

ABSTRACT

A needle stick injury (NSI) means the skin is accidentally punctured by a used needle. Some staff members attached to the healthcare institutes are at a higher risk of NSI (Carry A; 2016). Refrain from NSI is a must of any blood related infection control programme in the work place. All hospitals or healthcare settings should have regulatory measures in place through a working nosocomial infection control team. This study addressed the burning issue of NSI and aims at determining the occurrence of NSI among various categories of staff. The study setting National Hospital of Sri Lanka (NHSL) is the largest tertiary care government hospital in Colombo, Sri Lanka.

Methodology: Pre tested self-reporting questioner and Check list was adopted for collecting data from selected 386 Nursing officers and Health care assistants (HCA).193 from each category. In The Designing phase also the same tool was applied to develop new structure intervention to address the identified issues regards to knowledge, attitude and practices in NSI. FCD was conducted for identification of existing gaps (Gap analysis). The study was conducted in three components, Pre interventional, Interventional and post interventional component. A Training module and WHO approved Injection safety tool kit was introduced to Accident wards as interventions.

Results: It was, Evident from the study about gaps related to NSI management. Both Groups (NO and HCA) evident with a highly significance different after interventions. Improvement of reporting culture for NSI (0.05, 0.001) evident with a significance difference. Awareness on PEP was also improved significantly (0.003, 0.049). Some variables tested on the attitude of HCA on further training need were statistically significant in pre and post intervention ($p < 0.05$).

Limitation of the study:

The time gap between the intervention and post interventional assessment was two months which was not enough to change the attitude and practice. Only the Knowledge component of HCA showed a significance difference. To achieve a satisfactory result from application of Injection safety tool kit it is needed at least one year. To avoid observational bias (Hawthorne effect) during application of the Check list researcher had to apply Video techniques.

Recommendation:

In service training programme should be conducted continuously. Regular monitoring and evaluation measures should be taken. WHO injection safety tool kit should be generalized all over the Country.