



HOSPITAL MELAKA

PROSEDUR KUALITI

Pengurusan Kecederaan Alatan Tajam

No. Dokumen

PK - HM - KS - 02

No. Keluaran : 01

Disemak oleh

Tandatangan :

Nama : DR. RUBEN KUMAR A/L MANIAM
Jawatan : KETUA UNIT KESELAMATAN DAN KESIHATAN
PEKERJAAN

Tarikh : 15.01.2018

Disokong oleh

Tandatangan :

Nama : DR. MOHD ROSLI BIN TOMPANG
Jawatan : TIMBALAN PENGARAH PERUBATAN III

Tarikh : 15.01.2018

Diluluskan oleh

Tandatangan :

Nama : DR. HATIJAH BINTI HJ. MOHD TAN
Jawatan : PENGARAH

Tarikh : 15.01.2018



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REKOD PINDAAN

Bil.	Nombor / Tajuk Dokumen	Keluaran	Keterangan	Mukasurat terlibat	Tarikh Pindaan



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1. OBJEKTIF

Memastikan keselamatan, kesihatan dan kebajikan anggota perubatan yang sedang bekerja terhadap risiko kepada keselamatan dan kesihatan yang berbangkit daripada aktiviti pekerjaan dengan merancang, menyelaraskan dan memantau aktiviti berkaitan keselamatan dan kesihatan pekerjaan pada tahap yang tinggi di kawasan hospital dan premis-premis lain di bawah pentadbirannya dengan mengambilkira kehendak undang-undang serta mendidik dan membudayakan amalan kerja selamat dan sihat di tempat kerja.

2. SKOP

Skop bidang tugas unit adalah luas di mana ia berfungsi sebagai sekretariat untuk Jawatankuasa Keselamatan dan Kesihatan Hospital Melaka dan juga menyelaraskan segala aktiviti-aktiviti jawatankuasa mengikut Akta Keselamatan dan Kesihatan Pekerjaan 1994.

3. RUJUKAN

- Manual Prosedur Kerja
- *Sharps Injury Surveillance Manual, Occupational Health Unit, MOH 2007*
- *QA Manual Incidence Rate of Needle Stick Injuries Among Health Care Worker Within The Ministry Of Health Occupational Health Unit KKM 2nd Edition 2002*

4. TERMINOLOGI

ID	<i>Infectious disease</i>
Y/M	Yang Menjaga
CCU	<i>Coronary Care Unit</i>
ALATAN TAJAM	termasuk semua peralatan tajam yang digunakan di fasiliti kesihatan (cth : semua jenis jarum, <i>scalpel</i> , <i>trochar</i> , serpihan kaca, <i>lancet</i> dan peralatan tajam yang lain)
ANGGOTA YANG TERLIBAT	kakitangan di bawah Kementerian Kesihatan Malaysia, pelatih di bawah Kementerian Kesihatan Malaysia, pelajar perubatan, kakitangan sokongan di bawah fasiliti kesihatan yang mendapat kecederaan alatan tajam
PENYELIA YANG BERTUGAS	Pakar Perubatan / Pegawai Perubatan / Penyelia Jururawat / Ketua Jururawat / Penolong Pegawai Perubatan / Penyelia



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5. TANGGUNGJAWAB DAN TINDAKAN

