Prevention and management of sharps injuries: Inspection of NHS Organisations

Report of an inspection initiative 2015/16

Introduction

This report describes the findings of an HSE inspection initiative delivered in 2015/16 by inspectors and occupational health specialist inspectors. Its main purpose was to identify any common causes of non-compliance with legislation designed to protect staff from the risk of exposure to blood borne viruses (BBVs). Forty NHS organisations were visited across England, Scotland and Wales.

The inspection initiative

This was not a random sample of NHS organisations. The visits were targeted to organisations where intelligence suggested there might be non-compliance, for example from reported RIDDORs[1] and / or purchasing data. The initiative aimed to:

- Obtain sufficient evidence to assess compliance with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 by inspecting health and safety management systems at both corporate and operational levels;
- Engage with worker representatives;
- Provide feedback to the organisation, identifying areas of concern and taking enforcement action where appropriate.

The distribution of the forty organisations selected was; 34 from England (including 3 ambulance Trusts), 4 from Wales, and 2 from Scotland (one a dental hospital). Throughout the report, the term 'organisations' is used and includes Trusts in England and Boards in Scotland and Wales.

Both structured and opportunistic data were used to assess risks. This included: a document review of the organisation's relevant policies and procedures, planned and ad hoc interviews with key staff (including managers responsible for health and safety, occupational health, infection control, procurement and clinical areas), and site inspections.

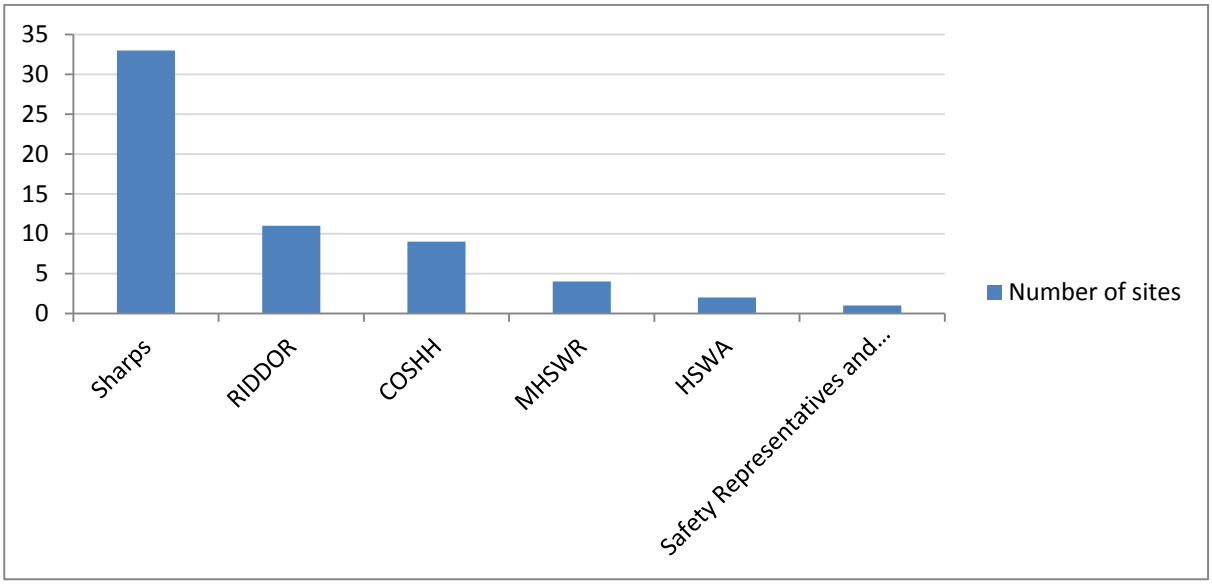
Inspectors observed practices and questioned staff of all grades and disciplines. A proforma, based on the requirements of the Sharps Regulation and the HSE guide 'Managing for Health and Safety' was used to collate information in the majority of cases. HSE's operational guidance provides further information on how the inspections were planned.

