

The purpose of this procedure is to prevent or minimise the likelihood of injury from the use and disposal of Clinical Sharps Devices within NHS Lothian.

The procedure provides an outline of good practice in order to comply with the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. By default NHS Lothian will provide when available safety engineered clinical sharps devices.

The procedure is for use by managers and also provides information for staff of those Services who use and dispose of Clinical Sharps Devices.

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### 1. Risk Assessment

Every ward/dept where clinical sharps devices are used MUST have assessed the risks associated with their use and disposal. Those findings must be recorded on the NHS Lothian General Risk Assessment Form. For example the assessment should list those devices used and activities undertaken and outlines the control measures needed to prevent injury, particularly during disposal.

Where a Clinical Sharps Non Safety Device is used then this should also be subject to a risk assessment with the findings recorded on the form the Clinical Rationale for the Use of Non Safety Devices. (Opt Out Form)

### 2. Review

Once completed, risk assessments should be reviewed annually to confirm they remain valid or sooner if there has been a significant change in terms of the clinical sharps devices in use, any task/ procedures undertaken, or following the review findings from an adverse event. An audit on the use and disposal of clinical sharps devices may also prompt a review.

### 3. Hierarchy of Control

For standard risk assessments there is a hierarchy of control that outlines each step that should be taken to determine the nature of any risks and suitable control measures and these are detailed below.

#### 3.1 Eliminate / avoid the use of non safe clinical sharps devices

A key consideration is to ensure that Non Safe Clinical Sharps Devices are only to be used where they are absolutely required and only where a safer clinical sharps device is not available or appropriate for the task. An appropriate risk assessment to explain why a non-safe device is required for a given task/procedure **must** be in place (recorded using the Clinical Rationale for the Use of a Non Safety Device/Opt Out form). The form must be signed off by a Clinical Director or Clinical Nurse Manager and a Trained Health and Safety

Representative then submitted to the Health and Safety Department data base for storage, future reference, circulation and annual review.

### Clinical Sharps Device: Patients

Patients who are self administering medication may bring their own clinical sharps device in to hospital; this will have to be considered in the risk assessment. Health Care Workers (HCW) must not administer the medication using the patient's own clinical sharps device where the patient has been assessed as competent to carry out this function for themselves. Patients in ward areas should be informed that, where possible, they self administer in the presence of the HCW so that they can be observed disposing of the sharps appropriately into the sharps container provided. This will minimise risk to other staff and patients.

Patients may also be undertaking supplementary blood glucose monitoring with their own equipment and should be issued with hospital single use lancets for this and should also have access to a sharps container provided by the Ward/Department concerned.

### 3.2 Substitute the sharp with a safer alternative

Traditional, unprotected clinical sharps devices must be substituted with a 'safer sharp device' where a safe sharps device is available. Safer sharps devices are those which incorporate features or mechanisms to prevent or minimise the risk of injury; this may include devices that are self activating or operator activated and slide or pivot to cover the needle after use.

Self activating devices are preferential to operator activated as it does not rely on the member of staff to control the safety mechanism of the device. Self activating Safety Devices should have the guard activated against a hard solid surface and must not be activated using both hands.

When buying clinical sharps devices the NHS Lothian Procurement System must be followed this takes the following factors into consideration:

- The device does not compromise patient care
- The reliability of the device
- The HCW must be able to maintain control over the procedure
- Other safety hazards or sources of blood exposure that use of the device may introduce
- Ease of use -is the safety mechanism design suitable for the clinical application?

The following considerations are also relevant when selecting a clinical sharps device:

- if activation of the safety mechanism is straightforward, it is more likely to be used;
- if the safety mechanism is integral to the device (i.e. not a separate accessory) it cannot be lost or misplaced;
- for many uses a single-handed or automatic activation will be preferable;
- the safety mechanism is not effective if it is easily reversible.

NHS Lothian will continue to source and make available safer clinical sharps devices equipment for use within our diverse clinical settings.

### 3.3 Personal Protective Equipment (PPE)

It should be noted that PPE, such as a nitrile glove, will not provide much protection from the sharps injury itself but may significantly reduce the risk of BBV exposure.

### 3.4 Exposure to Blood and Bodily Fluids

All HCWs who have the potential to be exposed to blood and body fluids in NHS Lothian are offered and strongly advised to have a Hepatitis B vaccination and a check on their immune status.

## 4. Preparation and Use of Clinical Sharps Devices

Once the status of the clinical sharps devices have been established (safety or non-safety) and the primary methods of control decided it is worth considering the following points during the completion of your risk assessment:

### 4.1 Preparation

- Ensure sharp bins are situated in suitable locations
- Ensure there are adequate sharps bins of appropriate sizes in your department
- Choose the safest device in relation to the task to be undertaken
- Use needleless/safety devices where appropriate
- Always take the sharps bins to the point of use and place it on a hard surface
- Always keep sharps bins out of the way of children and other vulnerable people

### 4.2 Use

- Follow correct method to ensure safe clinical practice when assembling the sharps bin – the bin must comply with British Standard BS7320.
- Ensure that date of assembly and name of assembler is clearly identified on the sharps bin
- Wear appropriate Personal Protective Equipment – non latex gloves, apron
- Carefully assemble the device to be used
- Do not bend needle
- Do not resheath needle
- Use tray system to carry sharps devices
- Do not use foil/cardboard trays
- Never carry sharps in your hand or pocket
- Activate temporary closure mechanism on sharps bin between use
- Never move an open sharps bin
- Always carry the sharps bin by the handle

- Be especially careful of sharps risks during emergency procedures
- Never overfill sharps bins
- Never try to retrieve anything from a sharps bin

## 5. Sharps Containers (Bins)

In NHS Lothian a number of sharps adverse events are due to inappropriate disposal after use where there is the greatest risk of BBV exposure, therefore sharps containers must be:

- readily available and placed within the area of use, such as wall mounted brackets or near patient disposal system (NPDS) trays for the HCW;
- available at the bedside for self-administering patients;
- readily available and appropriate for the HCW in the community to safely dispose of the clinical sharps device.

