ROYAL BOURNEMOUTH AND POOLE HOSPITAL NHS TRUST

Management of Needlestick Injuries and Accidents
Involving Exposure to Blood and Body Fluids

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ROYAL BOURNEMOUTH AND POOLE HOSPITAL N.H.S TRUST
STAFF RESPONSIBILITIES FOR COMPLIANCE WITH
PREVENTION AND MANAGEMENT OF NEEDLESTICK
INJURIES AND ACCIDENTS INVOLVING EXPOSURE TO
BLOOD AND BODY FLUIDS

Managers:

♦ To comply with statutory duties: provide/manage a safe working environment.
♦ Identify potential risks of microbiological and chemical hazards.
♦ Prevent and control exposure to those risks.
♦ Provide local written procedures to comply with policy.
♦ Inform employees of risks and ensure they are properly trained.
♦ Monitor exposure and where necessary amend procedures to reduce incidence.
♦ Ensure RIDDOR reporting where appropriate.

Staff:

♦ Identify, as teams, any problems (eg. insufficient sharps bins), or hazards in the workplace.
♦ Devise safe and reasonable practicable procedures for each task.
♦ Attend training.
♦ Report all incidents.

Site Managers:

♦ Manage exposures occurring outside Occupational Health working hours. 8.00-16.30 Monday to Friday.
♦ Ensure AIRS form is completed in all incidents.
♦ Ensure the healthcare worker is fast tracked through A&E.
♦ Approach the source patient and explain the incident. Give source patient information leaflet (available in site folder A&E).
♦ Determine risk factors of source patient.

A&E Triage Nurse:

♦ Fast track patient to medical staff this must happen within 30 minutes of attendance in the A/E department
♦ Complete risk assessment form (Appendix A) and return to Occupational Health Department.
♦ If PEP is to be commenced discuss with GUM/HIV physician on call. If PEP given arrange follow up with GUM Advisors.
♦ Determine Hepatitis B status of healthcare worker - consider HBIG.
♦ Take clotted sample from healthcare worker for serum storage.
♦ Reassure healthcare worker.
MANAGEMENT OF NEEDLE STICK INJURIES & ACCIDENTS INVOLVING EXPOSURE TO BLOOD AND BODY FLUIDS

Definition

Exposure of the skin or mucous membranes to blood or other body fluid from any patient.

First Aid  For ALL exposures:

a) Skin puncture wounds from used and potentially contaminated needles or instruments should be encouraged to bleed and then washed thoroughly (but not scrubbed) with soap and water.

b) Splashes of blood or body fluid into the mouth should be washed out thoroughly with copious amounts of tap water.

c) Splashes of blood or body fluids into the eyes should be well irrigated with a normal saline eyewash or running water.

Reporting Accidents

This is essential in EVERY case.

1. All incidents must be reported to your manager or supervisor and to the Occupational Health Department. Outside normal working hours of Occupational Health, accidents should be reported to the Accident and Emergency department for risk assessment and then reported to Occupational Health at the earliest opportunity. (next working day) N.B. For risk assessment: PEP is necessary within the hour for optimum benefit.

2. Record all inoculation/exposure incidents on a Staff Accident form if appropriate or in the Accident Book. Complete an Adverse Incident Reporting System (AIRS) form.

3. Please Note: It is NOT acceptable simply to send blood to the laboratory from the patient involved and/or staff. It is in everyone’s interest to adhere to this policy.
**Further Action**

Subsequent action will depend on the nature of the exposure and the likelihood of the ‘source’ being a high risk group for Hepatitis or HIV Infection.

1. a) When the source (usually a patient) of the contaminated Sharp or material is known, blood should be taken for Hepatitis B, C, screening and HIV antibody screening from the source. HIV tests require informed patient consent to be given in most circumstances, and consent **MUST** be documented in the patient’s notes. Pre-test discussion should be carried out by ward medical staff, who should also take the blood sample. See Appendix B and C  **Request forms MUST** be signed. HIV Counselling can be done by the HIV nurse advisors in GUM but they will not take the blood.

b) If the source belongs to a recognised high risk group the administration of hepatitis B immunoglobulin (HBIG) plus hepatitis B vaccine may be indicated before blood test results are known. HBIG and further advice is available from the Medical Microbiologists.