TANGGUNGJAWAB	TINDAKAN
<p>Anggota yang terlibat</p> <p>Anggota yang terlibat</p>	<p>5.1 Pengurusan kecederaan alatan tajam</p> <p>5.1.1 Melakukan tindakan <i>first aid</i> dengan membersihkan anggota badan yang cedera dengan air bersih</p> <p>5.1.2 Melaporkan kejadian dan kecederaan kepada penyelia yang bertugas / atas panggilan</p>
<p>Penyelia Yang Bertugas/ Atas Panggilan</p> <p>Unit Keselamatan dan Kesihatan Pekerjaan</p>	<p>5.2 Notifikasi</p> <p>5.2.1 Mengisi borang notifikasi OHU SIS-1 / WEHU A1-A2 dalam tempoh 24 jam</p> <p>5.2.2 Membuat salinan notifikasi dan disimpan di Wad/Unit/Jabatan terlibat</p> <p>5.2.3 Menghantar notifikasi yang telah dilengkapkan ke Unit Keselamatan dan Kesihatan Pekerjaan</p> <p>5.2.4 Menghantar notifikasi OHU SIS-1/WEHU A1-A2 ke Unit Keselamatan Pekerjaan dan Alam Sekitar, Jabatan Kesihatan Negeri Melaka (KPAS)</p>
<p>Penyelia Yang Bertugas/Atas Panggilan</p> <p>Ketua Jururawat Y/M CCU</p> <p>Pegawai Perubatan atas panggilan <i>Active 2</i></p> <p>Ketua Jururawat Y/M CCU</p>	<p>5.3 Rujukan</p> <p>5.3.1 Memaklumkan insiden kepada Pegawai Perubatan atas panggilan <i>Active 2</i></p> <p>5.3.2 Mengiringi pesakit ke CCU</p> <p>5.3.3 Menerima pesakit untuk dilihat oleh pegawai perubatan & mendapatkan perawatan awal (<i>Post Exposure Prophylaxis</i>)</p> <p>5.3.4 Melihat pesakit , menilai risiko penyebaran penyakit dan memberi perawatan (<i>Post Exposure Prophylaxis</i>)</p> <p>5.3.5 Mengisi dan melengkapkan borang OHU SIS-2a</p> <p>5.3.6 Mendapatkan temujanji di Klinik ID untuk rawatan susulan</p>
<p>Anggota yang terlibat</p> <p>Pegawai Perubatan Klinik ID</p> <p>Ketua Jururawat Klinik ID</p>	<p>5.4 Rawatan susulan</p> <p>5.4.1 Mendapatkan perawatan susulan di Klinik ID mengikut temujanji yang telah ditetapkan</p> <p>5.4.2 Mengisi borang OHU SIS-2b semasa rawatan susulan dijalankan</p> <p>5.4.3 Menyimpan dokumentasi di Klinik ID sepanjang tempoh perawatan pesakit</p>

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<p>Ketua Jururawat Klinik ID</p> <p>Unit Keselamatan dan Kesihatan Pekerjaan</p>	<p>5.5 Registri</p> <p>5.5.1 Menghantar borang OHU SIS-2a dan OHU SIS-2b yang telah lengkap ke Unit Keselamatan dan Kesihatan Pekerjaan setelah pesakit tamat rawatan</p> <p>5.5.2 Menghantar registri yang telah dilengkapkan ke Unit Keselamatan Pekerjaan dan Alam Sekitar, Jabatan Kesihatan Negeri Melaka (KPAS)</p>	



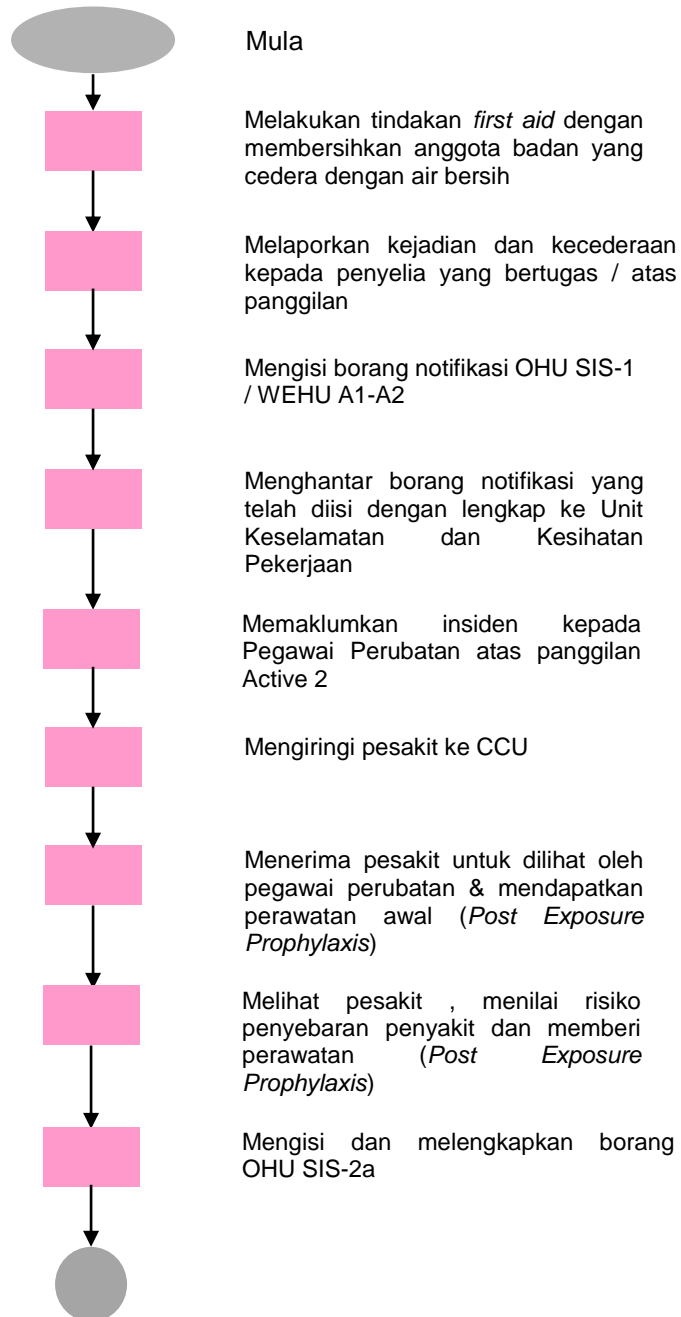
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6. CARTA ALIRAN






