Guidance for Health Care Workers on managing Needlestick/Sharp Injuries and Human Bites In members of the General Public

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DOCUMENT CONTROL		**POLICY NO.**	
Policy Group	Infection Control		
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1. PURPOSE AND SCOPE

The purpose of this document is to provide all NHS Dumfries and Galloway staff, with advice and guidance on the management of needle/sharp injuries and bites affecting members of the General Public.

The National Infection Prevention and Control Manual provides over arching mandatory guidance for NHS employees in the event of an Occupational Blood Borne Virus exposure incident (Chapter 1, Section 1.10).

Such incidents are unusual, but when they do occur they can cause anxiety in those who have sustained the injury or, in the case of children, their carers or parents. While the risks in public health terms remain relatively low, the incidence of discarded sharps in parks, playgrounds and other public areas, generate great public concern. Other situations may involve cleaning staff in a domestic setting or the police searching premises.

Bites, though unpleasant, pose less of a risk because the skin of the bitten person is rarely penetrated. Situations, where bites occur are very varied and will range from a social carer being bitten in the course of his or her work by a child or a vulnerable adult to a deliberate act against another in an argument or involving the police.

1.1: Legislative position

As employers, local councils have a responsibility under Section 2 of the Health & Safety at Work etc Act (HSWA) 1974 and in particular, responsibility in relation to:

- The Management of Health & Safety at Work Regulations 1999 (SI 1999 No. 3242) and the Control of Substances Hazardous to Health Regulations 2002 (SI 2002 No. 2677).
- Sharps fall within the definition of controlled waste in terms of the Environmental Protection Act 1990 and therefore will require to be disposed of (destroyed by incineration or rendered safe by other licensed treatment methods) in accordance with the requirements of the Scottish Environment Protection Agency.
- Section 34 of the Environmental Protection Act 1990 (Duty of Care) places a duty on waste producers, carriers and disposers to ensure that controlled waste is properly handled and disposed of at a licensed disposal facility.

- Section 2 of the Occupiers Liability (Scotland) Act 1960 places a duty on the occupier of land to take reasonable care for the safety of, “a person entering thereon in respect of dangers which are due to the state of the premises or to anything done or omitted to be done on them”.

2. POLICY AIMS

- To assist healthcare professionals when dealing with enquiries relating to needle/sharp injuries and bites affecting members of the public;
- To provide education and support for the general public in understanding the risks associated with such injuries particularly in relation to children and vulnerable adults;
- Following such an incident, ensure action is taken to reduce the risk of the member of public developing a BBV infection;
- To provide healthcare professionals with a framework to assist them in undertaking risk assessments.

3. RESPONSIBILITIES

Chief Executive

The Chief Executive has overall strategic responsibility for ensuring that Board policies comply with all legal, statutory and good practice guidance requirements.

Executive Directors, Associate Directors, General and Nurse Managers, Clinical Leads and Departmental Heads are responsible for:

- Complying with NHS Dumfries and Galloway’s Health and Safety policy.
- Complying with NHS Dumfries and Galloway’s Adverse Incident Reporting policy
- Providing a safe and healthy working environment for employees, contractors, members of the public, patients and visitors (Health and Safety at Work Act, 1974), and Environmental Protection Act 1990.
- Assessing and managing risk according to the Management of Health and Safety at Work Regulations 1999.

- Identify and assess the risks to health of microbiological and chemical hazards, prevent and control exposure to the risks, inform and train employees, monitor exposure and implement health surveillance where appropriate (COSHH, 2002).
- Report incidents, diseases and dangerous occurrences (Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 1995 – RIDDOR).
- Continuing to explore any needle/sharp safety devices which may be available for their work area.

All Staff:

Having been provided with the necessary information, instruction and training, staff will be responsible for checking that their work activity and action in the event of a needle/sharps injury or human bite complies with this current approved policy.

4. ORGANISATIONAL ARRANGEMENTS

Community needle/sharps injuries and bites are incidents that happen to members of the general public.

4.1: Community needle/sharp injuries or bites include:

- Percutaneous inoculation injuries via needles, blades, 'sharps' or teeth
- Splashing of blood/body fluids onto mucous membranes e.g. eye or mouth or damaged skin e.g. weeping eczema
- A human bite which breaks the skin/causes bleeding.

4.2: Advice on the initial management of the injury

The following advice should be given:

- Encourage the wound to bleed, by gently squeezing but **not** sucking
- Wash the wound thoroughly with warm, running water and soap and dry with a disposable paper towel/paper
- Cover with a waterproof plaster/dressing.