Sharps containers must be used according to manufacturer's instructions and the following points of good practice:

- All sharps should be handled as little as possible and must be disposed of safely in the appropriate container by the person using it at the time & at the point of use;
- The temporary closure mechanism must be opened prior to the disposal of the sharp;
- Sharps containers must not be filled above the manufacturer's marked line;
- Sharps containers should be dated on assembly and sealed and disposed of when the manufacturer's marked line is reached or within 3 months from the start of use.
- Finally sealed and marked sharps containers should be placed in the correct final disposal point for uplift as per local instructions/protocols.
- Hands / fingers must not be placed in the sharps container to deposit or remove items;
- Be aware of the colour coding of sharps containers depending on the category of waste.
- Date and signature on closing must be completed on sharps bin when ready for disposal, the sharps bin is ratchet tagged
- Dispose of sharps bin securely as per waste management policy/procedure
- The porter/transport driver will not uplift any sharps containers/bins which do not have appropriate boxes completed or if not sealed.

## 6. Information, Instruction and Training

Information during induction and refresher training must be provided which covers:

- the correct use of Clinical Sharps Devices
- the safe use and disposal of the Clinical Sharps Devices
- what to do in the event of a clinical sharps devices injury / near miss

- arrangements for Health Surveillance and other procedures

Training in the use of new clinical sharps device products is provided by the supplier, and internally via the Practice Education Facilitators, during Clinical Skills Update Sessions and various linked e-learning modules (e.g. NHS Lothian BBV etc, NES CMLN Intramuscular Injection, NES CSMLN Cannulation)

For most devices a cascade system of demonstration is in place and records of this training must be held by the ward/department.

## 7. Arrangements in the event of a Clinical Sharps Devices injury

These arrangements are set out in detail in the [Occupational Health Guidance](#)

In brief staff should:

- Apply first aid to the wound by encouraging it to bleed, washing with warm soapy water and applying a dry, clean dressing.
- Advise the manager of the incident / adverse event so that an assessment can be completed to establish the risk status of the source blood and an adverse event can be completed in Datix.
- Contact the Occupational Health Service (Monday – Friday 0800-1600 hrs.) on 0131 536 1135
- Out of hours (16.00pm - 08.00am) please contact Switchboard on 0131 537 6000 for sharps / contamination injury advice.

The Occupational Health Service will determine what follow up plan will be undertaken with the person in terms of any post exposure prophylaxis or bloods taken. Further details are available on the Occupational Health website: [Needlestick Injury](#)

## 8. Investigation of a Clinical Sharps Devices Injury /Near Miss (Adverse Event)

Any adverse event investigation is about preventing recurrence but in order to do this, sufficient information must be provided on, e.g.:

- The type of clinical sharps device involved, was it a safe or non safe clinical sharps device;
- The procedure being undertaken at the time e.g. before/during/after but before disposal/during disposal/after disposal what body fluid was involved;
- Whether the injured person had been appropriately informed, instructed and trained and this was up to date.

The investigation should establish whether the existing control measures are adequate and in terms of causal factors what the immediate, underlying and root cause(s) were. This should be proportional to the potential severity of the incident / adverse event, including near misses.

Clinical Sharps Devices related adverse events reported may include used / contaminated device(s) found inappropriately discarded e.g. on bedside tables, windowsills, in waste bags, or sent to Laundry. Although not all result in clinical sharps devices injury a good number do

therefore it is also important to report, investigate and implement actions for both injuries and near misses.

Following investigation any areas for improvement must be actioned in terms of information, instruction, training and potentially supervision to eliminate / reduce the risk of recurrence.

In certain circumstances, a Clinical Sharps Device (needlestick) event may require to be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases or Dangerous Occurrences Regulations 2013 (RIDDOR). These circumstances include a needlestick injury from a confirmed high risk patient or other source e.g. Hepatitis B.

If a member of staff who was exposed to a BBV seroconverts and this is diagnosed by a registered medical practitioner, this should also be reported to the HSE.

Further details on the investigation methodology are contained in the NHS Lothian Adverse Event Management Policy and Procedure.

Further information or advice is also available from the Health and Safety Department, Occupational Health or Infection Prevention and Control Teams respectively.

## 9. Associated Materials/References

- Clinical Sharps Devices Policy
- Clinical Rationale for the Use of Non-safety Sharp Devices
- Worked Example of the Clinical Rationale for the Use of Non-safety Sharp Devices
- Example General Risk Assessment for Clinical Sharps
- NHS Lothian SOP for Needlestick Injuries etc 2014
- National Infection Prevention and Control Manual