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 <p>HOSPITAL MELAKA</p>	<p>PROSEDUR KUALITI</p> <p>Pengurusan Kecederaan Alatan Tajam</p>	<p>No. Pindaan: 00 Tarikh: 15.01.2018</p>
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7. REKOD KUALITI

BIL.	JENIS REKOD	LOKASI	TEMPOH PENYIMPANAN
1.	Borang OHU /SIS 1, 2a, 2b	Unit Keselamatan dan Kesihatan Pekerjaan	30 tahun
2.	Registri <i>Sharp Injury Surveillance</i>	Unit Keselamatan dan Kesihatan Pekerjaan	30 tahun
3.	Kad/ Fail Rawatan Pesakit Luar	Bilik Kad / Klinik ID	30 tahun

LAMPIRAN

- Lampiran 1 Borang Notifikasi OHU SIS 1, 2a, 2b
Lampiran 2 Carta Alir Pengurusan Kecederaan Alatan Tajam

8. INPUT

- 8.1 Sumber Manusia
- 8.2 Data / Informasi
- 8.3 Peralatan

9. PENGURUSAN RISIKO

Rujuk Fail Pengurusan Risiko

10. KLAUSA BERKAITAN

- 5.0 Kepimpinan
- 6.1 Tindakan menyatakan risiko & peluang
- 6.2 Objektif kualiti & perancangan untuk mencapainya
- 7.1 Sumber pemantauan & pengukuran
- 7.4 Komunikasi
- 7.5 Maklumat didokumentasikan



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»1. JOB CATEGORY (Please tick [✓] where applicable)

- | | | | |
|--|--------------------------|-----------------------------------|--------------------------|
| * Medical Officer / Medical and Health Officer /
House Officer | <input type="checkbox"/> | * Pharmacist / Pharmacy Assistant | <input type="checkbox"/> |
| * Matron / Sister / Staff Nurse / Assistant Nurse /
Midwife / Community Nurse | <input type="checkbox"/> | * MLT / Lab Assistant | <input type="checkbox"/> |
| * Medical Assistant | <input type="checkbox"/> | Radiology Staff | <input type="checkbox"/> |
| * Specialist / Consultant (please specify speciality) : | <input type="checkbox"/> | Hospital Support Service Staff | <input type="checkbox"/> |
| | | Kitchen Staff | <input type="checkbox"/> |
| | | Administration Staff | <input type="checkbox"/> |
| | | Public Health Overseer | <input type="checkbox"/> |
| | | Health Inspector | <input type="checkbox"/> |
| | | Health Attendant | <input type="checkbox"/> |
| | | Driver | <input type="checkbox"/> |
| | | Storekeeper | <input type="checkbox"/> |
| | | Trainee (please specify) : _____ | <input type="checkbox"/> |
| | | Others (please specify) : _____ | <input type="checkbox"/> |
- DENTAL**
- | | |
|--------------------------|--------------------------|
| Dental Specialist | <input type="checkbox"/> |
| Dental Officer | <input type="checkbox"/> |
| Dental Nurse | <input type="checkbox"/> |
| Dental Surgery Assistant | <input type="checkbox"/> |
| Dental Technician | <input type="checkbox"/> |
| Dental Assistant | <input type="checkbox"/> |