- Wash skin, eyes or mouth with plenty of water if a splash injury has occurred(water used for rinsing the mouth must not be swallowed).
- Do not use bleach on the injury
- **Seek immediate advice from GP and/or the Emergency Department**
- **Assess whether a significant injury has occurred:**

4.3: Risk Assessment of injuries (Appendix 2, Pg 20)

Care is required in assessing the risk posed by the source of exposure, as the outcome may dictate the need for complex therapy for the injured person. In most instances involving exposure of a member of the general public to a needle stick/sharp injury, the source will be unknown. The risk assessment should be based on the circumstances and nature of the injury and should consider the following factors:

- **Location** - where the injury occurred (Was it at home, school, park etc?)
- **The injury**- did the sharp actually puncture/ pierce the skin?
- **The type of needle/sharp implement** - there is greater risk from injuries with a hollow bore needle such as a hypodermic needle rather than a solid needle such as tattoo or sewing needle.
- **The user** or **source** - is there any information about the user of the needle/sharp etc. Is the user known to have a BBV or can it be found out by requesting to test the user? Or is the user a member of a high risk group e. g injecting drug user?
- **Exposure** - what type of exposure percutaneous/ splashing?
- I**mmunisation status** - has the injured person been vaccinated for Hepatitis B/ tetanus? When/ how many received?

4.3.1: Injury type

High – risk injury	Low – risk injury
• Percutaneous exposure eg needlestick /other sharps injury • Exposure on broken skin • Mucous membrane exposure (eg eye/ inside mouth) • Human bite	Splash on intact skin – there is no known risk of BBV transmission from exposures to intact skin

It is imperative that the injured individual receives the following information so he or she can make decisions regarding treatment and follow up:

- Quantification of risk (High/Low risk)
- Sero-conversion times – normally 6 months but not less than 3
- Treatment options – immediately and follow up

4.3.2: Level of Risk

High – risk Body fluid	Low – risk body fluid (unless blood stained)
• Blood • Blood stained low risk fluid • Semen • Vaginal secretions	Blood Vomit Saliva Faeces

All BBV tests have a window period, which is a time after infection during which the antibody response, and infection itself, cannot be detected by the usual testing methods. It is important to establish whether the person being tested could be in the window period, or has been at risk of exposure to infection during the window period for each virus. If they have been at risk they should be offered re-testing, assuming they are negative, after the appropriate window period. It should also be taken into account in relation to the need to continue HIV PEP in the HCW.

Window periods	
HIV	1-3 months
HCV	3-6 months
HBV	3-6 months

Box 3: Window periods

4.4: Removal of the sharp from location of the incident

Can the injured individual tell you where the offending sharp is? If appropriate contact the Environmental Standards Officer or Police Headquarters (Appendix 1, Pg 19) in order that the offending sharp can be removed. If they have the sharp with them dispose in a sharps bin.

4.5: Management of human bites (Appendix 3, Pg 21)

The principles of management for Human bites are the same as those for needle/sharp injuries. Hepatitis B, C and HIV should be considered in any person with a human bite, although the risk is small even if the perpetrator (or source) is infected.

The risk is greatest if the skin is broken and there is blood in the perpetrators saliva. If possible an enquiry should be made into the risk status of the perpetrator. If the immunisation schedule is incomplete or unknown, a dose of tetanus containing vaccine should be given at the time of treatment.

4.6: Management of significant injuries (Appendix 2, Pg 20)

A significant injury is penetration of the skin by a needle or other sharp object that is, or is suspected to be, contaminated with another person's blood or body fluid, or when a human bite breaks the skin. If the skin or mucous membrane has been penetrated the following is the recommended course of action:

- Offer to take blood for storage all types for all injuries. 5-10 ml clotted blood sample should be taken and the Microbiology Laboratory request form should be marked; "*Blood for storage - not for testing - for the attention of the Consultant Microbiologist*". Consent for sampling is required. The sample will be stored for a minimum period of one year. The baseline blood sample may assist the investigation of subsequent illness in the injured person. Testing of the

patient after 6 months (not less than 3 months) may not be necessary and would only be done with the person's consent.

- The laboratory request form should clearly state:
    - the name of the injured individual
    - date of birth/CHI
    - full details of the injury including time of injury and area of body injured.

5: BLOOD BORNE VIRUSES

5.1: Hepatitis C

Members of the public acquiring injuries from HCV positive or high risk* infected sources should be advised that there is at present **no** vaccine available to prevent HCV. Immediate, post-exposure prophylaxis has not been shown to be beneficial and is therefore **not** routinely recommended. However, a sample of the injured individual's blood should be stored at the time of the incident. It is important that those exposed receive appropriate follow up so that treatment can be initiated should they become infected.

Screening: HCV PCR testing should be performed at 6 and 12 weeks with anti HCV testing at 12 and 24 weeks. If patient tests positive prompt referral should be made to a specialist HCV centre/Infectious Diseases Consultant.

