



Community Infection Prevention and Control  
Guidance for Health and Social Care

# Sharps Management and Inoculation Injuries

**SHARPS MANAGEMENT AND  
INOCULATION INJURIES**

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**SHARPS MANAGEMENT AND INOCULATION INJURIES**

# SHARPS MANAGEMENT AND INOCULATION INJURIES

## 1. Introduction

### Sharps

Sharps include needles, cannulas, stitch cutters, scalpels, medical instruments, intravascular guide wires, razor blades, broken glass and other sharp objects.

Sharps which are handled inappropriately or not disposed of correctly are dangerous.

## 2. Good practice in sharps management

### HEALTH AND SAFETY

Health care employers, their contractors and employees have legal obligations under the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations). All employers are required to ensure that risks from sharps injuries are adequately assessed and appropriate control measures are in place.

### NEEDLE MANAGEMENT

- Avoid unnecessary use of sharps.
- For certain procedures, needle free equipment is available and should be used where reasonably practicable.
- Sharps should only be used where they are required, e.g., not for collection of urine samples from catheter bags.
- Where it is not practicable to avoid using sharps, safer sharps incorporating protection mechanisms should be used.
- Do not re-cap needles. In dentistry, if re-capping or disassembly is unavoidable, a risk assessment must be undertaken and appropriate safety devices should be used.
- Dispose of needle and syringes as one unit into a specified sharps container.
- If it is necessary to detach the needle, great care must be taken, preferably using the device on the sharps container.
- Request assistance when using sharps with reluctant or confused service users.

- Do not carry sharps in the hand; always use a sharps tray with an integrated sharps container.
- Do not pass sharps from hand to hand.
- Always carry sharps containers away from the body.

### ENSURING SAFE USE

- All staff (clinical and non-clinical) should be educated in the safe use and disposal of sharps and the action to take in the event of an injury.
- Sharps containers should be situated in a safe and secure place and not accessible to other service users or visitors.
- In rooms or areas where sharps containers do not need to be moved, they should be wall-mounted at the point of use (i.e., where the sharp is used).
- At no time should a sharps container be placed on the floor.
- Sharps containers should comply with the UN 3291 and British Standard BS7320.
- The correct size of the sharp container to be used should be determined according to the volume of sharps generated. Sharps containers should be disposed of when no more than  $\frac{3}{4}$  full, or when the container has been in use for three months, whichever is first.
- Always assemble sharps containers correctly, with lid securely fastened to base.
- Sharps containers should be taken to point of use, using an injection tray with an integral sharps container.
- Sharps, needles and syringes should be placed into the sharps container by the person using them.
- Needles and syringes should be placed into the correct colour coded sharps container:
  - Purple lid – sharps contaminated with cytostatic or cytotoxic medicines
  - Yellow lid – sharps contaminated with medicines
  - Orange lid – sharps not contaminated with medicines.
- After disposing of a sharp into the sharps container, the aperture should be moved into the temporary closure 'closed' position.
- Never press down the contents to make more room or attempt to retrieve an item from the sharps box.
- All apertures must be 'locked' prior to disposal.
- Sharps containers must be labelled with date and signature, when assembled, locked and disposed of. They must be labelled with their source prior to disposal.
- Sharps containers must not be placed inside waste bags prior to disposal.

### 3. Prevention of inoculation incidents

An inoculation incident is where the blood/body fluid of one person could gain entry to another person's body, such as:

- a sharps/needlestick injury with a used instrument/needle
- spillage of blood or body fluid onto damaged skin, e.g., graze, cut, rash, burn
- splash of blood or blood stained body fluid into eye, mouth or nose
- human bite causing skin to be broken.

Many accidental exposures to blood and body fluids are, therefore, not classed as inoculation incidents, e.g., splashes on to intact skin. In these circumstances, washing the contaminated area thoroughly with liquid soap and warm water is all that is required. Exposure to vomit, faeces and urine (unless visibly blood stained) and to sterile sharps are also not considered as inoculation injuries.