2. A 6ml clotted blood sample (red top) must be obtained from the injured or exposed person and stored in the Microbiology Department for future testing if necessary. **N.B.** Whenever samples are taken from the exposed person you **MUST** give details of the hepatitis B vaccination history on the request form.

**HEPATITIS B**

Action required:

1. **Source HBsAg Negative:** no further action necessary.

2. **Source HBsAg Positive**

   a. **Exposed person already received a full course of Hepatitis B Vaccine**

      i. If hepatitis B antibody (anti - HBs) level known to be > 100 iu/ml and a booster dose has been given 5 years after the primary course, no further action is needed (long term immunity can be assumed).

      If it is more than 2 years since the primary course was given, but the 5 year dose has not been given, it should be given now.

      ii. If the post primary vaccination course antiHBs level is unknown or <100iu/ml, take a 10ml clotted blood sample for the level to be measured.
Level >100 iu/ml: treat as for i.

Level >0, but <100 iu/ml: give vaccine booster.

Level <10iu/ml: give vaccine booster.

Hepatitis B immunoglobulin will also be required if exposure is considerable, defined as direct inoculation into a blood vessel or needlesticks involving hollow bore needles containing blood. Seek advice from the Medical Microbiologists if necessary.

b. Exposed person not vaccinated

i. Start course of hepatitis B vaccine.

ii. Hepatitis B immunoglobulin (HBIG) will also be required given intramuscularly at a different site to the vaccine if the exposure is considerable. Seek advice from medical microbiologists. HBIG is available from the Public Health Laboratory. HBIG should be given as soon as possible after exposure and certainly within 48 hours. It is of no value later than one week after exposure.

c. Exposed person vaccinated but not completed full course.

i. Take 10ml clotted blood and measure antibody level.

Level > 100iu/ml:
no further action necessary but vaccine course should be completed at recommended intervals.

Level < 100iu/ml:
give further dose and complete vaccine course. Seek advice from Occupational Health Medical Advisor and/or Consultant Microbiologists regarding intervals.

HBIG will also be required if exposure is considerable.

HEPATITIS C

There is no specific prophylaxis or vaccination available against Hepatitis C. There is therefore no immediate action which needs to be taken following exposure to a possible Hepatitis C status of the source.

Exposed health care workers should be managed as follows:

Known Hepatitis C infected source
- Obtain baseline serum for storage from health care worker
- Obtain clotted blood sample (serum) for HCV RNA testing at 6 and 12 weeks
- Obtain serum for HCV antibody (anti-HCV) at 12 and 24 weeks
Source known not to be infected with Hepatitis C
- Obtain baseline serum for storage from health care worker
- Obtain follow up serum if symptoms or signs of liver disease develop

Hepatitis C status of source unknown
- Obtain baseline serum for storage from health care worker
- A risk assessment should be performed of the likelihood that the source is Hepatitis C positive (assessed by clinician in charge of patient and Occupational Health and Consultant Microbiologist depending on circumstances).
  
  HIGH RISK – Manage as known infected source
  LOW RISK – Obtain serum for anti-HCV testing at 24 weeks.

Health care workers found to have acquired Hepatitis C infection following occupational exposure should be referred immediately for specialist assessment. Early treatment of acute Hepatitis C infection may prevent chronic Hepatitis C infection.

HEPATITIS C (HCV)

The risk of HCV seroconversion after occupational exposure appears to be low but not negligible. The risk of hepatitis C virus transmission after percutaneous injury is not well established but estimate’s range from 2.7% to 10%. Hollow-bore needles, blood filled or with visible traces of fresh blood and source patients co infected with HIV are associated with a higher risk of seroconversion. Splashes to mucosal surfaces and intact skin carry the lowest risk.