*** Source patients who are known to be current or past injecting drug users should be considered high risk for HCV infection.**

5.2: Hepatitis B

Assess the injured person's Hepatitis B immune status (most members of the general public will not be immunised) and should be managed as Table 1(below).

5.2.1: Table 1 HBV Prophylaxis for Reported Significant Exposures

HBV Prophylaxis for Reported Significant Exposures based on guidance from the Joint Committee on Vaccination and Immunisation[1] The Green Book will provide up-to-date information see http://www.dh.gov.uk/greenbook

[1] Immunisation Against Infectious Disease: The Green Book. Department of Health 2006.

HBV status of Person exposed		Significant exposure			Non-significant exposure	
		HBsAg positive source	**Unknown source**	**HBsAg negative source**	**Continued risk**	**No further risk**
A	**Known Responder to HBV (>10mIU/ml)**	Consider one booster dose vaccine	Consider one booster dose vaccine	Consider one booster dose vaccine	Consider booster dose of HB vaccine	No HBV prophylaxis. Reassure
B	**2 or more doses of HB vaccine given, or course completed but response unknown**	Give one dose of HB vaccine followed by a second dose one month later.	Give one dose of HB vaccine	Finish course of HB vaccine	Finish course of HB vaccine	No HBV prophylaxis. Reassure
C	**Unvaccinated or only had one dose of HB vaccine given**	Accelerated course of HB vaccine* HBIG x1 in other arm	Accelerated course of HB vaccine*	Initiate or complete Course of HB vaccine	Initiate course of HB vaccine	No HBV prophylaxis. Reassure
D	**Known non responder to vaccine (anti HBs <10mIU/ml)**	HBIG x1. Consider booster dose of HB vaccine. A second dose of HBIG should be given at one month	HBIG x1. Consider booster dose of HB vaccine. A second dose of HBIG should be given at one Month.	No HBIG. Consider booster dose of HB vaccine.	No HBIG. Consider booster dose of HB vaccine	No prophylaxis. Reassure

Table 1

*An accelerated schedule consists of doses given at zero, one and two months a booster may be given at 12 months for those at continuous risk.

5.3: HIV: When to use Post Exposure Prophylaxis (PEP) (Table 2).

No data exists on the efficacy of antiretroviral post-exposure prophylaxis following exposure to HIV other than for occupational exposure in a health care setting.

PEP for non occupational exposure is most likely to be effective in situations where:

- The risk of exposure is considered high **(Table 3)**
- Such exposure is unlikely to be repeated
- PEP can be started promptly
- Good adherence to the regimen is considered likely

5.3.1: Table 2: Indications for PEP against HIV

	Known or strongly suspected to be HIV positive	**Source HIV negative**	**Source unknown**
Percutaneous injury (eg. Needles or sharps)	**PEP**	**NIL**	**NIL**
Exposure of broken skin (eg. Abrasions/cuts and eczema)	**PEP**	**NIL**	**NIL**
Exposure of mucous membrane (eg. Eye)	**PEP**	**NIL**	**NIL**

5.3.2: Table 3: Exposure Risk

Body Fluids – High Risk **Exposure to any of these fluids whether through percutaneous injury, contact with a mucus membrane, contact with non-intact skin, sexual exposure or sharing injection drug equipment poses a risk.**	**Body Fluids – Low Risk** **Exposure to these fluids is not considered an exposure unless they contain visible blood**
Blood Pleural fluid Blood-stained low risk fluid Saliva associated with dentistry Semen Amniotic fluid Vaginal Secretions Breast milk CSF Synovial fluid Pericardial fluid Unfixed tissues or organs Peritoneal fluid	Urine Vomit Saliva Faeces Nasal secretions Sputum Sweat Tears

5.4: Indications for PEP

At all times it is important to take into account the view of the patient regarding the side effects of PEP. The exposed persons understanding of the following should be documented:

- The need to start or resume relevant measures to reduce the risk of exposure to HIV
- The lack of evidence of efficacy of PEP in these circumstances and the differing view of experts about its use in this context.
- Known side effects and unknown toxicity of the drugs to be prescribed
- The importance of close adherence which may improve efficacy and reduce the risk of infection with drug resistant HIV, should infection supervene despite PEP
- Arrangements for follow up
- Symptoms and signs which may be associated with HIV sero-conversion.

***If PEP is offered to the injured party (Appendix 5, Pg 23)**

5.5: Follow up

Where the patient has been managed within the Emergency Department or a Minor Injuries Unit a letter should be sent to the GP stating the following:

- What has happened
- What action has been taken
- The recommended follow-up (on clinical grounds)

Hepatitis B – prevention; if an accelerated course of vaccine is used the GP should make an appointment for the patient at 1 and 2 months to ensure completion of the course.

