

Improving reporting of sharp injuries

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There is considerable under-reporting of contaminated needlestick and other sharp object injuries among health-care workers. Some general and psychological factors contribute to such low reporting. Continued training of staff, a sympathetic attitude and clarification of some general issues might improve reporting of such incidents.

Under-reporting of sharp injuries sustained by health-care workers is well documented (Mangione et al, 1991; Tandberg et al, 1991), and has been reported to be as low as 65–70% of actual injuries sustained. Surgeons, who suffer the majority of needlestick injuries, are particularly unlikely to report them (Hettiaratchy et al, 1998). Various reasons have been put forward for this, such as time constraints, lack of perception of risk, performing own risk assessment, lack of knowledge of the reporting mechanism, or dissatisfaction with follow-up procedures (Haiduven et al, 1999).

Failure to report such injuries may affect the individual health workers. Hepatitis B, hepatitis C and human immunodeficiency virus (HIV) infection constitute the most common forms of blood-borne viral infections of serious concern following sharp injuries. Assessment, prophylaxis and treatment of these conditions necessitate early reporting. When a surgeon is involved, his/her future patients are also at risk (Hettiaratchy et al, 1998).

This article explores the possible reasons for under-reporting and considers necessary steps that would improve reporting.

Psychological effects following sharp injuries are well recorded but often underestimated. This, together with certain practical issues, may explain why some health-care workers (particularly surgeons) fail to report such incidents regularly.

EASE OF REPORTING: HOW ARE WE DOING?

The procedure of reporting should be user-friendly, non-threatening, efficient and confidential. The current system of reporting involves

using a common incident form (in quadruple) that incorporates the individual's personal details. Is it really necessary to fill in an A3-sized form? Are four copies essential? Another important consideration is that the fourth copy of the form remains accessible in the ward or theatre. Does this not undermine the confidentiality of reporting? This would be ironic, considering how much attention is paid to maintain the right of confidentiality of the patients. It is worth considering whether the current system of reporting needlestick injury requires simplification (Shiao et al, 1999).

SHARP INJURY: MORE THAN A PHYSICAL TRAUMA

If the health-care worker is a doctor, it is often expected that he or she would identify the risk factors, obtain the patient's consent for appropriate tests and collect blood samples. Occupational health protocol ensures that the incident has been 'documented'. The doctor may expect a phone call the next working day from the occupational health department for confirmation of the incident. The routine workload, on call and emergency duty commitment could interfere with such reporting. This applies to a variable extent to other health-care workers too.

In these situations, one may suffer from anger, anxiety, disappointment and occasional post-traumatic stress disorder (David and David, 1997; Povolny, 1997; Howsepian, 1998). Emotional support is critical and one should be treated with sensitivity and compassion (which can be absent).

Junior surgeons performing as independent operators have been shown to be at particular risk (Camilleri et al, 1991). How is a (junior) surgeon perceived after having reported a

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needlestick injury at operation? Was it an accident or was it a lack of safe operative skill? — ‘How did you prick yourself again?’ One may expect a verbal warning to be more careful. There is also fear of professional discrimination, reprisal and job loss, if a disease is contracted. Potential for marital and family difficulties soon follows (David and David, 1997). On the other hand, there is a risk of being considered silly and overreacting (Povolny, 1997). Although these can not be put forward as excuses for not reporting an incident, nevertheless they do influence reporting.

WHY BOTHER TO REPORT?

All surgeons should ideally have immunity to hepatitis B and there is no effective prophylaxis against hepatitis C. Patients at low risk can not be asked to undergo HIV testing (because of the low probability of HIV infection, psychological reasons and influence on insurance). Therefore, when a surgeon sustains a sharp injury and the patient is at low risk, the equation appears simple — is there any point in reporting the incident? Rattner et al (1994) found that doctors performed their risk assessment after needlestick injuries and were more likely to report high risk exposures.

However, this view is likely to change with availability of treatment of hepatitis C which is proven to be most effective if employed in an early stage of the acute phase (Sata et al, 1997). Hence early detection of hepatitis C is extremely important.

COMPENSATION: WHERE DO WE STAND?

The issue of compensation becomes complicated by under-reporting. It is worth mentioning that the matter of compensation had always been a complicated issue in its own right. Tereskerz and Jagger (1997) depicted a gloomy picture on this issue of health law and ethics. It was felt that workers who were occupationally exposed to or

infected by HIV or other blood-borne pathogens were vulnerable to being left without adequate workers’ compensation benefits, or even without any benefits.

A major hurdle for health-care workers was to meet the definition of an occupational disease, which varied among jurisdictions and in some cases was so restrictive that infected health-care workers were unlikely to qualify for benefits. The issue for those meeting the statutory requirements was one of obtaining adequate compensation. Tereskerz and Jagger recommended broadening of the definition of occupational disease and recommended elimination of provisions that compel the claimant to prove that a specific occupational incident resulted in acquiring the disease.

There is always the potential for legal argument when compensation issues are involved. During one such long and humiliating court battle where a nurse contracted HIV infection following sharp injury, the employer’s lawyers suggested that she had contracted the virus from a sexual partner or had intentionally injured herself (Povolny, 1997).

In the UK, there is a complacent attitude towards the issue of compensation. This is best exemplified by the peer comment made on an incident where a doctor received a compensation for a mental health problem that she had developed after a needlestick injury at work. Hayes (1999), a GP, commented on the incident by referring to his own experiences, which were similar in nature, if not worse. He felt let down by the NHS regarding his own case, but he felt that the decision to award compensation to the doctor was profoundly mistaken as it would set a precedent for other workers to sue the NHS.

HOW TO IMPROVE REPORTING?

Working towards a safer working environment and education of the staff would keep sharp injuries at the minimum. Ease of reporting, availability of effective prophylaxis against all

KEY POINTS

- Continued effort is necessary to keep the working environment safe.
- Staff should be educated to be aware of the consequences of sharp injuries and be trained to take preventive actions.
- Easiness of reporting would be extremely helpful.
- A sympathetic attitude is essential.
- A clear understanding of the future job prospects and career is required, should one contract a disease.
- The issue of compensation is not clear and should be made transparent.

major blood-borne pathogens and transparency of compensation issue would maximize reporting of such injuries. Staff should not be 'blamed' for sustaining sharp injuries and be treated sympathetically. Until that happens, it is unlikely that there will be a major change in reporting of such injuries.

COMMENT

Failure to report in recent times has been thought to be the result of a decline of fear of viral infection via needlestick injuries (Nash and Goon, 2000). In the author's opinion, the fear has not declined. It has just configured to a practical shape of under-reporting. HM

Conflict of interest: none.

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