HUMAN IMMUNODEFICIENCY VIRUS - HIV

THIS POLICY APPLIES TO ALL POSSIBLE EXPOSURES, WHETHER THEY INVOLVE STAFF, PATIENTS OR MEMBERS OF THE PUBLIC

IF THERE IS A RISK OF HIV EXPOSURE, INDIVIDUALS MUST BE DEALT WITH URGENTLY TO OBTAIN PROPHYLAXIS AS SOON AS POSSIBLE AND PREFERABLY WITHIN ONE HOUR

A. The source patient should be tested for HIV antibody. This requires informed consent to be given. See appendix B - pre HIV test discussion. (Note: a situation may arise exceptionally where it is necessary to balance the interests of the exposed person against those of the source patient in deciding if a blood sample already obtained for other purposes could be tested for HIV infection. A doctor must be able to justify such a course of action ref: Serious Communicable Diseases, GMC.)

These tests are not performed out of hours for this indication as the decision whether or not to start prophylaxis treatment must not be based solely on the results of an HIV antibody test and because any prophylaxis should be given within an hour of exposure.

Note: When the source patient is known for any exposure incident it is recommended that hepatitis B, C and HIV tests are carried out as a routine from that
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patient. For high risk sources or exposures these tests should be arranged as quickly as possible.

A blood sample must be taken from the injured or exposed person and sent to the microbiology laboratory to be stored. This will be used for future testing if necessary.

B. Introduction

The risk of seroconversion following a single percutaneous exposure to HIV is only 0.3% and following mucous membrane and skin exposure, 0.1% and <0.1% respectively. A recent study suggested that this risk can be reduced still further if anti-retroviral drugs are taken prophylactically, starting as soon as possible after exposure, preferably within 1 hour. Since a combination of anti-retroviral drugs will be more effective in suppressing viral replication and reduce the risk of the development of resistance, a four week course of triple anti-retroviral post-exposure prophylaxis (PEP) is now recommended in certain circumstances.

Three types of exposure pose a risk:

(i) percutaneous exposure, eg. needlestick
(ii) exposure of broken skin
(iii) mucous membrane exposure

The risk of transmission in increased with

- deep injuries
- hollow bore needles
- needles/sharps that are visibly blood stained
- needles that have been in an artery or vein
- a high viral load in the source e.g. patient with AIDS/terminally ill

PEP should be considered whenever there has been exposure to material known to be, or strongly suspected to be, infected with HIV.

High risk body fluids are: blood, amniotic fluid, vaginal secretions, semen, breast milk, CSF, peritoneal fluid, pericardial fluid, synovial fluid, unfixed tissues and organs and saliva in association with dental surgery. PEP should not be offered following contact through any route with urine, vomit, saliva and faeces unless they are visibly bloodstained.

C. Staff should go for risk assessment in the Occupational Health Department or A & E as soon as possible. Members of the public should go to A&E.

A Risk Assessment incident form should be completed and this can be done in OHD or A&E. Details to be noted include the date, time, type and significance of exposure; the infectivity of the source blood/body fluid/tissue, the source name, hospital number, location and consultant.
D. The Triage Nurse in the A&E Department should fast track the patient to be seen urgently by a doctor (within 30 minutes of arrival within the department). Details need to be collected (see previous paragraph) to enable a risk assessment to be done. Additional expert advice is available from Dr E Herieka, Consultant on G.U. Medicine or the G.U.M physician on call, or a GUM Health Advisor (via RBH switchboard). If none of the above are available contact the on call Consultant Microbiologist. A decision about the need for post-exposure prophylaxis can then be made based on the level of risk. A patient information leaflet outlining the possible side effects of the prophylactic drugs and how to obtain follow up treatment and advice should be given to the patient.

If there is a risk of exposure to HIV, PEP must be started immediately and preferably within one hour.

The following should be recommended:
- Combivir (Zidovudine 300mg & lamivudine 150mg) bd
- Nelfinavir 1.25g bd with food

It should be noted that these anti-retroviral drugs are not licensed for incidents involving their use as prophylaxis against HIV infection and a disclaimer should be signed by the recipient (Appendix C).