HCV RNA – testing should be performed at 6 and 12 weeks with anti HCV testing at 12 and 24 weeks (Sign 92 2006). If the patient tests positive, a prompt referral should be made to Dr G Jones on telephone 01387 241787.

HIV – if the patient consents to an antibody test then this should be performed by the GP after 13 weeks or, 12 weeks after cessation of PEP.

6. INFORMATION SOURCES FOR THE GENERAL PUBLIC

Website information and an advice sheet is provided for the General Public

Information Sources for Patients - Appendix 6 (Pg 25)
Can PEP stop me getting HIV? (Information sheet for patients) - Appendix 7 (Pg 26)

7. MONITORING

Responsibility for monitoring the application of this guidance will rest with the NHS Dumfries and Galloway Infection Control Committee. These issues will be considered annually and will be reported to the Staff Governance Committee and Area Partnership Forum.

Basis for Evaluation will include:

Emergency Department / Minor Injuries data where it exists.

This guidance will be reviewed on a biannual basis with amendments being made as appropriate.

8. EQUALITY AND DIVERSITY

No major negative impacts were identified.

Positive impacts

The policy supports early treatment in the event of an injury and the opportunities for general public awareness.

Negative impacts

Travelling to a service may be problematic if the person is limited by public transport particularly out of hours.

9. DOCUMENT CONTROL SHEET

Document Status

Title	Guidance for healthcare Workers on managing needlestick/sharps injuries/ Human bites in members of the general public
Author	Elizabeth Scotney V1 Elizabeth Scotney V2
Approver	Dr Nigel Calvert CPHM
Document reference	
Version number	V3

Document Amendment History

Version	Section(s)	Reason for update
	ALL	Bi-annual review required in accordance with corporate document development
V3	All	Bi-annual review and updated in accordance with current legislation.

Distribution

Name	Responsibility	Version number

Associated documents

- UK Health Department. HIV Post-Exposure Prophylaxis: Guidance from the UK Chief Medical Officers. Sept 2008
- Control of Substances Hazardous to Health Regulations 2002
- Scottish Executive Health Department. Needlestick Injuries – Sharpen Your Awareness 2001
- UK Health Department. Guidance for Health Care Workers – Protection Against Infection with Blood Borne Viruses Recommendations of the Expert Advisory
- Reporting of Injuries Diseases and Dangerous Occurrences Regulations 1995
- Health and Safety at Work Act 1974
- HSE. Blood Borne Viruses in the Workplace – Guidance for Employers and Employees. Reprinted 2008

10. ACTION PLAN FOR IMPLEMENTATION

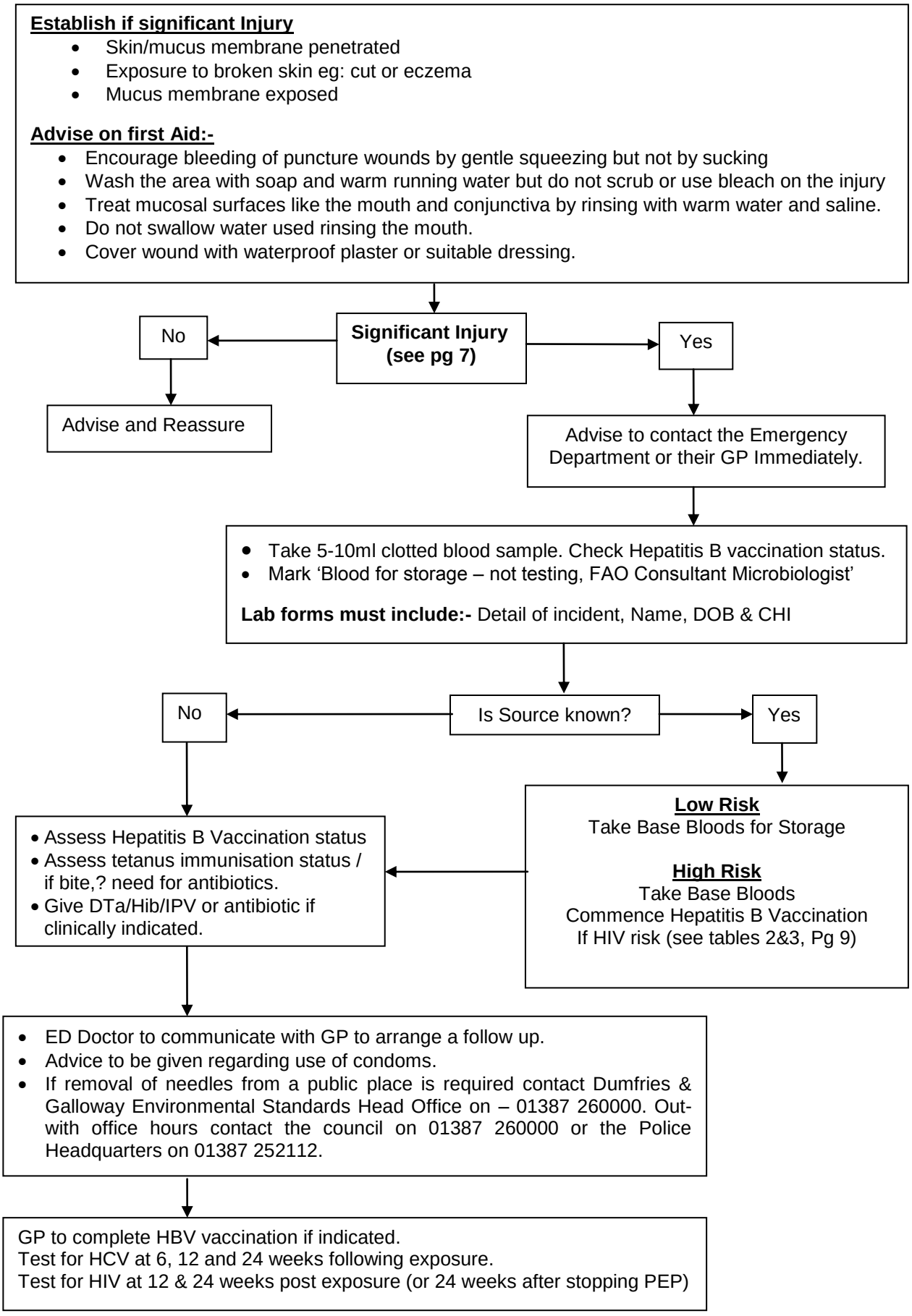
Action	Lead Officer	Timeframe
Place in Infection Control Intranet folder and also on the HPT website. Communicate to all staff via ICC updates	Andrew McCulloch	
Alignment with needlestick/sharps and bites policy for NHS staff	Nigel Calvert	
Dissemination to senior staff through line management	Occupational Health, Public Health	
Dissemination to all staff via line management / Senior Charge Nurse Group	Occupational Health and Public Health	
Use policy	All Staff	