Compliance with the above guidance on sharps management should reduce the risk of contaminated sharps injury.

In addition:

- inexperienced staff should avoid performing invasive procedures which might result in a sharps injury
- all staff should protect their skin, as the skin is an effective barrier to micro-organisms. Skin should be intact whilst at work, cuts/abrasions should be covered with impermeable dressings
- the use of disposable gloves provides additional protection as long as dexterity is not impeded. New venepuncturists learning the procedure should be taught to undertake the procedure with gloves
- disposable gloves should be worn for invasive procedures and where there is a risk of exposure to contaminated sharps
- facial personal protective equipment should be worn where there is a risk of blood splashing on the mucous membranes (eyes, mouth and nose).

### 4. Always

- Use Standard Precautions.
- Dispose of single-use items after one use.
- Dispose of waste as per local policy.

## 5. Risk of infection from inoculation incidents

Following a specific exposure, the risk of infection will vary depending on the nature of any pathogens in the service user's blood, the type of inoculation and the amount of virus in the service user's blood or body fluid at the time of exposure.

Surveillance studies indicate that the risk of seroconversion following exposure to blood from HIV infected service users is about 1 in 300 for percutaneous (needlestick) injury and 1 in 1,000 for mucous membrane exposure.

The risk of acquiring Hepatitis B virus from a Hepatitis B antigen positive source is in the order of 1 in 3, for an unvaccinated individual. Vaccination is protective.

The risk of acquiring Hepatitis C through inoculation with a Hepatitis C positive source is in the order of 1 in 30.

## 6. Action to be taken following an inoculation incident

Following an inoculation incident, the post exposure procedure must be followed.

### Immediate management of inoculation injuries

- **Bleed it** - if there has been a puncture wound, encourage bleeding of the wound by squeezing it under running water (do not suck the wound).
- **Wash it** - the injured area or damaged skin should be washed thoroughly and dried. Blood or body fluid splashes to mucous membranes or conjunctivae should be irrigated copiously with water.
- **Cover it** - cover the wound with a waterproof dressing.
- **Report it** - report the injury to your manager immediately and complete an incident form.
- **Seek advice** - seek medical advice immediately from your Occupational Health provider/GP. Out of normal office/surgery hours, attend the nearest A&E department and inform your Occupational Health provider as soon as possible afterwards.

Where A&E advice has been sought, a communication should be given to the relevant Occupational Health service/GP to ensure that they are able to a) follow up and give any on-going support, and b) complete the organisational reporting procedure.

## 7. Management of significant exposures

The term source is used for the individual whose blood or body fluids were involved, and the term recipient for the individual who has been exposed.

A risk assessment should be made based on the significance of the exposure, the recipients' prior immunity to Hepatitis B and the known or likely status of the source for blood borne viruses. This should be carried out by GP/Occupational Health or A&E.

If the source service user is known, every attempt should be made to obtain a blood specimen for testing for blood borne viruses. To avoid discrimination, it is standard practice for the source of the incident to be offered tests for the three main blood borne viruses, Hepatitis B, Hepatitis C and HIV. Appropriate pre-test counselling and informed consent is a pre-requisite of testing the source.

Bloods from the recipient will also be required for serum save. The taking of blood specimens and the approach to the source for permission to test should be managed by a third party, i.e., somebody other than the recipient of the injury.

## 8. Reducing the risk of Hepatitis B transmission

Hepatitis B vaccination is effective in preventing Hepatitis B transmission.

- All staff exposed to sharps or other inoculation risks should have had the opportunity for Hepatitis B vaccination and antibody measurement to check for their response.
- All staff likely to be in contact with sharps or inoculation risks should be aware of their immunisation status regarding Hepatitis B. Optimal management of health and social care workers can only be achieved if their vaccination status is known.
- Depending on the circumstances of the exposure and the immune status of the recipient, the recipient may be advised to have immediate additional vaccine doses or to receive Hepatitis B immunoglobulin.
- Seeking early advice is the key to successful intervention to prevent transmission.

