



## **TURNING POINT SOMERSET GUIDELINES FOR THE SAFE HANDLING AND STORAGE OF CLINICAL WASTE**

### **Introduction**

- The aim of this document is to facilitate the safe handling storage and disposal of clinical waste during the course of working with Turning Point Somerset.
- Guidance is given on measures to protect workers against occupational infection with blood borne viruses.

This document should be read in conjunction with:

- Turning Point Health and Safety Manual sections 3.15 (Immunisation of Staff) and 3.16 (Infection Control and Infectious Diseases)
- Turning Point Somerset Needle Exchange guidelines
- Turning Point Somerset guidelines on Needle Stick Injury

### **Responsibilities**

The Service Manager will be responsible for:

- The overall management of health and safety aspects of the service across Somerset.
- Ensuring that these guidelines are followed across the service and reviewed.
- Agreeing specifications with contractors and monitoring the service to ensure contractors fulfil the specified requirements of the contract.

Team Leaders will be responsible for:

- Implementing the agreed guidelines within their service areas.
- The overall health and safety aspects of service provision in their designated area including undertaking and reviewing risk assessments and vaccinations of workers.
- Ensuring that all staff are aware of their individual responsibilities.
- Ensuring that induction and in-house training is completed as outlined in these guidelines.

Staff and volunteers are responsible for:

- Awareness of and compliance with agreed guidelines within their service.
- Awareness of their individual responsibilities.
- Taking up recommended vaccinations (or signing disclaimer).

### **Appendices**

#### **Appendix 1:**

Guide to be displayed in the needle exchange/ear acupuncture room

**Appendix 2:**

Viral Risks in Health Care Settings (detailed outline of blood borne viruses)

**Appendix 3:**

Disclaimer (for those not wanting to be vaccinated)

**Definitions:****Clinical Waste**

- All waste which is contaminated with blood or other potentially infectious bodily fluids.
- This includes used needles and syringes returned during needle exchange transactions, ear acupuncture needles, tissues that are used to stop blood flow after ear acupuncture and materials used to clean up body fluids.

**Blood-Borne Viruses**

- This document covers known blood-borne viruses (BBVs) including Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV).
- There are practical advantages in adopting common infection control policies to prevent the transmission of BBVs and this is reflected in the guidance.
- Appendix 2 describes each of these viruses in detail.

**Sharps Safes**

- Containers that are puncture resistant, of adequate depth and capacity and conform to British Standards (BS7320).

**Turning Point Workers**

- This policy covers all paid Turning Point employees and volunteer workers.

**Needle Stick/Sharps Injury**

- Skin puncture caused by contaminated needles.
- "Sharps" in this context are any sharp edged instruments, broken glassware or any other item which may be contaminated in use by blood or body fluids and which may cause laceration or puncture wounds.

**Training****Employees and Volunteers**

- Training will be given to all staff and volunteers on induction and a record of this kept on their file (refer to Health and Safety Manual section 3.31 Appendix 3.31 for Health and Safety Induction Checklist). Team Leaders will be responsible for ensuring that this happens.

The following must be covered:

- Potential risks of transmission of BBV's.
- Guidelines on Handling and Storage of Clinical Waste (as outlined in this document and from risk assessments completed).
- Guidelines on dealing with spillages.
- Effective and safe sealing and handling of sharp safes.

- Procedure following a needle stick injury (refer to Turning Point Somerset Needle Stick Injury guidelines).

### **Cleaning Staff**

- Cleaning staff must receive information on the potential risks of needle stick injury on induction.
- Team Leaders will be responsible for ensuring that this happens.

The following must be covered:

- Ensure that cleaners are aware of the nature of the agency and answer any questions to reassure them about clinical waste and storage procedures.
- Specific risks that may be associated with their role e.g. needle and syringes discarded in the bins, especially in the toilet area.
- Talk through this possibility and discuss the ways in which the risks can be minimised e.g. increased awareness and visual search, not putting hand directly into the bin to pull contents out.
- If a needle/syringe (or sharp object) is found or spillage of bodily fluid, a paid worker needs to be told immediately, so that the incident can be dealt with.