»2. WHERE DID THE SHARPS INJURY OCCUR? (Please tick [✓] where applicable)

- | | | | |
|---|--------------------------|----------------------------|--------------------------|
| Ward (please specify): | <input type="checkbox"/> | Accident & Emergency | <input type="checkbox"/> |
| ----- | | Dental Clinic | <input type="checkbox"/> |
| At patient's bedside | <input type="checkbox"/> | Labour Room | <input type="checkbox"/> |
| Side room / nurses table | <input type="checkbox"/> | Intensive Care Unit | <input type="checkbox"/> |
| Elsewhere in the ward (please specify): | <input type="checkbox"/> | Specialist Clinic | <input type="checkbox"/> |
| ----- | | Laboratory | <input type="checkbox"/> |
| Operating Theatre | <input type="checkbox"/> | School / College / Faculty | <input type="checkbox"/> |
| * Health Clinic / Polyclinic | <input type="checkbox"/> | Others (please specify) : | <input type="checkbox"/> |
| | | ----- | |

3. HOW DID THE SHARPS INJURY OCCUR? (Please tick [✓] where applicable)

- 3a) While handling patient or needle/sharps:**
- | | | | |
|------------------------------------|--------------------------|---------------------------------------|--------------------------|
| While inserting needle in line | <input type="checkbox"/> | Passing / Transferring equipment | <input type="checkbox"/> |
| While manipulating needle in line | <input type="checkbox"/> | While inserting needle in patient | <input type="checkbox"/> |
| While withdrawing needle from line | <input type="checkbox"/> | While manipulating needle in patient | <input type="checkbox"/> |
| | | While withdrawing needle from patient | <input type="checkbox"/> |
- 3b) While in operative field or during suturing procedures or autopsy:**
- | | | | |
|---------------|--------------------------|--------------------------------------|--------------------------|
| Suturing | <input type="checkbox"/> | * Palpating / Exploring | <input type="checkbox"/> |
| Incising | <input type="checkbox"/> | Manipulating suture needle in holder | <input type="checkbox"/> |
| Tying sutures | <input type="checkbox"/> | * Passing / receiving equipment | <input type="checkbox"/> |

(* delete where is not applicable)
(*) to be filled in the registry



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1. RISK ASSESSMENT OF THE INJURY (Please tick [✓] where applicable)

1.1 Type of injury / exposure:

1.1.1 Mucous membrane / skin integrity compromised:

- Large Volume (e.g. several drops, major blood splash and / or longer duration (i.e. several minutes or more))
- Small Volume (e.g. few drops, short duration)

1.1.2 Intact skin:

- Yes
- No

1.1.3 Percutaneous exposure:

- More Severe (e.g. large-bore hollow needle, deep puncture, visible blood on device, or needle used in source patient's artery or vein)
- Less Severe (e.g. solid needle, superficial scratch)

1.2 If the injury was to the hands, did the sharp item penetrate:

- Double pair of gloves
- Single pair of gloves
- No gloves

2. RISK ASSESSMENT OF THE SOURCE (Please tick [✓] where applicable)

2.1 Source:

- Known (Proceed to Q.2.2-2.10)
- Unknown (Proceed to Q.3)

2.2 Name: _____

2.3 NRIC No: _____

2.4 Ward / Clinic: _____

2.5 Admitted / Walk-in for: _____

2.6 Risk factors (if any):

- IVDU
- Had unprotected sex
- Blood products recipient

2.7 If source patient known but not tested, what is the reason? _____

2.8 For HIV infected source patient, 2.8.1 On antiviral treatment:

- Yes
- No

2.8.2 If yes (on antiviral treatment):

2.8.2.1 • Drugs used (current): _____

2.8.2.2 • Drugs used in the past: _____

2.8.2.3 • Latest viral load: _____

2.9 Results of tests: (Please tick [✓] where applicable)

Pathogen	Test	Result			Date & Time drawn		
HIV	Anti-HIV	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not Tested	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year Time : _____
Hepatitis B	HBsAg	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not Tested	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year Time : _____
Hepatitis C	Anti-HCV	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not Tested	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year Time : _____
Others		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not Tested	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year Time : _____

