
Volunteers	N

10. COMMUNICATION, IMPLEMENTATION, MONITORING AND REVIEW

This policy will be communicated to all stakeholders within The State Hospital via the intranet and through the staff bulletin. It will be published on the intranet page under “The State Hospital Infection Control Manual”.

All documents are monitored and reviewed on an ongoing basis by the policy author and Infection Control Committee as part of working practice.

This policy will be formally reviewed 2 yearly or earlier if required.

GUIDELINES FOR SAFE USE AND DISPOSAL OF SHARPS

Sharps which are handled incorrectly and not disposed of adequately are dangerous. Staff who fail to safely dispose of sharps which they have used and thereby cause a hazard to others, are in breach of the Health and Safety at Work etc Act 1974 and could be liable to prosecution and disciplinary action.

The term “Sharp” applies to, for example, needles, cartridges, glass ampoules/vials, disposable razors, administration sets and any other contaminated disposable sharp instrument or item.

ASSEMBLY OF SHARPS DISPOSAL CONTAINERS

- Sharps disposal containers must conform to British Standard CE marking or BS7320: 1990.
- Assemble containers as per manufacturer’s instructions.
- Ensure that base and lid of container are securely fitted together.
- Label container with date brought into use.

USE OF SHARPS

- **Always** wear suitable disposable gloves as per Hospital policy.
- **Never** leave sharps lying around.
- **Never** walk about with unguarded sharps.
- **Never** keep syringes with needles attached in your pocket.
- **Always** request assistance when using sharps with unco-operative patients.
- **Always** take a sharps container to the place where you use the sharp.

DISPOSAL OF SHARPS

It is the responsibility of the person using the sharp to ensure its safe disposal.

- Dispose of sharps immediately after use into an approved sharps disposal container
- Dispose of needles and syringes as a single unit where possible
- Remove needles from syringes only when essential, e.g., when transferring blood to a container, or when the needle is disposable but the syringe is not – needle forceps or other suitable devices should be readily available
- Drop sharps into container aperture from approximately 2 inches above
- Ensure sharps containers are placed off the floor, and as near as practicable to sites of use, and make certain that unauthorised people cannot gain access to them
- **Do not** dispose of sharps with other clinical waste
- **Do not** expose sharps containers to extreme temperatures unless this is part of the disposal process
- **Do not** re-sheath needles
- **Do not** throw sharps into disposal containers, or drop them from a great distance
- **Do not** overfill sharps containers (fill line is clearly marked)- provide adequate numbers of containers
- **Do not** attempt to retrieve items from sharps containers or press down on contents to make more room

CLOSURE OF SHARPS CONTAINERS

Sharps containers should be handled with extreme care.

- Seal containers as per manufacturer’s instructions before removal from the clinical area, when

- three-quarters full, or at maximum intervals not exceeding one week
- Always carry sharps disposal containers by the handles provided and hold away from your body
- Label with point of origin and date sealed, then send for disposal via the appropriate route i.e. incineration or maceration/disinfection
- Place damaged used sharps containers into a larger secure container and properly label the outer container
- Do not allow used sharps containers to accumulate. Convey to a secure storage area while awaiting final disposal
- Do not place used sharps containers ready for disposal into waste bags

SHARPS DISPOSAL CONTAINER SPILLAGES

Procedure for dealing with spillages

- Seek help to guard the area while dealing with spillage
- Collect together a new correctly assembled sharps disposal container, protective clothing/equipment and items required to disinfect the area after removal of spillage
- Wear disposable gloves, apron and eye protection or other personal protective equipment as appropriate
- Using, for example, a plastic dustpan, carefully collect spilled items and transfer to new sharps disposal container