### **Immunisations**

- All paid staff and volunteers must be advised to have a full course of Hepatitis B immunisations and a blood test to establish immunity.
- Dates must be recorded (refer to record sheet in Health and Safety Manual section 3.15)
- Those who decline to be immunised must be advised of the potential risk and sign a disclaimer (Appendix 4).

**\* No Turning Point worker will participate in the handling of clinical waste until induction in this area is completed. \***

### **Procedure for the Safe Handling of Clinical Waste**

- All needle/syringes, injecting paraphernalia and other containers or vessels containing used injecting equipment (e.g. bottles, cans, boxes etc...) MUST be disposed of in an appropriately sized sharp safe container.
- All clients should be encouraged to place used injecting equipment in sharps safes provided by Turning Point before attending the needle exchange.
- Clients should be informed about the safe level to fill sharps containers (see instructions on sharps container) and how to close them securely once full. They must be encouraged to secure the sharp safe before returning it to the agency.
- Those clients who present with loose needles and syringes on attendance at the service must be handed an appropriately sized sharps container and asked to place the used equipment into it themselves.
- Any equipment that is brought to the service in containers (e.g. cans, boxes or bottles), bags or any other vessel which is not a sharps container, known or suspected to contain used equipment must be placed directly into an appropriately sized sharp safe by the individual presenting to the agency. Workers MUST NOT attempt to search through bags or containers to separate out used equipment from other paraphernalia.

- Small sharp safe containers (0.45-1 litre) can be counted and placed by the client directly into the 60 litre containers supplied by the contractors for disposal of clinical waste.
- Large sharp safe containers (4-7 litre) returned to the agency must be checked **VISUALLY** by workers at each needle exchange transaction to ensure that they are safe to be handled.
- Sharp safes returned in bags must be removed from the bag by the client so that they can be visually inspected and left out of the bag for safe storage.
- Any bags that have carried clinical waste into the needle exchange can be either re-used by the client or placed directly into the 60 litre container by the client.
- Any large sharp safe containers that are damaged/punctured or overfilled must be placed by the client into a 30 litre sharp safe container which can then be sealed safely by the client.
- Once assessed as safe sharp safe containers must be stored in a designated area.
- It is recommended that no larger than 4 litre sharp safe containers are given out so that if they are returned damaged they can be safely contained.
- Needle exchanges must have 30 litre sharp safe containers in stock so that damaged sharp safe containers and large amounts of loose clinical waste can be stored safely. These must not be given out.
- Appendix 1: Guidance for Safe Disposal of Clinical Waste – to be displayed in the needle exchange

### **Doorstep Needle Exchanges**

- Doorstep needle exchanges must only be undertaken by paid staff deemed as competent by their line manager (see Turning Point Somerset Needle Exchange guidelines).
- Clients asking for a doorstep needle exchange must be asked if they have any used equipment to return and if they are in a sharp safe container.
- If returns are not in a sharp safe or the sharp safe is damaged in any way a 30 litre sharp safe container must be taken to the door and returns placed into it and sealed by the client so that returns are contained in a sharp safe before being taken into the office.
- Team Leaders must undertake a risk assessment and develop a procedure in each office for safe handling of clinical waste during doorstep needle exchange transactions.

### **Spillage of Clinical Waste and Body Fluids**

- The area where a spillage of clinical waste or body fluids occurs must immediately be closed to all but the person designated to deal with the incident.
- Any spillages must be dealt with immediately by a paid worker.
- Volunteers who discover spillages must inform a paid worker immediately.
- All spillages must be reported to the line manager and recorded in the incident book.