2.10 Results disclosed to source patient:

- Yes
- No

2.10.1 Date results disclosed: _____

Day Month Year

() To be filled in the registry*



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3. RISK ASSESSMENT OF THE EXPOSED HEALTH CARE WORKER (Please tick [✓] where applicable)

3.1 Marital status:

- Married
- Single
- Divorced

3.2 Pregnancy status:

- Yes
- No
- Not Applicable

3.3 Hepatitis B immunization status:

3.3.1 History of hepatitis B immunization before the exposure:

- No
- One dose
- Two doses
- Three doses

Level of antibody to hepatitis B (anti-HBs), if tested: _____ mIU/ml

Date of anti-HBs blood test : (as in 3.3.2): Day Month Year

3.4 Baseline blood test:

Pathogen	Test	Result			Date & Time drawn		
HIV	Anti-HIV	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/>	Time : _____	Day Month Year
Hepatitis B	HBsAg	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/>	Time : _____	Day Month Year
Hepatitis C	Anti-HCV	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/>	Time : _____	Day Month Year
Others :		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/>	Time : _____	Day Month Year

3.5 Is Post-exposure prophylaxis started?:

- Yes
- No

3.6 Is follow-up required?

3.7 Assessment done by :

Name of Physician / Medical Officer : _____

Department : _____

Hospital : _____

Date : _____

(9) to be filed in the registry

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1.3 Borang OHU-SIS 2b



**SHARPS INJURY SURVEILLANCE
OCCUPATIONAL HEALTH UNIT
MINISTRY OF HEALTH**

*"Rakan Anda Dalam Meningkatkan Kesihatan Pekerja"
"Your Partner In Enhancing Workers Health"*



OHU/SIS-2b

MANAGEMENT OF THE EXPOSED HEALTH CARE WORKER SECTION (OHU/SIS-2b)

OHU/SIS-2b : Post-Exposure Management (Treatment and follow-up of the exposed healthcare worker)
(to be filed by staff from Infection Control Team / Occupational Health Unit / Occupational Safety and Health Committee Secretary)

1. Management of the Exposed Health Care Worker:
(Please tick (✓) where applicable)

1.1 Post exposure Prophylaxis (PEP) given:

+ Yes

+ No

PEP	Requirement	Data given	Data Completion	Duration/ Medication/ Comments
HBIG	<input type="checkbox"/> 1 dose	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	
	<input type="checkbox"/> 2 doses	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	
HIV PEP	<input type="checkbox"/> Basic regime	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	
	<input type="checkbox"/> Expanded regime	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	
Others :		<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	

(*) to be filed in the registry

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»1.2 Hepatitis B Immunization Needed: (Please tick (✓) where applicable)

- Yes
- No

Immunization	Dose	Date given	Medication/Duration/Comments
Hepatitis B (Immunization)	<input type="checkbox"/> First dose	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year	
	<input type="checkbox"/> Second dose	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year	
	<input type="checkbox"/> Third dose	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year	

Test	Result	Date given
Anti-HBs (1-2 months after completion Hepatitis B immunization) mIU/ml	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year

»1.3 Follow-up blood test: (Please tick (✓) where applicable)

Pathogen	Test	Result	Date drawn
HIV	Anti-HIV (At 6 weeks post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
	Anti-HIV (At 3 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
	Anti-HIV (At 6 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
Hepatitis B	HBsAg (At 6 weeks post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
	HBsAg (At 3 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
	HBsAg (At 6 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
Hepatitis C	Anti-HCV (At 6 weeks post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
	HCV RNA (At 6 weeks post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
	Anti-HCV (At 3 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
	Anti-HCV (At 6 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
Others:		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year

(To be filed in the registry)

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1.6. Comments and subsequent actions based on the results: (Please tick [✓] where applicable)

1.6.1 Seroconversion status:

+ Yes

+ No

1.6.2 If yes, referral to:

+ Physician from relevant discipline for further clinical management

Name of Physician : _____
 Department : _____
 Hospital : _____

+ Hospital Director / District Medical Officer of Health for assessment of work task involving 'exposure prone procedure' (EPP)

