Management and prevention of sharp injuries: Inspection of NHS trusts/boards

Report of an inspection initiative 2010/11

This report describes the findings from an inspection initiative delivered by a national team of specialist inspectors in occupational health during 2010/11. It summarises how the twenty-two NHS organisations visited managed the risks of sharps injuries which can expose employees to blood borne viruses (BBVs).

Key Findings

- Sixteen had a specific policy for the prevention of BBVs.
- Ten had clear corporate strategic aims and objectives to prevent and reduce the risk/incidence of exposure to BBVs through sharps injuries.
- In only six, staff at all levels demonstrated a good understanding of their roles and responsibilities.
- Competent advice was available in all organisations, however, the arrangements and resourcing were not always adequate.
- In four, the safety representatives were not consulted.
- Specific training on the prevention and control of BBVs was not provided to all staff and/or uptake of training was patchy.
- Risk assessments were generally generic. Only four organisations undertook specific assessments for BBVs and sharps injuries.
- ‘Safer devices’ were used in 18, but in some their use was limited.
- Less than half undertook proactive monitoring. Those who did monitor could demonstrate a reduction in injuries.
- Only half carried out some form of auditing and review. This ranged from full health and safety audits to more limited audits of post-incident procedures.

Improving standards

All organisations should ensure they are complying with legislation that is relevant to managing the risks to employees from exposure to blood borne viruses. Particular attention should be paid to:

- Providing written policies and procedures with clear lines of accountability.
- Carrying out suitable and sufficient risk assessments, following the COSHH hierarchy, including use of safer devices.
- Assessing the contribution and role of competent advisors, ie health and safety, risk management, occupational health and infection control.
- Ensuring staff are informed of the risks and implement control measures, including reporting sharps injuries.
- Ensuring suitable monitoring and auditing arrangements are in place.
The Inspection Initiative

The purpose of the initiative was to assess how NHS organisations manage the risks of sharps injuries, which can expose employees to BBVs.

22 organisations were selected at random; 3 Boards in Scotland and 19 Trusts in England (18 Acute, 1 Primary Care, 1 Teaching and 2 Ambulance). Throughout the report, the term ‘organisations’ is used and includes the Trusts in England and the Boards in Scotland.

Both structured and opportunistic data collection were used to assess risks. This included: a document review of related policies and procedures; planned interviews and site inspections.

Inspectors observed practices and questioned staff of all grades and disciplines at random. A proforma based on the POPMAR1* framework for managing health and safety, was used to collate the information. It focused on six key areas:

1. the provision of policies and procedures for the management of sharps that explain roles, responsibilities and arrangements.
2. the completion of suitable and sufficient risk assessments.
3. the provision of suitable and sufficient instruction and training.
4. active monitoring, eg inspecting and checking that arrangements are being implemented and controls working.
5. reactive monitoring, eg investigating relevant sharps incidents.
6. auditing implementation and compliance with policies and procedures.

The summarised findings are set out using the above key areas as headings. As only 22 organisations were inspected out of over 400 in England, Scotland and Wales, the sample is not representative and it is not possible to draw conclusions about the performance of the NHS in general.

Regulatory Context

Relevant legislation includes;

- Health and Safety at Work etc Act 1974;
- Management of Health and Safety at Work Regulations 1992;
- Control of Substances Hazardous to Health Regulations (COSHH) 2002 (as amended); and
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995.

* POPMAR - Policy, Organising, Planning, Measuring Performance, Auditing and Review, HSG65.
1 The provision of policies and procedures for the management of sharps that explain roles, responsibilities and arrangements.

Only 16 of the 22 organisations visited had policies in place for the prevention of BBVs and the management of sharp injuries.

Policy and procedures

Of the policy documents, ten were good, with clear strategic aims and objectives. Six were adequate, but lacked detail, and six were poor, dealing mainly with post-incident procedures. These also lacked clarity about roles and responsibilities, risk assessment, and control measures.