Appendix 1

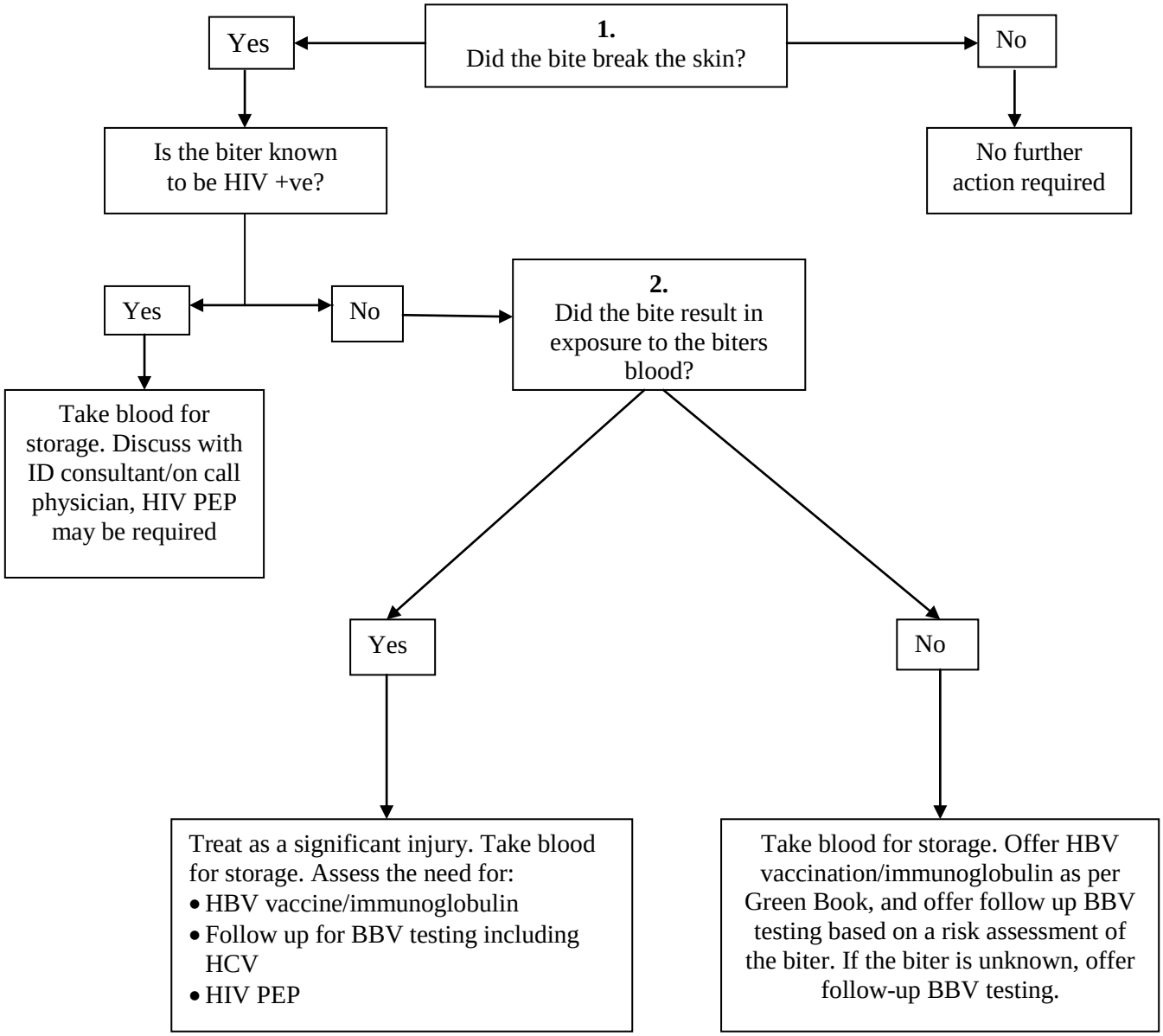
LIST OF USEFUL CONTACTS IN DUMFRIES AND GALLOWAY