### **Clinical Waste Spillage**

- Clinical waste must NEVER be handled directly.
- Items (e.g. needles/syringes or tissues contaminated with blood) must be put into a sharp safe container using the protective equipment supplied for this purpose:
  - a. Tongs/pincers – to pick up needle/syringes and sharps;
  - b. Dustpan and brush (it is recommended that latex gloves are worn) – to pick up needle/syringes and sharps;
  - c. Protective gloves (these gloves are not puncture proof and must only be used for spillages where there are no needles);
  - d. Latex gloves (it is recommended that workers double glove for extra safety);
- All protective equipment and spillage kits must be accessible for workers. Equipment must be checked and cleaned or disposed of after use and re-ordered if necessary.

### **Spillages of Body Fluids**

- When a spillage of body fluids occurs (e.g. blood, vomit, urine, faeces) spillage kits must be used and the instructions on the pack followed:
  1. Put on gloves and apron.
  2. Apply the absorbent disinfectant compound to the spillage. Allow to gel for at least 90 seconds.
  3. Scoop up gelled spillage and dispose of it along with the scoop, into the yellow bag provided.
  4. Spray the spill area with the disinfectant provided.
  5. Put gloves, paper towel and any other items that have been used into the yellow bag and seal with the twist tie. Dispose of the bag safely.
  6. Clean hands with the disinfectant wipe as a safety precaution.
- Once all waste has been placed safely into the yellow bag provided, the bag must be sealed and placed into the 60 litre sharp safe container stored in the area designated for clinical waste.
- Once a spill kit has been used a new one must be ordered to replace it.

### **Storage of Clinical Waste**

- All clinical waste must be placed into an appropriately sized sharps container for storage.
- All sharps containers must be sealed and placed into a designated area for clinical waste away from any public access.
- A risk assessment must be completed by the Line Manager within each service and an area designated for storage of clinical waste. It is recommended that this is an area that is away from clean injecting equipment, is lockable and is specifically designated for clinical waste.
- A holding area may also be needed where sharp safes can be kept temporarily ready for collection when the clinical waste area becomes full. This area must also be away from public access and lockable.
- It is the responsibility of paid staff to check designated clinical waste areas on a regular (defined within local risk assessments) basis to ensure that waste is stored safely.

### **Ear Acupuncture**

- Paid staff and volunteers who practice ear acupuncture are responsible for the safe handling and disposal of needles that are used during sessions.
- All needles must be accounted for and disposed of in a sharp safe container.
- A risk assessment must be completed by the line manager which must be reviewed annually or after any incidents.
- Refer to the Turning Point Somerset Ear Acupuncture protocol for full details of the procedure to be followed.

### **Transport of Clinical Waste**

- There are occasions when clinical waste will need to be transported from a satellite service or outreach visit to a designated place for safe disposal.
- A risk assessment should be undertaken with the Line Manager before transportation takes place.
- All clinical waste must be placed in an appropriately sized sharp safe container by the client.
- Small sharp safe containers (0.45 litre-1 litre) must be placed into a 30 litre sharp safe, which is then sealed for transportation.
- The boot shelf must be put in place to cover the containers during transportation.
- Once the clinical waste is in the car the worker must go directly to the designated place for safe disposal.
- As a registered charity Turning Point is exempt from the need to have a licence to carry waste (confirmed in writing by the environment agency 2001).

### **Disposal of Clinical Waste**

- Clinical waste must be taken to and stored in designated areas only.
- Turning Point has a contract for disposal and incineration of clinical waste with a licensed contractor.

**Review date: June 2007**

## **GUIDANCE ON THE SAFE DISPOSAL OF CLINICAL WASTE**

### **Client brings in small sharp safe containers (0.45-1 litre):**

- Ask the client to remove the sharp safe containers from any bag so that they can be counted.
- Ask the client to place the sharp safe containers directly into the 60 litre containers provided by the contractors for disposal of sharp safes.
- The client can either re-use their own bag or place it into the 60 litre container with the sharp safes.