One organisation took a strategic approach to reduce the incidence of injuries from sharps. They used performance indicators and their policy for management and prevention of infection demonstrated clear commitment to reduce exposure to blood borne viruses.

Understanding roles, responsibilities and arrangements:

Generally, staff interviewed during the visits had an implicit rather than explicit understanding of the specific policies and procedures. However, they generally knew the risks of BBVs and principles of infection control.

In six organisations, board members and staff clearly understood their roles and responsibilities. Standards were better where board members were more involved in the development of policy, risk assessment and control measures.

One Board had introduced a ‘Concern Action Reports System’. There were clear lines of accountability in this system, which was well documented.

In the remaining organisations, there was variable understanding among board members and staff at all levels. In some, there was an assumption by the board that line managers and staff understood their roles and responsibilities, but they did not seek confirmation. Others undertook quarterly audits and housekeeping reviews, with results reported to the board. In some, managers demonstrated little commitment, which resulted in confusion as to who did what, and failure to challenge poor practice.

In one organisation, staff said that although roles, responsibilities and procedures were in place, junior doctors were less vigilant. This was reflected in the incident statistics.

In another, there was limited commitment from the Board. The Infection Control Lead Nurse had taken a negative approach to the extent to which ‘safer devices’ could reduce injuries. The Infection Control policy and the Occupational Health policy were not compatible and employees were confused about what policy to follow.

Communication and consultation

Most organisations had a multidisciplinary approach and staff were happy to pool their knowledge and work with each other. Staff were actively involved in developing policies, procedures and information leaflets/posters raising awareness of BBVs and the benefits of safer sharp devices. Difficulties only arose where some disciplines were not included, for example on the health and safety committee, or in the risk management process.
In one organisation, the operational risk management team had produced an in-house short publication for staff.

In four organisations, the safety representatives were not consulted and there appeared to be a poor understanding of their roles and functions.

In one organisation, they had not set up a health and safety committee and in another the health and safety committee had not met for several months.

In one organisation, neither the infection control team nor the occupational health teams were involved in the risk management process or incident investigation.

In another, where four contractors provided the occupational health service there were communication problems.

**Competent advice**

At nearly all organisations competent advice was available from occupational health, infection control and health and safety staff, all of whom held appropriate qualifications.

At one organisation, HSE issued an Improvement Notice to improve occupational health input into staff training.

2 The completion of suitable and sufficient risk assessments.

Overall, risk assessments were generic, and only four had undertaken specific assessments. Four organisations had not assessed the risk at all.

One infection control team completed independent needlestick injury assessments, using a risk matrix, as well as specific assessments.

HSE issued an Improvement Notice at one organisation for failure to provide safety devices to reduce exposure to BBVs from cannulation, as identified in their risk assessment.

Some assessments were poor, resulting in risks not being controlled. Often control measures, including the provision of equipment and systems of work, were based on long-standing procedures rather than tailored to the risk arising from individual situations or tasks.

In one organisation, they had not followed the risk hierarchy and considered options to eliminate the risk or substitute with a safer device.

In another organisation, the risk assessment had not included all types of ‘sharps’ used in the workplace, eg the use of razors pre-surgery.

The health and safety team were often the only specialists used in the risk management process. In many cases, infection control and occupational health staff were not included, sometimes because of lack of resource, but more generally, because the process did not require their involvement.

Some organisations were in the process of adopting a system whereby generic assessments would be adapted and tailored for higher risk tasks, such as in accident and emergency departments.
Safety device use

18 organisations used safety devices, but four did not. The main reason given was cost. It was unclear if traditional practices had remained because either senior managers had decided not to meet the costs, or those assessing risk believed that they would not be met.

Four used a wide range of devices, including safety cannulae, retractable lancets, needle-free devices, pre-filled syringes with safer devices and sharp safe butterfly needles.