Summary of findings

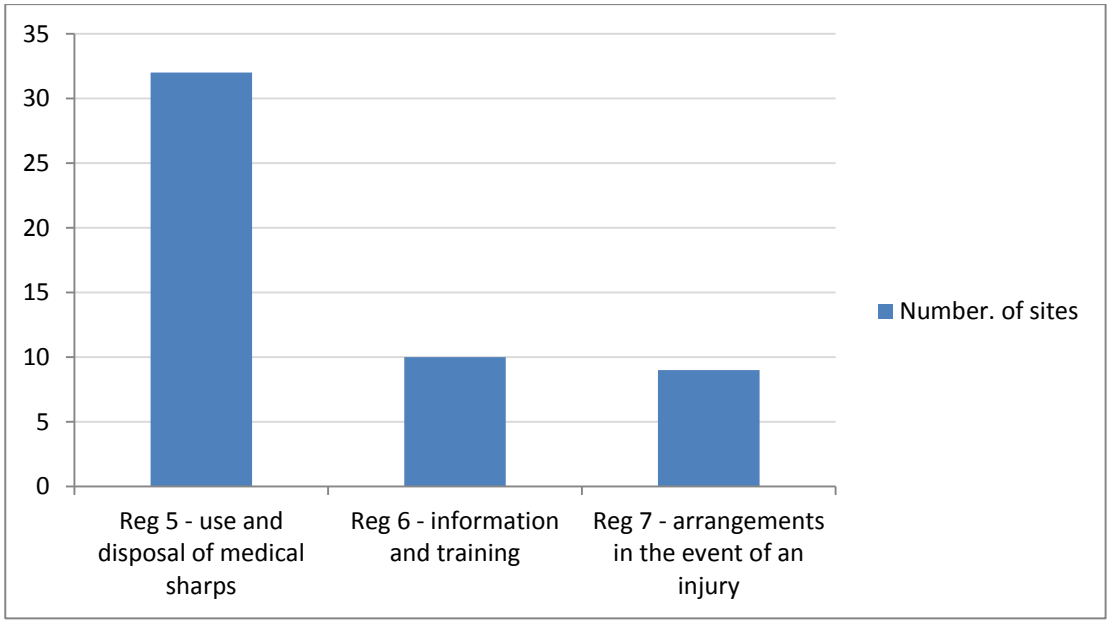
Anonymised data is provided at Annex A to show the action taken, where needed, at each of the forty organisations

[1] RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These Regulations require employers, the self-employed and those in control of premises to report specified workplace incidents - http://www.hse.gov.uk/healthservices/riddor.htm

- Health and safety breaches were identified in 90% of organisations visited.
- 83% failed to fully comply with the Sharps Regulations.
- Improvement notices were issued to 45% of the organisations visited
- The chart below shows the legislation for which breaches were found



- The distribution of breaches of the Sharps Regulation across the sites is shown below



- Sometimes there were multiple breaches of the Sharps Regulations at one site.

Types of failings found

1. Use and disposal of medical sharps
   - Generally, there was failure to use safer sharps where reasonably practicable, or inconsistent use of safer sharps across the organisation. For example:
     - On occasions there was an inconsistent strategic approach by organisations to sharps management, for example, there were initial reviews but this was not

followed through over time or across the organisation, or employees were not represented on the steering group.
    - There were a few instances where there was no sharps prevention strategy in place
    - organisations had failed to provide needles with safety mechanism that are readily available e.g. hollow bore hypodermic needles;
    - instances were identified where organisations had not distinguished between individual preferences and reasonable practicability;
    - although there was some introduction of safer sharps, there was still widespread use of non-safe devices including scalpels, winged IV cannula and other sharps devices;
    - failures to ensure non-safe sharps are removed once safer sharps are in place. There was evidence of non-safe and safe sharps being stored together. This led to confusion for staff who were unsure which item to use, they could take the wrong item by mistake, or personal preferences informed their decision making;
    - a need for better communication with procurement to ensure that only safer sharps were purchased and available, where reasonably practicable;
- There were a number of instances where the sharps bins were at low level, which was potentially within reach of children, or, the temporary closures were not being used; and
- Sharps bins were not always located at point of use. It was observed where used needles were left on trolley rather than being disposed of in a sharps bin