Emergency Department, DGRI	01387 246 246
A&E Department, Galloway Community Hospital	01776 707 707
Minor Injuries Unit, Newton Stewart Hospital	01671 402 015
Thomas Hope Hospital, Langholm	01387 380 417
Minor injuries unit, Castle Douglas	01556 502 333
Duty Consultant microbiologist DGRI (through switchboard)	01387 246 246
Consultant physician & infectious disease specialist, DGRI	01387 246 246
Duty Infectious disease physician, Brownlee Centre, Gartnavel	0141 211 3000
Dumfries and Galloway Council	030 33 33 3000
Environmental Standards	030 33 33 3000
Environmental Standards – Stranraer office	01776 702 151
Blood Borne Virus Nurses, Public Health	01387 272 724
Health Protection Team, D&G	01387 272 724
Police Scotland	101
Syringe and needle disposal – Environmental Standards Tel: Fax:	030 33 33 3000 01387 245 972

Appendix 2


Establish if significant Injury
Skin/mucus membrane penetrated
Exposure to broken skin eg: cut or eczema
Mucus membrane exposed
Advise on first Aid:-
Encourage bleeding of puncture wounds by gentle squeezing but not by sucking
Wash the area with soap and warm running water but do not scrub or use bleach on the injury
Treat mucosal surfaces like the mouth and conjunctiva by rinsing with warm water and saline.
Do not swallow water used rinsing the mouth.
Cover wound with waterproof plaster or suitable dressing.
Significant Injury (see pg 7)
No
Yes
Advise and Reassure
Advise to contact the Emergency Department or their GP Immediately.
Take 5-10ml clotted blood sample. Check Hepatitis B vaccination status.
Mark 'Blood for storage – not testing, FAO Consultant Microbiologist'
Lab forms must include:- Detail of incident, Name, DOB & CHI
Is Source known?
No
Yes
Low Risk
Take Base Bloods for Storage
High Risk
Take Base Bloods
Commence Hepatitis B Vaccination
If HIV risk (see tables 2&3, Pg 9)
Assess Hepatitis B Vaccination status
Assess tetanus immunisation status / if bite,? need for antibiotics.
Give DTa/Hib/IPV or antibiotic if clinically indicated.
ED Doctor to communicate with GP to arrange a follow up.
Advice to be given regarding use of condoms.
If removal of needles from a public place is required contact Dumfries & Galloway Environmental Standards Head Office on – 01387 260000. Out-with office hours contact the council on 01387 260000 or the Police Headquarters on 01387 252112.
GP to complete HBV vaccination if indicated.
Test for HCV at 6, 12 and 24 weeks following exposure.
Test for HIV at 12 & 24 weeks post exposure (or 24 weeks after stopping PEP)