## 9. Reducing the risk of Hepatitis C transmission

No specific post exposure prophylactic measures are advised beyond basic first aid. In the event of a source proving to be Hepatitis C positive, specific

advice on subsequent testing and management will be provided through the Occupational Health service, including advice on preventing onward transmission.

## 10. Reducing the risk of HIV transmission

In the case of a significant exposure to a known or suspected HIV infected source, or if there is evidence of AIDS related illness, then HIV post exposure prophylaxis (PEP) should be offered. HIV post exposure prophylaxis should ideally be started within one hour of exposure, but can still be offered up to 2 weeks later. Advice must be sought from the Occupational Health Service/GP or A&E, who will perform a risk assessment, advise the recipient, and can initiate therapy.

## 11. Exposure incidents in the community

Occasionally, members of the public will present to GPs following a community exposure, typically an injury with a discarded syringe. In this instance, where the source is unknown, an accelerated course of Hepatitis B vaccine is recommended. Community prevalence of HIV and Hepatitis C remain low and no specific action in respect of these viruses is indicated.

The incident should be reported to the Consultant in Communicable Disease Control (CCDC) at your local Public Health England Team.

If the source is known, a risk assessment is required and further intervention may be advised. GPs should discuss these cases with the CCDC or the local consultant microbiologist.

Persons subject to penetrating human bites should also be offered a course of Hepatitis B vaccination and should have their wound medically assessed because of the risk of bacterial infection.

Community incidents	
Counsel regarding risk	Risk is low for discarded needles. For needlesticks/inoculations from a known positive source, the risk is detailed in this guidance
Consider the need for antibiotic prophylaxis	Particularly for human bites, or injuries following fights
Immunise the service user using the accelerated schedule	3 doses of Hepatitis B vaccine at 0, 1 and 2 months with a booster at 12 months
If previously vaccinated offer a booster of vaccine	

In the event of an unimmunised service user exposed to a known Hepatitis B positive source, consider the use of Hepatitis B immunoglobulin following discussion with CCDC or consultant microbiologist	HBIG is only available for named service users through the CCDC or consultant microbiologist and is seldom indicated in community incidents
Consider testing for Hepatitis C at 3 and 6 months in the case of significant exposure to a used needle	
In the event of exposure to a known HIV positive transmission risk, consider the use of PEP for HIV	

Blood tests on the recipient are not strictly necessary, but may be done if the service user wishes to have specimens stored for medico-legal purposes depending on the nature of the incident. Following discussion with the consultant microbiologist or CCDC, it may be appropriate for some service users to arrange follow-up blood tests for blood borne viruses where significant risk or anxiety is present.

If a cache of needles has been discovered, the Local Authority should be contacted to arrange for their safe disposal.

## 12. Terminology

Relevant abbreviations	
HIV	Human Immunodeficiency Virus
HCV	Hepatitis C virus
HBV	Hepatitis B virus
HBe Ag	Protein associated with infectious hepatitis B virus
HBs Ag	Surface protein of hepatitis B virus
Anti- HBe	Antibody to HBe Ag
HBIG	Human immunoglobulin with high titre of anti HBs. Used for post exposure prophylaxis

## 13. Additional IPC resources

The North Yorkshire and York Community Infection Prevention and Control (IPC) team have produced a wide range of innovative educational and other IPC resources, including sharps management, e.g., Actions to be taken following a sharps injury, blood splash or body fluid incident poster. These

resources are designed to assist your organisation in achieving compliance with the Health and Social Care Act 2008 and CQC requirements. Further information on these high quality evidence-based resources is available at [www.infectionpreventioncontrol.co.uk](http://www.infectionpreventioncontrol.co.uk)

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