2. Risk assessment
    - Often there was a failure to assess risks of exposure to blood borne viruses from sharps injuries. For example:
        - lack of suitable and sufficient risk assessments around the use of non-safe sharps in areas where it was not reasonable practicable to use a safety device, such as paediatric vascular access;
        - failure to focus on the potentially higher risk areas such as emergency or maternity services departments, and
        - there were no safe procedures for working with, and disposal of, sharps in areas where it had been identified that safer sharps were not reasonable practicable. (This should be noted in the risk assessment, and sufficient detail given on the preventative and protective measures to be taken to control the risk).

3. Information and training
    - On occasions there was evidence that the training did not include information that was relevant to the activities. For example:
        - Staff not been provided with adequate information and instructions on what to do when presented with patients' own insulin and standard needles;
        - Although sharps management was included on mandatory training, staff had difficulties demonstrating levels of compliance;
        - Checks had not been made to ensure that employees were practising the correct techniques;
        - Employees who had been trained to use safer sharps were not consistent in explaining how they would deploy the safety guard on e.g. the hollow bore needles, and

    - Lack of consistency in reporting sharps injuries to the organisations' own internal occupational health services.

4. Investigations and reviews
    - There were instances of a lack of a robust system in place to investigate sharps injuries, record the findings from the investigation (including the underlying cause) and apply any lessons learnt to prevent recurrence. Organisations are required to identify what measures they will implement to ensure necessary action to prevent recurrence, and
    - Instances were found where the policies for the management of sharps were out of date and did not acknowledge the trust's statutory duties.
    - There were a few occasions where the policies and procedures for managing the risk of exposure to BBVs due to sharp injuries had not been reviewed and revised since the Sharps Regulations been in place.

5. Reporting of injuries
    - A number of instances of failing to report RIDDORs, or to report correctly as dangerous occurrence, when appropriate
        - Approximately in a quarter of visits, it was found that Trusts had not reported any incidents to HSE that met RIDDOR criteria

Examples of good practice

- Having infection control working closely with health and safety staff, and using occupational health at a strategic level is potentially a good model for maintaining continuous improvement in the prevention and management of sharp injuries.
- Notices around the organisation promoting safer sharps
- Procurement had a process in place to remove and replace traditional sharps with a safer device where reasonably practicable
- Identifying high risk areas from internal data, and having systems in place to review these areas
- Where it was identified that there was no suitable safer sharp device available, and non-safety devices needed to be used, these were stored in the relevant area together with the risk assessment and procedure for working with those devices. They were only available as non-stock items, and approval was needed before purchasing.
- Learning points from an analyses of incidents was included in training and other information sources, and
- Employees' written instructions were included as part of mandatory training.

What have we learnt?

- Although this report is not representative of compliance levels in all NHS organisations, the failings described appear to represent common causes of non-compliance. These lessons can therefore be learned more widely.
- The scope of the Sharps Regulations do not apply to pharmaceutical manufacturers, and the significance of this limitation has been highlighted by the inspection initiative. This was shown by the number of pre-filled medical devices, such as flu vaccines, used by NHS organisations for which alternatives with safety devices are not available.

What next

- HSE is publicising the findings from this initiative to health and social care employers and employee representative bodies to encourage improvements in how staff are protected from the risk of exposure to blood borne viruses (BBVs).
- The findings will used as evidence in the Government's statutory post implementation assessment of the effectiveness of the Sharps Regulations
- HSE will bring the relevant findings to the attention of the pharmaceutical manufacturers' representative bodies, and other relevant regulators.