Hospital Director / District Medical

 Date of appointment : _____

Name of attending Medical Officer : _____
 Department : _____
 Hospital : _____
 Date : _____

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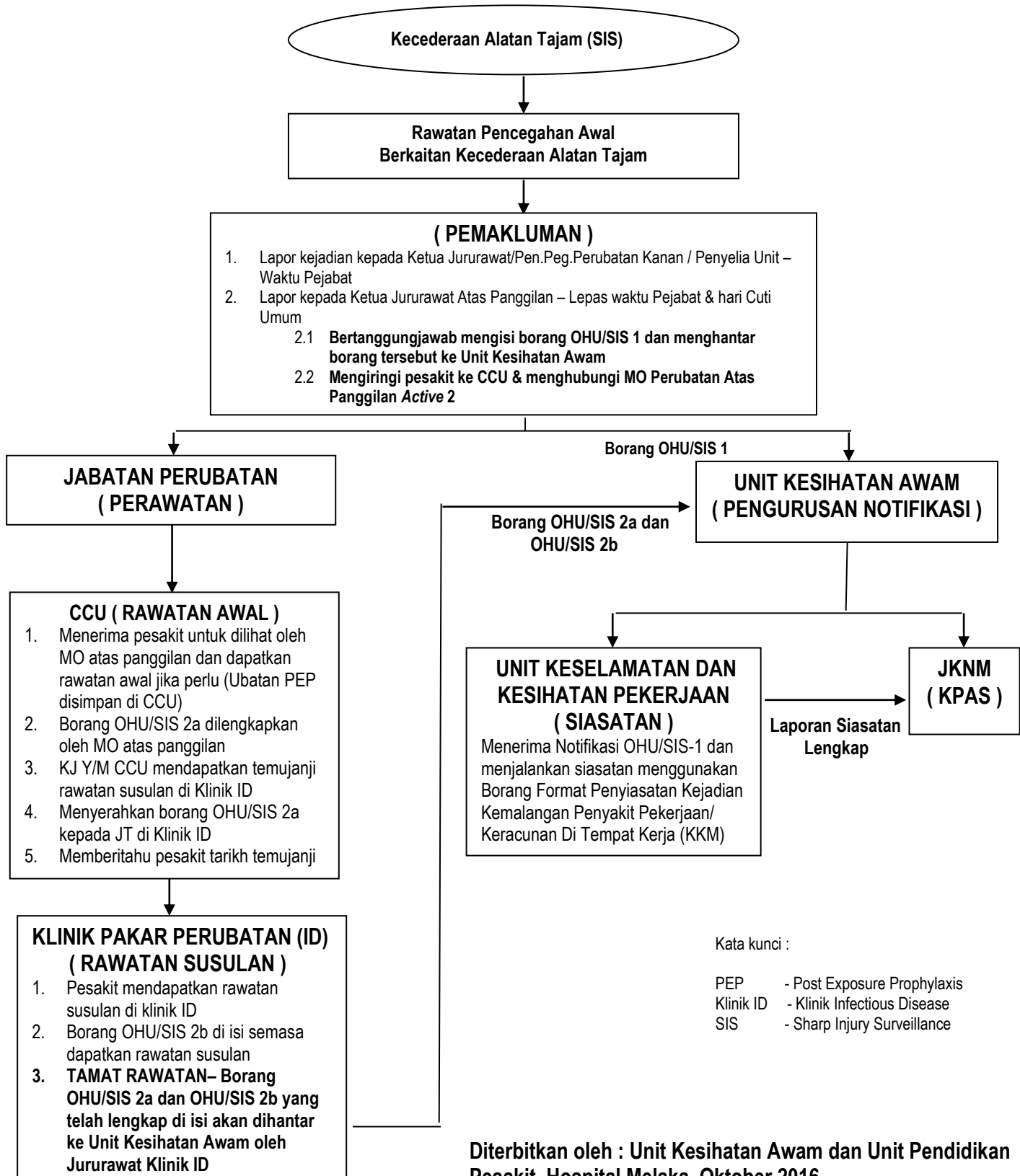
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Lampiran 2

Carta Aliran Pengurusan Kecederaan Alatan Tajam Hospital Melaka



Diterbitkan oleh : Unit Kesihatan Awam dan Unit Pendidikan Pesakit, Hospital Melaka, Oktober 2016