NB:
(i) These drugs are prescribed on “a named patient basis”.
(ii) The recipient should be advised about possible short term side effects.
(iii) The following factors may need to be considered/discussed with the HIV physician, GUM Physician on-call, pharmacist or a GUM Health Adviser:
- could the health care worker (HCW) be allergic to one of the above.
- could there be an interaction with other medications eg. Phenytoin, antibacterials.

The immediate PEP will be dispensed in an initial 3 day treatment pack containing the above three anti-retrovirals. The remaining course will be prescribed at the follow up assessment which should be arranged through the GUM Department. The initial PEP treatment packs will be available in Pharmacy and A&E Poole Hospital. (A supply is also available in A&E, Occupational Health Pharmacy and GUM Department at RBH).

(i) If the HIV status of an identified high risk source is unknown, it may be necessary to commence PEP pending further risk assessment, discussion and testing. Source patients should be tested for HIV antibodies provided informed consent has been obtained.

(ii) With an unidentified source, eg. a discarded syringe and needle, PEP would not normally be indicated.
(iii) Although Combivir is not contra-indicated in the second and third trimester of pregnancy in the short term, there is limited experience of the use in pregnancy of protease inhibitors. Decisions on PEP in pregnancy, therefore should take into account the balance of risk in the mother and her baby and, normally, if indicated, only ZDV and Lamivudine would be recommended (discuss with HIV physician, the GUM physician, GUM Health Advisers, the GUM physician on-call).

(iv) If the recipient is a child, dosages should be discussed with a paediatrician/pharmacist.

(v) If the source patient is or has been on anti-retroviral treatment, alternative drug regimens may need to be considered. (Contact the HIV physician, GUM physician on-call).

It is Trust Policy that needlestick accidents should be reported and investigated urgently and that PEP should be given within one hour of exposure. However, if there is a delay in reporting a high risk exposure, it may be worth considering PEP up to two weeks from exposure.

**Patient (exposed person) counselling and follow up for exposures assessed as significant and with a source known or strongly suspected to be HIV positive.**

(i) Initial post exposure management and counselling in OHD and A&E should include:

- assurance of confidentiality
- reassurance that transmission risk is low
- the need for post-exposure prophylaxis
- the risk of toxicity of PEP and the need for regular medical follow-up
- obtaining a blood specimen (5-10ml serum) from exposed person for storage
- management of hepatitis B, hepatitis C and other risks appropriately
- arrangement of follow-up appointment for monitoring and counselling in the GUM Dept., RBH. If the patient needs further immediate counselling contact a GUM Health Adviser.
- Obtain bloods for FBC, LFT’s, U&E’s, before PEP is started.
- Pregnancy test may need to be done prior to commencement of PEP.
- Patients on PEP need monitoring of FBC, LFT’s and U+E’s at 1, 2 and 4 weeks in the GUM department.
- Confirmation that an incident form has been completed.
(ii) Post exposure follow-up by Occupational Health/GUM RBH.

- emphasise the need for pre-HIV test counselling and the availability of further advice and support
- monitor effects of prophylaxis if given
- emphasise the need for follow-up at 3 months and 6, 12 months post exposure, with HIV testing and serum storage
- emphasise the need to report interim illness
- explain the need to prevent further possible transmission (protected sexual intercourse, avoidance of pregnancy, blood, organ and semen donation)
- with health-care workers, provide reassurance that in general, work restrictions during follow-up are not appropriate
- report management and outcome to PHLS CDSC

CONTRAINDICATIONS

Any renal or hepatic insufficiency is a relative contraindication. Pregnancy requires specific specialist consultation before starting treatment. Refer to on-call GUM Physician if out of hours.

All exposed persons will require follow up. Those taking triple therapy and prophylaxis following exposure to HIV must agree to regular virological, clinical and haematological monitoring whilst taking drug and at intervals for six months thereafter. This will be co-ordinated by the Genito-urinary Medicine Department. RBH.
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**SOURCES OF ADVICE:**

**GUM Physicians**
- Dr. El Bushra Herieka: Ext. 4918
- Dr. A. DeSilva: Ext. 4656
- Dr. M. Haywood: Ext. 4660

or on-call GUM physician out of hours: via hospital switchboard.