HSE

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Annex A

Anonymised enforcement data

Organisation	Breaches identified	Enforcement action taken NB: NOC = notice of contravention IN = improvement notice
1	None	N/A
2	Sharps Regs 2013 - Reg 5(1)(b) HSWA S2 Sharps Regs 2013 - Reg 7(1)	NOC & IN
3	Sharps Regs 2013 - Reg 5(1)(b) Sharps Regs 2013 - Reg 6 RIDDOR 2013- Reg 7	NOC & IN
4	COSHH 2002 - Reg 11 Sharps Regs 2013 - Reg 5(1)(b) RIDDOR 2013 - Reg 7	NOC & IN
5	Sharps Regs 2013, Reg 5(1)(b) COSHH 2002 - Reg 6(1)	NOC
6	HSWA S2 Sharps Regs 2013, Reg 5(1)(b), 6(1), 6(4), 7(1)(c)	NOC & IN
7	HSAW S2 RIDDOR 2013 - Reg 7	NOC
8	RIDDOR 2013 - Reg 7, 9,12 Sharps Regs 2013 - Reg 5(1)(b), Reg 5(2), Reg 6(4) MHSW Regs 1999 - Reg 3(1)	NOC
9	RIDDOR 2013 - Reg 7 Sharps Regs 2013 - Regs 5 & 7 MHSW Regs 1999 - Reg 3(1)	NOC & IN
10	Sharps Regs 2013 - Reg 5(1)(b)	NOC
11	RIDDOR 2013 - Reg 7 Sharps Regs Safety Representatives and Safety Committee Reg 1977	NOC
12	Sharps Regs 2013 - Reg 5(1)(b) RIDDOR 2013 - Reg 7	NOC
13	Sharps Regs 2013 - Reg 5(1)(b), Reg 6(1), Reg 7 (1)(c)	NOC
14	Sharps Regs 2013 - Reg 5(1)(b), Reg 6(1), Reg 7 (1)(c)	NOC & IN
15	COSHH 2002 - Reg 6 Sharps Regs 2013 - Reg 5(1)(b), 5(2), 6(1), 6(4) MHSW 1999, Reg 3(1)	NOC & IN
16	Sharps Regs 2013, Reg 5(1)(b)	NOC

17	None	N/A
18	Sharps Regs 2013 - Reg 5 (1)(b), 7(1)(b)	NOC
19	Sharps Regs 2013 - Reg 5(1)(b), 5(2) RIDDOR 2013 - Reg 7	NOC & IN
20	COSHH 2002 - Reg 6(1)	NOC
21	COSHH 2002, Reg 6 Sharps Regs 2013, Reg 7(1)	NOC
22	Sharps Regs 2013, Reg 5(1)(b), 6(4) RIDDOR 2013, Reg 5(1)	NOC & IN
23	Sharps Regs 2013, Reg 5(1)(b)	NOC
24	Sharps Regs 2013, Reg 5(1)(b)	NOC
25	Sharps Regs 2013, Reg 5(1)(b), 5(1)(a), 5(1)(c), 7(1) RIDDOR 2013	NOC & IN
26	Sharps Regs 2013, Reg 5(1)(b) RIDDOR 2013	NOC
27	Sharps Regs 2013, Reg 5(1)(b)	NOC & IN
28	Sharps Regs 2013, Reg 5(1)(b), 5(1)(c), 5(1)(d), 6(4)	NOC & IN
29	Sharps Regs 2013, Reg 5(1)(b)	NOC & IN
30	Sharps Regs 2013, Reg 5(1)(b) COSHH 2002 Reg 7	NOC
31	Sharps Regs 2013, Reg 5(1)(b), 6(4)	NOC
32	Sharps Regs 2013, Reg 5(1)(b), COSHH 2002, Reg 6(1) MHSW 1999, Reg 7(3)	NOC & IN
33	None	N/A
34	COSHH 2002, Reg 6(1), Sharps Regs 2013, Reg 5(1)(b)	NOC & IN
35	Sharps Regs 2013, Reg 5(1)(b)	NOC
36	Sharps Regs 2013, Reg 5(1)(b)	NOC
37	None	N/A
38	Sharps Regs 2013, Reg 5(1)(b)	NOC & IN
39	Sharps Regs 2013, Reg 5(1)(b), 6(4), 7(1)(b)©	NOC & IN
40	COSHH Regs 2002, Reg 6(1), 9 2(a), 12(4)	NOC & IN