### **Client brings in large sharp safe containers (4-7 litre):**

- Ask the client to remove the containers from any bag so that they can be visually inspected.
- If the sharp safe is damaged in any way and/or cannot be safely sealed give the client a larger sharp safe container (30 litre) to place the damaged container into and ask the client to seal it.
- Once safely contained and sealed the sharp safe can be placed by the client in the area designated for clinical waste.

### **Client brings in used equipment in a can, bottle, bag or any other type of container that is not a sharp safe:**

- Ask the client to place the container directly into an appropriately sized sharp safe container (this may be the 60 litre containers provided by contractors).
- If another size of sharp safe is needed (e.g. 4-30 litre) ask the client to seal the container and place it directly into the area designated for clinical waste.

### **Used injecting equipment is found on the premises**

- Inform a paid worker and close the area.
- The paid worker dealing with the spillage must follow the procedure outlined in the clinical waste guidelines and use the protective equipment supplied.

### **Bodily fluid found on the premises**

- Inform a paid worker and close the area.
- The paid worker must follow the procedure outlined in the clinical waste guidelines and follow the instructions on the bodily fluid spillage kits.

**VIRAL RISKS IN HEALTH CARE SETTINGS –**

**Taken from UK Health Departments “Guidance for Clinical Health Care Workers: Protection Against Infection With Blood-borne Viruses” – Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis.**

## General Principles

The BBV's which present cross-infection hazards to HCW's are those associated with a carrier state with persistent replication of the virus in the human host and persistent viraemia. These include HIV and several hepatitis viruses, considered separately in the following paragraphs. For other rarer potentially blood-borne viruses, specialist virological advice should be sought.

In general, occupational risks of transmission of BBV's to HCW's arise from the possibility of exposure to blood and exceptionally to certain other body fluids or body tissues from an infected patient (see table 1). Semen and breast milk may pose a risk of BBV infection but exposure of HCW's is considered unlikely in most health care settings.

**TABLE 1: Body fluids etc. which should be handled with the same precautions as blood**

- I. Cerebrospinal fluid  
Peritoneal fluid  
Pleural fluid  
Pericardial fluid  
Synovial fluid  
Amniotic fluid  
Semen  
Vaginal secretions  
Breast Milk
- II. Any other body fluid containing visible blood, including saliva in association with dentistry
- III. Unfixed tissues and organs

## Human Immunodeficiency Virus (HIV)

HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, urine, breast milk and cerebrospinal, synovial and amniotic fluids. However only blood, blood products, semen, vaginal secretions, donor organs and tissues and breast milk have been implicated in the transmission of infection. There is good evidence from studies of household contacts of infected people that HIV is not spread by close social contact even when this is prolonged, as in a family setting. A small number of cases of "household" transmission of HIV have occurred, but transmission is most likely to have occurred through exposure to infected blood or blood contaminated body fluids.

Although HIV transmission may occur in health settings, most HIV transmission occurs:

- By unprotected penetrative sexual intercourse with an infected person (between men or man and woman);

- By inoculation of infected blood. At present in the UK this results mainly from drug misusers sharing blood contaminated injecting equipment;
- From an infected mother to her baby before or during the birth or through breast-feeding.

There is at present no vaccine to prevent HIV infection.

### **Hepatitis B Virus (HBV)**

Hepatitis B virus surface antigen (HbsAG) may be found in blood and virtually all body fluids of patients with acute hepatitis B and carriers of the virus but blood, semen and vaginal fluids are mainly implicated in the spread of HBV infection.

Transmission usually occurs:

- By unprotected sexual intercourse;
- By injecting drug misusers sharing blood contaminated injecting equipment;
- Perinatally from an infected mother to her baby.

Up to 90% of babies infected perinatally and around 5% to 10% of those infected as adults develop chronic carrier status. The persistence of the 'e' antigen correlates with a high level of viral replication and increased infectivity.

The most important measure whereby HCW's can be protected against HBV is by immunisation, which provides protection in up to 90% of recipients. Immunisation is not a substitute for good infection control practice since it provides no protection against infection with other BBV's.

