Guideline

Community needle stick injury

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<th>CHQ-GDL-65665</th>
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**Purpose**

This guideline provides best practice recommendations for the immediate assessment, management and follow-up of children who have sustained a community acquired needle stick injury. This guideline was developed in consultation with experienced Paediatric Infection Specialists.

**Scope**

This guideline provides information for all Children’s Health Queensland (CHQ) employees (permanent, temporary and casual) and all organisations and individuals acting as its agents (including Visiting Medical Officers and other partners, contractors, consultants and volunteers) caring for paediatric patients.

**Related documents**

**Procedures, Guidelines, Protocols**

- [CHQ-GDL-65664 Paediatric Guideline: Post-Exposure Prophylaxis for HIV](#)
- [Queensland Health – Clinical Information about HIV and AIDS. Post-exposure prophylaxis (PEP)](#)
## Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>BBV</td>
<td>Blood borne virus</td>
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<tr>
<td>CHQ</td>
<td>Children’s Health Queensland</td>
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<tr>
<td>CNSI</td>
<td>Community (acquired) needle stick injury</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency department</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HBig</td>
<td>Hepatitis B Immunoglobulin</td>
</tr>
<tr>
<td>HBsAb</td>
<td>Hepatitis B surface antibody</td>
</tr>
<tr>
<td>HBsAg</td>
<td>Hepatitis B surface antigen</td>
</tr>
<tr>
<td>HBV</td>
<td>Hepatitis B virus</td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C virus</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune deficiency virus</td>
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<tr>
<td>IDU</td>
<td>Injection drug use</td>
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<tr>
<td>IMPS</td>
<td>Infection Management and Prevention Service</td>
</tr>
<tr>
<td>IM</td>
<td>Intra-muscular injection</td>
</tr>
<tr>
<td>IU</td>
<td>International units</td>
</tr>
<tr>
<td>LMO</td>
<td>Local Medical Officer</td>
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<tr>
<td>MO</td>
<td>Medical officer</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
</tr>
<tr>
<td>QCH</td>
<td>Queensland Children’s Hospital</td>
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<tr>
<td>QSIS</td>
<td>Queensland Specialist Immunisation Service</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>TIG</td>
<td>Tetanus Immunoglobulin</td>
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</table>
Guideline

Management of community needle stick injury (CNSI):

Presentations of children to Emergency Departments (ED) following accidental needle stick injury are not uncommon and such injuries may be a significant source of anxiety. It is important to note that CNSI in the common scenario of accidental exposure to needles found in parks etc. are of very low risk of blood borne virus (BBV) transmission, with cases of BBV transmission by such CNSI not being documented in Australia.

Key aspects of the management of CNSI are:

- First aid
- Assessing injury
- BBV transmission risk
- Assessing and managing Tetanus and Hepatitis B immunity status
- Organising follow up serology and reassurance
- HIV post-exposure prophylaxis (PEP) is only a consideration in exceptional circumstances with higher risk exposures.

Recommendations are contained in the flow chart and notes below. The QCH Infection Management and Prevention Service (IMPS) are available for advice on the management of a child with CNSI, the (unlikely) need for PEP and to discuss follow-up (contact via QCH Switchboard).

PEP, if required, should be prescribed as soon as possible after the exposure and within 72 hours. A separate and linked guideline provides information on HIV PEP, which may be recommended in discussion with QCH IMPS in very high risk non-occupational BBV exposures.
COMMUNITY NEEDLE STICK INJURY

FIRST AID
Allow to bleed (if applicable)
Wash with soap and water

HISTORY AND RISK ASSESSMENT
Details of injury
Source status if known (Sections 1, 2 & 3 on p.5)

ASSESS TETANUS IMMUNISATION STATUS
Tetanus immunisation (TIG) (Table 2)

ASSESS HEPATITIS IMMUNITY
(Section 4 on p.6)
Establish immunisation history.

Request baseline serology: Hepatitis B (HBsAb (urgent), HBsAg), Hepatitis C, HIV ab.

HBsAb result: unless immunity previously documented, request urgently (within 72 hrs) to allow for immunisation if indicated.

HEPATITIS B IMMUNE STATUS?

FOLLOW UP
For low risk exposures refer to LMO for follow up testing – HIV, Hepatitis C and B (if initially non-immune) serology at 3 months post exposure (this guideline can be provided to GPs).