**GUM Health Advisors**
- Via switchboard at the Royal Bournemouth Hospital for the hours listed below
  - Ruth Woodward: BLEEP 0572
  - Tricia Moate: BLEEP 0575
  - Patricia Wharton: BLEEP 0574

<table>
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<th>Opening hours</th>
<th>Time</th>
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<tbody>
<tr>
<td>Monday</td>
<td>09.00 – 19.00 Ext. 4536</td>
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<tr>
<td>Tuesday</td>
<td>09.00 – 17.00</td>
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<td>Wednesday</td>
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<td>Thursday</td>
<td>09.00 – 19.00</td>
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<td>Friday</td>
<td>09.00 – 17.00</td>
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**Occupational Health**
- Dr. Mary Jenkins: Ext. 2035
  - Occupational Health Physician (Poole)
  - Diana Ford (Poole): Ext. 2035
    - Occupational Health Nurse
  - Poole Hospital Sharps Hotline: Ext. 8878
    - (recorded information)
  - Lucy Perkins: Ext. 4217
    - Senior Nurse Occ Health RBH
  - Dr R Thomas: Ext. 4217
    - SCMO RBH Medical Advisor

**Consultant Microbiologists**
- Dr. Simon Hill: Bleep 0423 Ext. 2300
- Dr. Paul Flanagan: Bleep 0817 Ext. 8673
- Dr Mick Martin: Air call via switchboard
- Dr Bill Gransden: Air call via switchboard

**Infection Control Nurse**
- Jacqui Campbell: Bleep 0706 ext. 4842
- Senior Nurse: Ext. 4842
- Ruth Middlemass: Ext. 4842

**Clinical Nurse Specialist**
- Hazel Allen: Ext. 5852 Bleep 2359

**Viral Hepatitis (HCV, HBV)**

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REFERENCES


UK Health Department (2002) Hepatitis C Infected Health Care Workers. DOH.

General Medical Council – Serious Communicable Disease 1997.
### MANAGEMENT OF NEEDLE-STICK INJURIES & ACCIDENTS INVOLVING EXPOSURE TO BLOOD AND BODY FLUIDS

#### NOTIFICATION OF INCIDENT

This form must be completed by the Triage Nurse for all staff members attending A&E or OHD following an exposure to blood or body fluids.

Forms completed in A&E **must be returned to OHD as soon as possible.**

<table>
<thead>
<tr>
<th>Name of Employee</th>
<th>Date of birth</th>
<th>Position</th>
<th>Directorate/Dept</th>
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<th>Date of incident</th>
<th>Date of Assessment OHD/A&amp;E</th>
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Give brief description of incident:

________________________________________________________________________
________________________________________________________________________

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<thead>
<tr>
<th>Name of patient if known</th>
<th>(source of blood or body fluid)</th>
<th>Date of birth</th>
<th>Hospital ID Number</th>
<th>Does the patient have a history of HIV</th>
<th>Hepatitis B</th>
<th>Hepatitis C</th>
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Does the patient have risk indicators for blood-borne viruses
Risk indicators: multiple sex partners, IV drug abuse, resident of Far East or sub-Saharan Africa, history of multiple blood transfusion.

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<tr>
<th>Did the incident involve:</th>
<th>Blood/high risk body fluids</th>
<th>Low risk body fluids</th>
<th>Not known</th>
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High risk = blood, semen, vaginal secretions, breast milk, saliva associated with dentistry. Low risk (unless blood stained) = urine, faeces, tears, saliva.