In the remaining 14, the use of safer devices was limited to, for example, intravenous cannulation, phlebotomy, and specialised units. They still used traditional needles in significant quantities.

In one organisation, managers were reluctant to consider safer devices.

In a few organisations, procurement departments worked with managers to trial devices and evaluate the costs and benefits. This led to safer devices being provided where costs were deemed negligible.

In some cases, risk assessments concluded that staff should ‘consider the use of safer devices’. However, the lack of a clear corporate steer and purchasing procedures meant these devices were often not available.

3 The provision of suitable and sufficient instruction and training.

Generally, staff were able to demonstrate knowledge of the risks and prevention of BBVs, but were not so clear on procedures to take following a sharps injury, for example ‘out of hours’.

All provided induction training covering infection control. Two provided specific training for the prevention of BBVs.

In six, induction training was mandatory. Where training was not mandatory, uptake was variable. Medical staff, at all levels, were least likely to attend. In some, temporary staff (bank nurses and locum doctors) were provided with training, but managers were not checking attendance.

Management training on risk assessment (not BBV risk specific) was only provided in 5 organisations. Training length varied from 1 to 4 day courses, all of which were Institute of Occupational Safety and Health accredited.

In others, awareness sessions were offered to staff, delivered by occupational health teams and/or nurses. In two organisations, communication with staff was inadequate.

One organisation had produced an electronic learning package on infection control, including BBVs. However, outreach/community staff often did not have access to it, and managers were not checking completion of training.

In another, managers who had received risk assessment training said they did not feel confident and/or were not clear about what was required in practice.

Generally, the intranet was the favoured route of communication. However, some found this problematic as not all had access. More than half of the organisations had posters on display in clinical areas.
One organisation had developed a screen saver on BBVs risks.

4 Active monitoring eg inspecting and checking that arrangements are being implemented and controls are working.

Less than half of the organisations undertook proactive monitoring. They did this in various ways, with ‘spot checks’ and observational audits being preferred options. Monitoring often involved health and safety, infection control and occupational health staff. Collaborative approaches were more effective.

Very often, the only monitoring undertaken was by contractors involved in the disposal of sharps bins, who carried out audits and reported misuse.

5 Reactive monitoring eg investigating relevant sharps incidents.

Staff reporting

All had systems in place for reporting sharps injuries. In some staff said forms were too complicated and cumbersome, resulting in under-reporting.

Typically, during ‘office hours’ staff reported incidents to Occupational Health to receive prophylactic treatment. At other times, they attended A&E. Procedures required A&E to notify Occupational Health of any incidents to allow follow-up. However, these systems were not always robust enough.

In general, there was a lack of clarity in relation to reporting under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).

Investigating incidents

Not all reported injuries were investigated. Investigation decisions did not appear to be based on any criteria. Occupational Health and Infection Control were often not involved, sometimes because of lack of resources.

Analysis of incident data

Most organisations collected incident data, some using the DATIX system. However, only a few analysed the data to identify trends, hot spots, or incident type. Where they did, they were able to use this data to inform risk assessments and to prioritise procurement of safer devices. The highest incidence by type was invariably attributed to venupuncture or cannulation.

Five organisations who analysed data and proactively monitored could demonstrate a reduction in injuries.

In the other organisations, reporting was not comprehensive or robust with different reporting methods to departments, such as human resources, health and safety and occupational health.

6 Auditing implementation and compliance with policies and procedures.

Only 11 organisations carried out some form of auditing and review. This ranged from full health and safety audits to more limited audits of procedures carried out post-incident.
In one organisation, the infection control team had developed a tool to assess compliance of infection control procedures.

Many organisations relied on contractors’ sharps disposal audits to ensure follow up procedures and post incident inoculations had been undertaken.

**Bibliography**


© Crown copyright If you wish to reuse this information visit www.hse.gov.uk/copyright.htm for details. First published 11/12