ASSESS IF EXPOSURE IS HIGH RISK FOR BBV
(Section 3 on p.5 and Table 1)

IF HIGH RISK:
• Discuss HIV PEP with IMPS (very rare for community-acquired needlestick injury to be high risk).
• HBIG will be indicated unless documented immunity.

Never Hepatitis B immunised or incomplete Hepatitis B immunisation (less than 3 doses):
Give HBIG and HBV vaccine and refer to LMO or QSiS (QCH) for completion of HBV vaccines at 1 and 6 months post exposure (Section 5 on p.7)
Do not wait for HBsAb result if never immunised.

Hepatitis B immunised
Organise for HBsAb result review and patient recall by ED for HBIG/HBV if indicated and for baseline serology results to be communicated

HBsAb less than 10 IU/mL (Section 5 on p.7)
Low risk exposure: HBV vaccine as soon as possible (but within one week).
High risk exposure: HBIG (within 72 hours) and HBV vaccine
Hepatitis B immune: Fully immunised and HBsAb more than or equal to 10 IU/L previously or on current test. No further action regarding Hepatitis B immunisation.
Section 1. Details of injury (CNSI)

Mechanism: e.g. accidentally picking up needle, stepping on needle, stuck by another person, unwitnessed injury and child too young to tell.

Exposure type: e.g. hollow bore needle, syringe barrel attached / not attached, gauge of needle.

Location: e.g. park, beach, back alley, home, others.

Disposal: if the discarded needle(s) still need(s) to be removed from a public area, call the Clean Needle Helpline on 1800 633 353 to arrange for proper disposal.

Section 2. Source

While it is important to ascertain the status of the source, this may not be possible if injury is sustained in a public area. The relative risk of the source being positive for BBV based on local prevalence and risk behaviours should be considered when giving recommendations concerning prophylactic measures. In Australia, the level of HIV infection in injecting drug users is below 3% and HIV incidence (percentage of new people infected each year) below 1%.¹

Section 3. Risk assessment

The risk of BBV transmission is dependent on the type of injury and the infection status of the source. The risk of acquiring BBV infection from discarded injecting equipment is extremely low. No cases of HIV infection in Australia have ever been identified due to discarded injecting equipment² (Table 1).

Factors that increase risk of BBV transmission

- Deep injury
- Device visibly contaminated with blood
- Needle directly placed into artery or vein
- Shared needles used for injecting drugs
- Source known to have untreated or advanced HIV/Hep B/C infection
- Hollow bore needles.³

HIV is a fragile virus outside the body, especially when exposed to unfavourable external environmental conditions. The blood volume in discarded needles is likely to be less than that associated with exposures in the health care settings.⁴
Table 1. Risk assessment for transmission of Blood Borne Viruses (BBV)* following CNSI

<table>
<thead>
<tr>
<th>Hospital Related Needle Stick Injuries</th>
<th>Community Acquired NSI</th>
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<tbody>
<tr>
<td>When the origin of needle is known</td>
<td>When the origin of needle is unknown **</td>
</tr>
<tr>
<td>- data from needle sharing in injecting drug users of unknown status (1)</td>
<td></td>
</tr>
<tr>
<td>**NSI in health care worker (3) (status known)</td>
<td>Unknown but at worst may be ~ 30% if source HepB ag +ve and child not vaccinated</td>
</tr>
<tr>
<td>**Hep B Up to 30% if source is HepBag +ve</td>
<td>1.3 - 4.9% ***</td>
</tr>
<tr>
<td>**Hep C 1.8% (range 0 - 7%) if source Hep C RNA +ve</td>
<td>Unknown but anticipated to be far less than previous column</td>
</tr>
<tr>
<td>**HIV ~ 0.3% if source known to be HIV +ve ****</td>
<td>0.0063% - 0.0084% ***</td>
</tr>
</tbody>
</table>

* BBV are viruses transmissible by significant exposure to contaminated bodily fluids and identifiable by current conventional laboratory methods e.g. Hep B, Hep C and HIV

** Most likely scenario presenting to Emergency Department

*** Results based on an prevalence of ~65% and <3% of HCV and HIV infections respectively in IDU’s in Australia, and a carrier rate of 80% and 100% for HCV and HIV respectively. (1)

**** If the blood on the outside and inside surfaces of the needle has dried the risk of HIV transmission is probably lower than 0.3% since the concentration of HIV diminishes by 90-99% within several hours after drying and continues to decrease gradually thereafter. (9,10)