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<tr>
<th>Did the incident involve:</th>
<th>Broken skin exposure</th>
<th>Mucous membrane exposure</th>
<th>Sharps injury</th>
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If sharps injury, was the injury:

<table>
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<tr>
<th>Deep</th>
<th>Superficial, light scratch or shallow pin prick</th>
<th>Not known</th>
<th>Did the needle or Sharps contain: Blood</th>
<th>Drugs</th>
<th>Not known</th>
</tr>
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ACTION TAKEN AND TREATMENT

Check adequate first aid (wash/flush)  YES  NO

Blood sample taken from source patient for Hep B&C, HIV  YES  NO

Date if known ______________________

Blood taken from staff member for:  current anti HBs level  YES  NO
storage  YES  NO
FBC, U&E’s, LFT’s, (pre PEP)  YES  NO

Is staff member protected against hepatitis B  YES  NO
(known to have adequate antibody level after vaccination)
pregnancy test (Pre PEP)  YES  NO

Staff accident form completed (where relevant)  YES  NO

AIRS form completed  YES  NO

If appropriate: Management of incident discussed with:  ________________

____________________________________________________________________

Treatment given:

**Hepatitis B:**

None / Booster / Accelerated vaccine course / Hep B immunoglobulin

**HIV:**

None / pep
Follow up: Advised to contact -

Occupational Health  YES  NO
Genito-urinary medicine physician  YES  NO

Form completed by: Signature  ____________________________

Print name  ____________________________

Position  ____________________________

Date  ____________________________
Infection Control Guideline No. 4

APPENDIX B
HIV TESTING: PRE TEST DISCUSSION

For the purposes of action being taken after a needlestick injury or exposure to blood/body fluids it is appropriate to inform the source (usually a patient) of the following:

1. Asking for a blood sample is standard hospital policy after every blood exposure regardless of perceived risk and is in line with Dept. of Health recommendations.

2. Their blood will be tested for hepatitis viruses and HIV antibody. It is most important that the patient knows it is an HIV antibody test which is being done, after pre HIV test discussion.

3. Discuss any possible risk factors and assess degree of risk. Check whether they are in the 3 month window period, ie. may have been exposed to HIV infection but not yet developed antibodies.

4. Provide information about the transmission of the HIV virus and the principles of safer sex.

5. Explain benefits of knowing a positive diagnosis for prognosis and treatments. Discuss who they would need to tell if positive, including GP, Dentist and sexual partners. Explain what a negative result means. (If very high risk they should have a repeat test in six months).

6. Reassure about confidentiality. Explain if negative, there should be no implications for life insurance and mortgages.

7. If the HIV test was positive a trained HIV Counsellor or Dr. would be responsible for giving the result to the patient and explain exactly what the test results mean.

8. Obtain patient's agreement to go ahead with the test.

9. The fact that a pre-test discussion took place should be recorded in the notes and signed and dated.

   It is also useful if this is recorded on the microbiology request form.

If the source has left hospital by the time the need for further action is taken the Trust must make every effort to contact the patient to instigate the sharps policy. There is no defence in the court room unless a chain of evidence can be shown to protect the staff member. Written legible evidence must be available in the Occupational Health record of staff member and patients’ medical records.
APPENDIX C
CONSENT FORM
FOR POST EXPOSURE PROPHYLAXIS

Patient Number: 
Surname: First Name: 
Date of Birth: 
Consultant: 

STATEMENT OF HEALTH PROFESSIONAL

- I have fully counselled the patient about Post Exposure Prophylaxis

Signed……………………………. Date ………………………………………..
Name ………………………….. Job Description …………………………….. 

STATEMENT OF PATIENT

- I confirm that I have been counselled and I fully understand the relative risk of developing HIV infection following occupational exposure to HIV positive material.

- I understand the risks of toxicity associated with Exposure Prophylaxis drugs.

- I am not aware that I have any liver or kidney disease. I am not pregnant. I confirm that I will take precautions to prevent becoming pregnant/fathering a child, whilst I am taking the drugs.

- I confirm that I will comply with regular virological, clinical and haematological procedures whilst I am taking the drugs and at intervals for up to six months thereafter. I give consent for my blood to be tested for the presence of HIV.

- I understand that these drugs are not licensed for Post Exposure Prophylaxis and are therefore prescribed on a named patient basis.