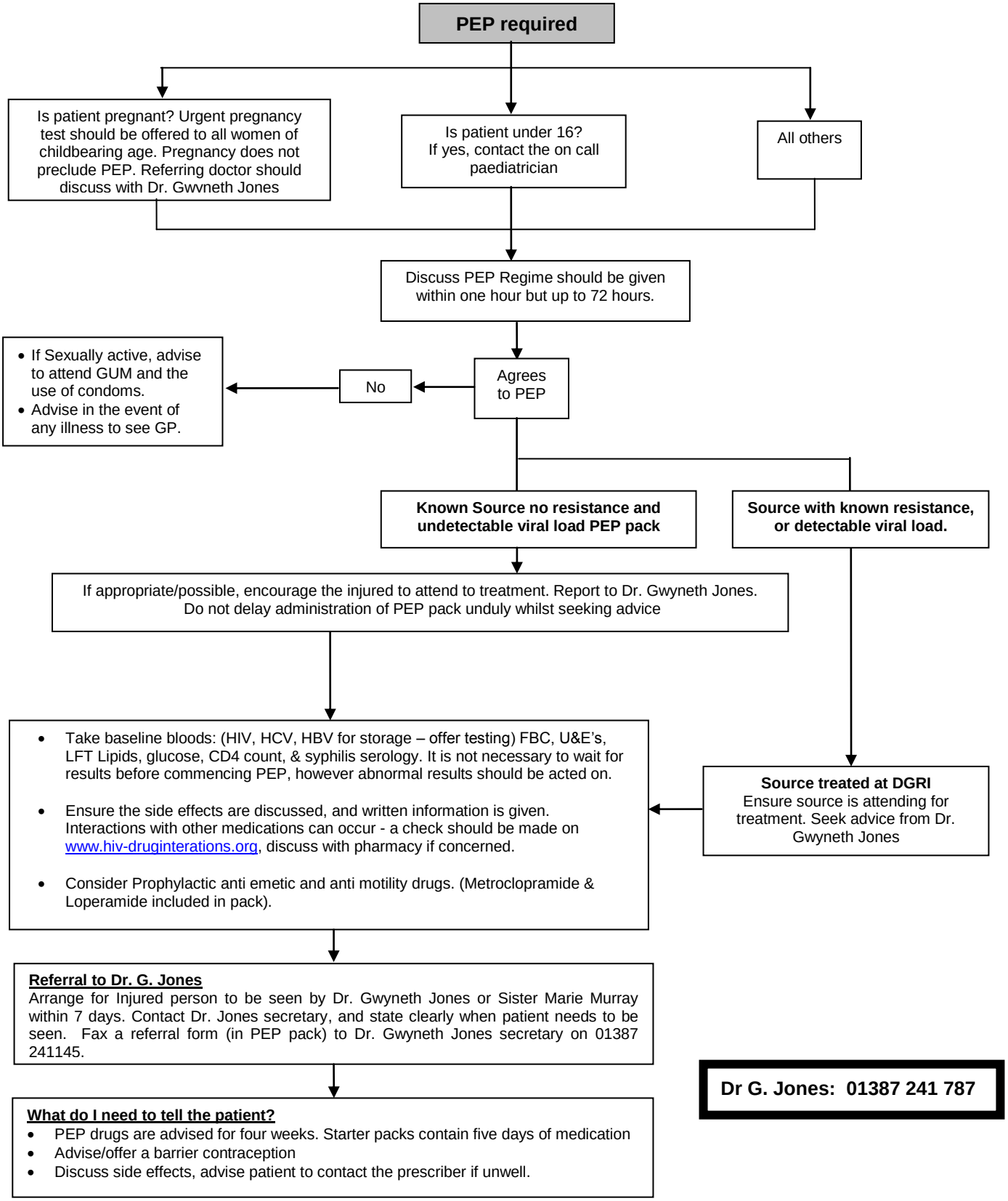
Appendix 3 Management of Human Bites



1. If the injury involves contact with HIV positive blood (whether or not it is a significant injury) discuss with Infectious Disease Physician on call.
   Persons who have had an injury which involved exposure to HIV infected blood should have follow-up post-exposure testing, medical evaluation and be offered specialist advice and support, whether or not they have received HIV PEP.
2. The clinical evaluation should also include the possibility that the person who inflicted the bite may have been exposed to bloodborne pathogens during the incident.
3. For bite injuries occurring outside the healthcare setting, it is likely that the biter will not be available for risk assessment or testing. HIV PEP would not be recommended in this situation unless the biter was known to be HIV positive.

Guidance for those prescribing HIV Post Exposure Prophylaxis (PEP)
General Public

Appendix 4



Appendix 5

If PEP is offered to the injured person

If PEP is offered, blood must be taken for storage (HIV, HBV and HCV). FBC, U&E, LFT's, lipids and blood glucose must be measured. It is not necessary to wait for results of blood tests before start PEP drugs, test results should be monitored and abnormal result should be acted on.

- It is important to discuss the side effects of PEP with patients, ensure the information cards in PEP have been provided. Check that the patient isn't taking any medication (including herbal remedies) that could interact with PEP drugs.
  A check should be made on www.hiv-druginteractions.org, discuss with pharmacy if concerned.

- Timing of the first dose of PEP: To be most effective, PEP should be started as soon as possible after the incident and ideally within one hour. PEP is generally not recommended more than 72 hours after the post-exposure. Decisions on initiation of PEP more than 72 hours after the exposure should be left to the discretion of local clinicians in discussion with the exposure recipient in full knowledge of the lack of evidence beyond this point.