Do not rush this procedure

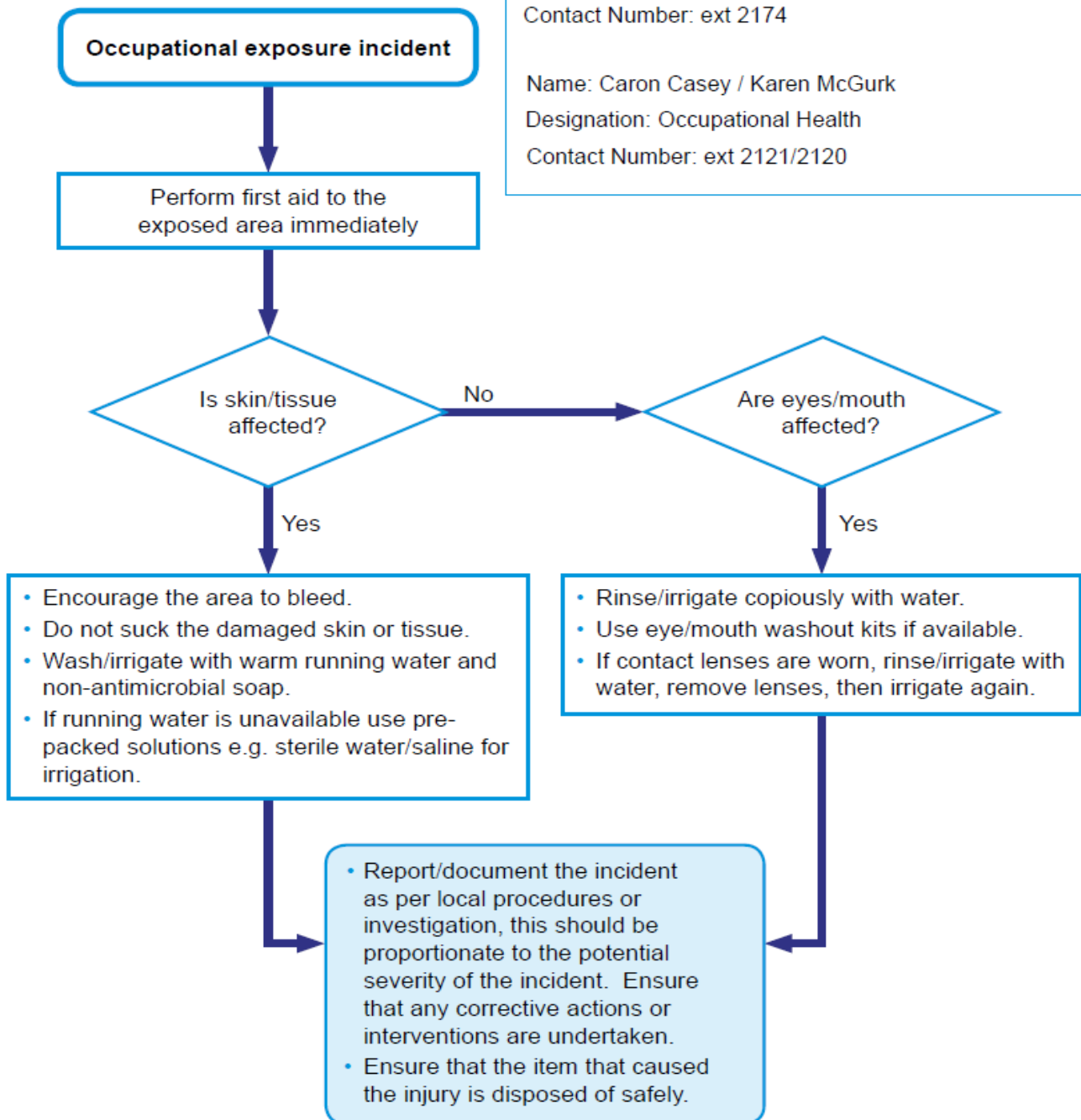
- Seal the sharps disposal container
- Clean the contaminated area as per *Section 8 "Management of Blood & Body Fluid Spillages"* of the National Infection Prevention and Control Manual
- Discard disposable protective clothing/equipment as '*Clinical Waste*' and wash hands thoroughly
- Complete Datix risk management report as per local guidelines
- Contact the Occupational Health & Safety Service if further advice is required

Best Practice: Management of occupational exposure incidents

Infection prevention and control/Occupational Health

Name: Karen Burnett
 Designation: Senior Nurse for Infection Control
 Contact Number: ext 2174

Name: Caron Casey / Karen McGurk
 Designation: Occupational Health
 Contact Number: ext 2121/2120



ASSESSMENT OF RISK FACTORS FROM SOURCE PERSON

(To be completed by the nurse in charge)

Immediate risk assessment is necessary to determine whether HIV prophylaxis should be started immediately on the injured person, it is concerned with possible risk factors in the person who is the source of the blood or body fluids.