Signature of Patient ………………. Date …………………………………..
Name (PRINT) …………………

Signature of Witness ……………... Date …………………………………..
Name (PRINT) …………………
MANAGEMENT OF NEEDLESTICK INJURIES & ACCIDENTS INVOLVING EXPOSURE TO BLOOD AND BODY FLUIDS
This is a summary: refer to full policy for details – issued January 2001

### Exposure to Blood and/or Body Fluids

1. Wash / clean affected area / encourage to bleed
2. Notify Site Manager (Bleep 2002)
3. Go to Occupational Health, if out of hours attend A&E reception immediately.
4. Complete AIRS form
5. Have blood sample taken for storage (and Hepatitis B antibody if appropriate)
   - **Further action depends on risk assessment. See policy and guidance below.**

#### Hepatitis B positive patient
- Staff immune protective level documented within last 2 years.
  - **No further action**
- Staff vaccinated but unsure of status or more than 2 years.
  - **Blood sample to test for Hep. B**
- Staff not vaccinated.
  - **Seek immediate advice**
  - Receive 1st dose Hep. B plus Hep B immunoglobulin. (Via Microbiology)

#### HIV positive patient
- **Low risk patient / incident** - arrange for source to be tested for Hep B, C and documented informed consent for HIV (during next working day).
- **High risk patient / incident** - follow flow chart Appendix C.

#### Hepatitis C positive patients
- No immediate action required discuss with Occupational Health.

#### Patients Hepatitis B or C or HIV status unknown
- **Low risk patient / incident** - follow flow chart Appendix C.
- **High risk patient / incident** - follow flow chart Appendix C.
MANAGEMENT OF HIGH RISK EXPOSURE TO BLOOD OR BODY FLUIDS

Accidental Exposure

Take clotted sample from Healthcare Worker for serum storage

Determine risk factors of source patient. (Complete Appendix A)

No risk factor identified

Source patient unknown. Significant injury

Risk assess clinical environment i.e. circumstances of exposure and epidemiological likelihood of HIV in the source

Low risk injury and low risk patient-environment

REASSURE HEALTHCARE WORKER THAT RISK OF TRANSMISSION OF BLOOD BORNE VIRUSES IS RELATIVELY LOW

If incident occurs outside normal working hours, future follow up and counselling will be offered by Occupational Health/GUM. Full guidance is offered in policy.

Source patient identified as high risk

HIGH RISK INJURY AND HIGH RISK PATIENT/ENVIRONMENT

Discuss with GUM / HIV Physician on call. Source patient will be counselled / tested by HIV Advisors.

Start PEP/HBIG. Notify Occupational Health on next working day
PATIENT INFORMATION LEAFLET FOLLOWING NEEDLESTICK INJURY TO A MEMBER OF STAFF

Unfortunately a member of staff has had a needlestick injury while he/she was attending to you. There is no risk to you from a member of staff but it is hospital policy, in line with Department of Health recommendations, to test the source patient (yourself) routinely for HIV, Hepatitis B and Hepatitis C.

One of our Health Advisors or ward doctors will come and see you to talk to you about the blood tests we need to take from you to test for HIV and Hepatitis B and C, and they will be able to answer any questions you may have. You will not be tested for HIV unless you agree to be tested.

A specimen of blood is taken from you and is sent to Poole Hospital microbiology laboratory for testing the next working day. You will be given this result as soon as possible by one of your ward doctors or a GUM Health Advisor. Should you be due to be discharged home before the result is expected back, please let the ward staff know so that alternative arrangements can be made. If you agree, you can give written permission for the result to be sent to your G.P. or alternatively, you can make arrangements to receive the results with a specific staff member.

If you have any worries or questions please do not hesitate to ask your ward doctors or sister for further information, or alternatively please contact the Health Advisors at RBH GUM Clinic on 01202-704536.

Opening hours

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<tr>
<th>Day</th>
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<tbody>
<tr>
<td>Monday</td>
<td>09.00 – 19.00</td>
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<td>Tuesday</td>
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<td>Wednesday</td>
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<td>Thursday</td>
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<td>Friday</td>
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