### **Hepatitis C Virus (HCV)**

HCV is the main cause of what was previously known as non-A non B-hepatitis. HCV is most frequently acquired by direct blood-to-blood contact and the commonest mode of transmission in the UK is the sharing of blood contaminated injecting equipment by injecting drug misusers. Both sexual and perinatal transmission can occur but in general these are less efficient modes of transmission.

There is at present no vaccine to prevent HCV infection.

### **Hepatitis D Virus (HDV)**

HDV causes infection only in those who have active HBV infection. HDV infection can occur either as co-infection with HBV or as super-infection of an HBV carrier. Since HDV depends on an HBV-infected host for replication, prevention of HBV infection by immunisation will also prevent HDV infection.

### **GB Virus-type C (Hepatitis G Virus)**

Recently a further BBV has been described, provisionally designated either as GBV-C agent or Hepatitis G Virus. The full clinical significance of infection with this virus, whether it is a true hepatotropic virus, and its natural history are as yet unknown.

### **Risks of Transmission of BBV's**

The risk of transmission of BBV's is greater from patient to HCW than from HCW to patient. The risk to the HCW for each virus is proportional to the prevalence of that infection in the population served, the infectious status of the individual source patient, which may or may not be known, and the risk of a significant occupational exposure occurring during the procedures undertaken. In the health care setting transmissions most commonly occurs after percutaneous exposure to a patient's blood by "sharps" or "needlestick" injury. The risk of transmission to a HCW from an infected patient following such an injury has been shown to be around 1 in 3 when the source patient is infected with HBV and is "e" antigen positive, around 1 in 30 when the patient is infected with HCV and around 1 in 300 when the patient is infected with HIV.

"Sharps" in this context are needles, sharp-edged instruments, broken glassware or any other item which may be contaminated in use by blood fluids and which may cause laceration or puncture wounds. Sharp tissues such as spicules of bone or teeth may also pose a risk of injury.

Most cases of occupationally acquired HIV infection have arisen from percutaneous exposure to HIV infected material, and of these the majority have followed injury from hollow needles in association with procedures where a needle or cannula is placed in a vein or artery e.g. venepuncture. Others have arisen through exposure of mucous membranes or non-intact skin to blood.

Transmission of BBV's may result from contamination of mucous membranes of the eye or the mouth, or of broken skin, with infected blood or other infectious material. The transmission risk after a mucocutaneous exposure are lower than those after a percutaneous exposure. The risk of acquiring HIV after a single mucocutaneous exposure is less than 1 in 2000. Mucocutaneous exposures occur more frequently than percutaneous exposure; the majority of both types of exposure are preventable.

BBV's are potentially transmittable by a human bite through mucous membrane exposure if the bite breaks the skin of the person bitten.

There is no evidence that BBV's can be transmitted by blood contamination of intact skin, by inhalation or by faecal-oral contamination.

Not all patients infected with BBV's have had their infections diagnosed. It is therefore important that all blood and body fluids and tissues are regarded as potentially infectious, and HCW's should follow precautions scrupulously in all circumstances to avoid contact with them.

Dear

Re: Hepatitis B vaccinations

I have been informed by your Team Leader that you have declined to have Hepatitis B vaccination in line with Turning Point's Health and Safety Policy and organisational recommendations.

We strongly urge you to revise this position as it has been acknowledged by the Department of Health UK Health Department Guidance for Clinical Health Care Workers and Protection Against Infection and Blood Borne Viruses that working with our client group puts us in a high risk environment.

A copy of this letter will be put on your file as an acknowledgement that you do not wish to have a Hepatitis B vaccination and that this is a fully informed choice on your part.

Yours sincerely

Janet Hucker  
Service Manager Turning Point Somerset

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**I have been informed of the organisational recommendations and the risk that I may incur by not having a Hepatitis B vaccination.**

**Signed:** .....

**Printed:** .....      **Date:** .....