Section 4. Serology

- Obtain verbal consent and provide pre-test counselling. Pre- and post-test counselling are important with respect to HIV and Hepatitis. A positive baseline test for HIV, Hepatitis B or C may indicate that the child has acquired the infection by mother to child transmission.
- Request (baseline) Hepatitis B (HBsAb & HBsAg), Hepatitis C and HIV serology. Hepatitis C and HIV are not essential for low risk exposures.
- Mark HBsAb “URGENT” and request laboratory staff to ring result through to ED.
- HBV serology is performed daily. On weekends and public holidays serology may be performed on next working day; this will generally be able to provide the result to action within 72 hours of exposure. If a long weekend, contact laboratory and discuss availability of earlier testing. Where this guideline is being used outside of QCH, please confirm testing arrangements with relevant pathology provider
- Do not send the needle or syringe for testing, as results on discarded injecting equipment are unreliable (and not generally performed by diagnostic laboratories).
Section 5. Hepatitis B immunisation

HBIG – to obtain at QCH call Blood Bank on (07) 3068 3555.

- Administer within 72 hours of injury (by intramuscular (IM) injection)
- Recommended schedule:

<table>
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<tr>
<th>Weight Range</th>
<th>HBIG Dose</th>
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<tr>
<td>Up to 30 kg</td>
<td>100 IU</td>
</tr>
<tr>
<td>More than 30 kg</td>
<td>400 IU</td>
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  **Note:** HBIG comes in vials of 100 IU and 400 IU (concentration is approximately 100 IU per mL).

- HBIG can be given and HBV vaccination commenced as soon as possible, but up to 7 days after exposure (**Note:** Limited evidence for efficacy for later treatment – early treatment preferred).

**Hepatitis B vaccine (IM)**

- For all less than 20 year old: Paediatric Engerix B® (10 microgram) 0.5 mL at 0, 1 and 6 months.
- **Alternative for 11 to 15 year olds (only):** Adult Engerix B® (20 microgram) 0.5 mL at 0 and 6 months.
- Arrange appropriate follow up with local medical provider (e.g. GP).
- Hepatitis B vaccine repeated at 1 (if required; see above) and 6 months after 1st dose.
- Repeat serology Hep B (HBsAb & HBsAg), Hep C antibody and HIV antibody at 3 months.

Section 6. HIV post exposure prophylaxis

If due to exceptional circumstances, HIV PEP may be appropriate, see CHQ-GDL-65664 Paediatric Guideline: Post-Exposure Prophylaxis for HIV and contact QCH Infectious Diseases to discuss.

Section 7. Management of Tetanus immunisation status

Needle stick injuries are regarded as ‘tetanus prone wounds’.

For full details on management of tetanus immunisation, please refer to the Australian Immunisation Handbook.

<table>
<thead>
<tr>
<th>History of tetanus vaccination</th>
<th>Time since last dose</th>
<th>Give appropriate tetanus booster vaccine</th>
<th>Tetanus immunoglobulin</th>
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<tbody>
<tr>
<td>More than or equal to 3 doses</td>
<td>Less than 5 years</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>More than or equal to 3 doses</td>
<td>5 to 10 years</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>More than or equal to 3 doses</td>
<td>More than 10 years</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Less than 3 doses or uncertain</td>
<td>-</td>
<td>YES</td>
<td>YES</td>
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Also refer to the CHQ-GDL-01023 Tetanus Prophylaxis in Wound Management, which has information on appropriate booster vaccines.
Acknowledgement

Children's Health Queensland would like to acknowledge the contribution made by:

- Dr Pam Palasanthiran, Dr Mathew O'Meara and Dr Emma Best, Sydney Children's Hospital, Emergency Department Community Needle Stick Injury: Management Protocol

Consultation

Key stakeholders who reviewed this version:

- Director – Infection Management and Prevention Service, Rheumatology and Immunology (QCH)
- Paediatric Infection Specialists, Infection Management and Prevention Service (QCH)
- Pharmacist Advanced - Antimicrobial Stewardship (QCH)

References and suggested reading


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**Guideline revision and approval history**

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**Keywords**

- Post exposure prophylaxis, PEP, HIV, antiretroviral, paediatric, non-occupational, community acquired needle stick injury, hepatitis B, hepatitis C, blood borne viruses, BBV, 65665

**Accreditation references**

- **NSQHS Standards (1-8):**
  - Standard 3. Preventing and Controlling Healthcare Associated Infections
  - Standard 4. Medication Safety