(A) Have the patient been tested for:

Test	(Yes / No)	Date of Last Test	Result +/-
HIV			
HBV			
HCV			
HCV PCR / viral load			

(B) If no answer the following questions (Please circle):

1. Have they ever injected drugs using sharing equipment? Yes No
2. Have they ever had sex with anyone who injected drugs? Yes No
3. Have they ever had sex with another man? Yes No
4. Have they ever had sex with someone from a country?
outside the UK, Western Europe, Canada, USA,
Australia or New Zealand? Yes No
If yes, please state which country _____
5. Have they ever had a blood transfusion in a country?
that is not listed above? Yes No
If yes, please state which country _____
6. Have they had an operation or injection in a country?
that is not listed above? Yes No
If yes, please state which country _____
7. Are they from a country not listed above? Yes No
If yes, please state which country _____
8. Have they ever had sex with anyone who could
answer yes to any of the questions above? Yes No
9. Have they had tattoos whilst in prison or from another unreliable source? Yes No
10. Have they been involved in any of the above activities in the last 6 months? Yes No

EXPOSURE RISK

HIGH BODY FLUID EXPOSURE = high risk injury + high risk body fluid

MEDIUM BODY FLUID EXPOSURE = high risk injury + low risk body fluid OR a low risk injury and a high risk body fluid

LOW RISK BODY FLUID EXPOSURE = low risk injury + low risk body fluid

A **significant injury** is one with the potential to transmit a blood borne virus.

The significance of the injury depends on two factors:

1. The type of injury (table 1)
2. The body fluid involved (table 2)

Table 1: Injury Type

High - Risk Injury	Low - Risk Injury
<ul style="list-style-type: none"> • Percutaneous exposure e.g. needlestick or other sharps injury • Exposure on broken skin • Human bites that break the skin • Mucous membrane exposure (e.g. eye) 	Splash on intact skin – there is no known risk of BBV transmission from exposures to intact skin

Table 2: Body fluids

High - Risk Body Fluid	Low - Risk Body Fluid	
Exposure to any of these fluids whether through percutaneous injury, contact with a mucus membrane, contact with non intact skin, sexual exposure or sharing injection drug equipment poses a risk	Exposure to these fluids is not considered an exposure unless they contain visible blood	
Blood Blood stained low risk fluid Semen Saliva associated with dentistry	Urine Vomit Saliva Faeces Nasal secretions Sputum	Sweat Tears

If injury involves contact with HIV positive blood (whether or not, it is a significant injury) advice should be sought from UHW A&E department.

Exposure risk is (please complete):

RISK FROM SOURCE PATIENT

Scenario	Risk from source patient
If BBV testing (part A of appendix 3) indicates a positive result	High risk
If BBV testing (part A of appendix 3) is NO and patient has answered YES to any questions in part B (of appendix 3)	High risk
If BBV testing has been completed less than 6 months of admission with negative result and the patient has answered YES to any questions in part B (of appendix 3)	Medium risk
If BBV testing has been completed more than 6 months following admission with negative results and YES to any questions in part B (of appendix 3)	Low risk

Patient is (please complete):

N.B if a patient has previously tested positive for Hepatitis C virus and is now HCV PCR negative (i.e. after treatment or spontaneously) they have cleared the virus and are free from virus at present.

If possible, obtain a blood sample from source patient as soon after the incident as appropriate.