- Where appropriate in a high risk situation, an initial dose of PEP can be given immediately pending further risk assessment and counselling.

- An urgent pregnancy test should be offered to all women of child bearing age, before PEP is commenced.

- If the exposed person is under 16 contact a paediatrician for further advice

- PEP drugs used in NHS Dumfries and Galloway are Combivir and Kaletra. Metoclopramide and Loperamide are also supplied in the pack (the choice of drugs is based on the Expert Advisory Group on AIDS guidelines).

- PEP treatment is four weeks. PEP packs will be available containing a five day course which is sufficient to cover weekends and bank holidays and are available in:
  - Emergency Department, Dumfries & Galloway Royal Infirmary
  - Bay 2, Out Patients Dept, Dumfries & Galloway Royal Infirmary
  - Emergency Department, Galloway Community Hospital Stranraer
  - Minor Injuries Unit, Newton Stewart Hospital
  - Thomas Hope Hospital, Langholm
  - Minor Injuries Unit, Castle Douglas Hospital

- If source patient is unknown, standard PEP pack should be given.

- When the source patient is known to be HIV positive, determine (if possible) what anti-viral therapy they are currently receiving, evidence of resistance or undetectable viral load, this can be obtained from the hospital notes or with the Consultant responsible for their care. If there is no resistance or detectable viral load, give standard PEP pack. If there is evidence of resistance or detectable viral load. If information is unavailable, seek advice form Infectious Diseases Consultant either here or elsewhere (see appendix 3 for contact details). Do not delay administration of standard PEP unduly, consider administering standard PEP whilst seeking further advice.

- PEP can be discontinued if the source patients HIV antibody test is negative.

- The prescriber must arrange for the receiver of PEP to be referred to the Infectious Diseases Consultant or Blood Borne Virus Nurse Specialist by contacting the Infectious Diseases Consultant secretary, providing all appropriate details. The referral form in the PEP pack should also be forwarded.

- Pending follow up and the absence of seroconversion, HCW's need not be subject to any modification of their working practices e.g. avoidance of exposure prone procedures. Advice should be given about safer sex and the avoiding blood donation during the follow up period.

Appendix 6

Information Sources for Patients

NHS Inform
Includes general advice – use index or quick search to find BBV, Hepatitis B, Hepatitis C or HIV PEP
Website**:** http://www.nhsinform.co.uk/
Tel 0800 22 44 88

NHS Choices
Includes general advice – use index or quick search to find BBV, Hepatitis B, Hepatitis C or HIV PEP
Leaflet: Can PEP (post exposure prophylaxis) stop me getting HIV?
Website: http://www.nhs.uk/Pages/HomePage.aspx

Terrance Higgins Trust
National Charity providing advice and support
General information about HIV and AIDS
Downloadable pages on *'Where does someone get PEP from'*
Website:
http://www.tht.org.uk/informationresources/hivandaids/postexposureprophylaxis/gettingpep/content.htm
Telephone: 0141 3323838

NHS 24 Language Line
For anyone whose first language is not English, or who have difficulties in explaining their needs in English.

Tel: **08454 242424** and say in English the language required

Appendix 7

Can PEP (post exposure prophylaxis) stop me getting HIV?
Information sheet for patients

It is possible, but it doesn't always work.

If you've been exposed to HIV (human immunodeficiency virus), PEP can stop you becoming infected with it. For example, if you've:

- had unprotected sex,
- had sex with someone who knew they had HIV and the condom broke
- been injured accidentally with an HIV-infected needle.

What is PEP?
PEP is a course of treatment with anti-HIV medication. Start taking the medicines as soon as possible after you've been exposed to HIV, ideally within a few hours. PEP is unlikely to work after 72 hours (three days) and won't usually be prescribed. The medicines are taken every day for four weeks.
PEP makes infection with HIV less likely. However, it's not a cure for HIV, and it doesn't work in all cases. Some strains of HIV aren't affected by the medicines, and the treatment may not work if you take the medicines incorrectly, or you don't take them soon enough.
The side effects from PEP are likely to be mild.

Where can I get advice about PEP?
If you think you might need PEP, visit your nearest sexual health (GUM) clinic or A&E department. You'll be asked some questions, for example:

- who you had sex with, to assess your risk of exposure to HIV, and
- whether you had oral, vaginal or anal sex.

PEP and HIV tests
You'll be asked to take an HIV test before taking PEP treatment, to check whether you already have HIV. If you don't agree to an HIV test, you won't be given PEP.
You'll also need an HIV test after the treatment to check that it's been successful.

Safer sex
Using a condom is the best way to prevent the spread of sexually transmitted infections (STI's), including HIV.

Source NHS Health Choices