RISK MATRIX

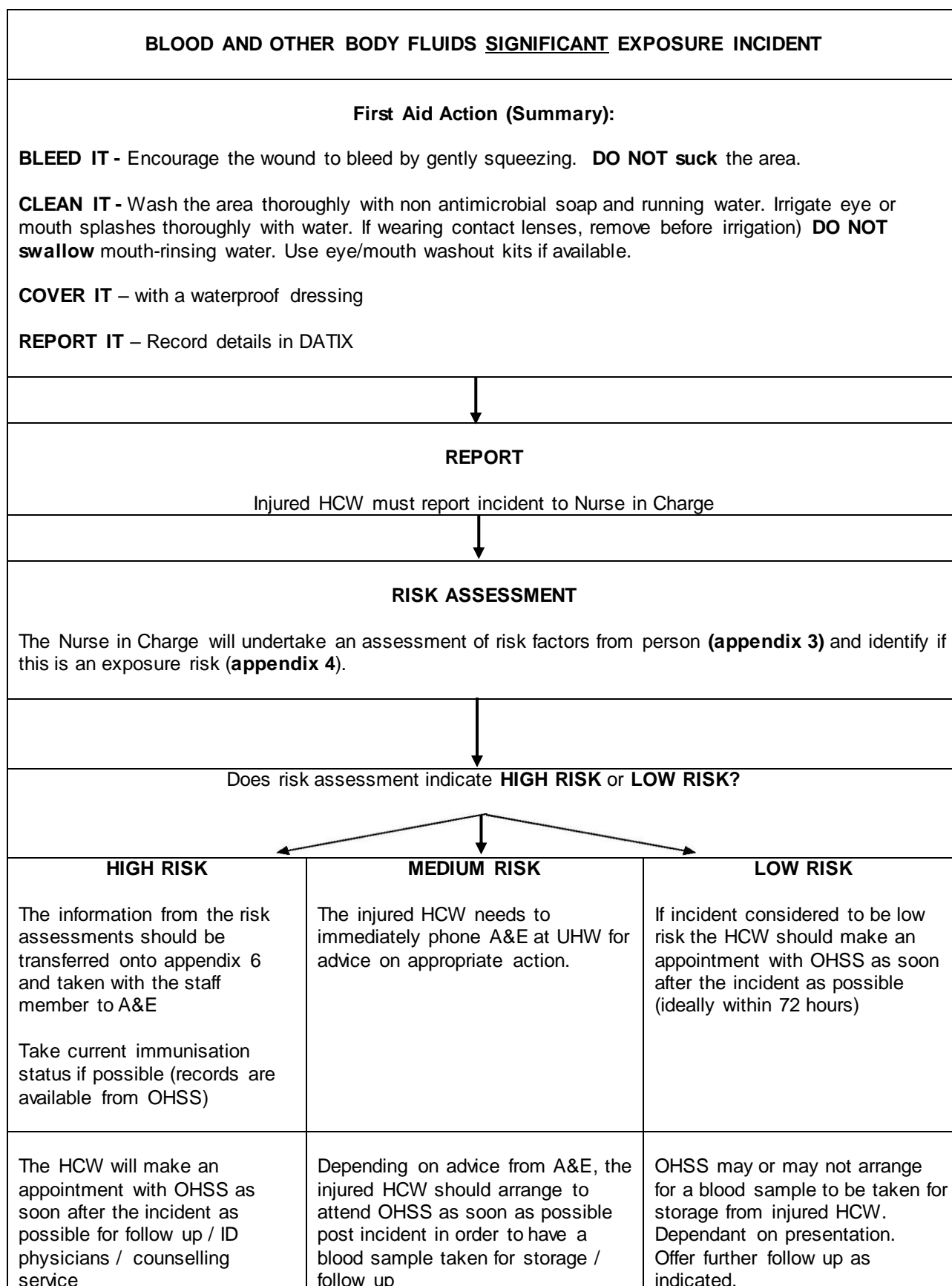
Exposure Risk (appendix 4)	Risk from source patient (appendix 5)		
	High	Medium	Low
High	High	Medium	Low
Medium	High	Medium	Low
low	Low	Low	Low

Exposure Risk (appendix 4)

Risk from source patient (appendix 5)

Overall Risk is (please complete):

SUMMARY FLOWCHART FOR BBV EXPOSURE FOR HEALTH CARE WORKER (HCW)



GUIDANCE FOR OCCUPATIONAL HEALTH AND SAFETY SERVICE RESPONDING TO INITIAL TELEPHONE CONTACT

1. Blood Borne Viruses Risk

- If risk assessment has previously been completed in the State Hospital, manage as per the result:
 - high risk incidents mean advise immediate attendance at A&E for consideration of HIV and /or HBV post exposure prophylaxis
 - medium risk phone A&E at UHW for advice on appropriate action
 - low risk as per instructions below
- If no risk assessment has been completed, ensure this is conducted as soon as possible and manage as below
- If OHSS is the point of first contact and the source is assessed as high risk, OHSS must ensure that the appropriate A&E Department (UHW) is notified, to ensure rapid assessment and treatment

2. Tetanus or Other Bacterial Infection Risk.

Tetanus and secondary infection are unlikely in sharps injuries or human bites that break the skin acquired in health care; however, advise the injured person to attend A&E for advice on further treatment if the sharp was contaminated by soil or was otherwise “dirty” or the injured HCW has never had a primary course of tetanus immunisation e.g., may apply to some people born before 1953.

In the vast majority of healthcare acquired sharps injuries this will not be necessary.

3. Low Risk Injuries

- Most injuries will be assessed as low risk and will not need immediate treatment in A&E
- Advise the injured HCW to attend OHSS for follow up as soon after the event as possible (ideally within 72 hours)
- OHSS action:
 - Take blood for storage
 - Review immunisation status and record details of the incident in the individual's OHS file
 - Take further action as determined by results of source testing

4. Record Advice

Record the advice given in notes.