Public Health Live: “Take Your Best Shot!”
Safe Injection Practices
NY State Department of Health
“One and Only Campaign”

May 19, 2011

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Conflicts of Interest

• The speakers and their viewpoints represent no conflicts of interest.

Guest Speakers

• Dr. Gus Birkhead
  Deputy Commissioner, Office of Public Health
  New York State Department of Health
• Gina Pugliese
  Vice President, Safety Institute
  Premier healthcare alliance
• Dr. Evelyn McKnight, Aud
  Co-Founder of HONOReform Foundation

Evaluations

Please visit www.phlive.org to fill out your evaluation and post test.
Nursing Contact Hours, CME, CHES are available.

Thank you!
Email Address

- phlive.ny@gmail.com

Learning Objectives

- Highlight the problem of unsafe injections/patient exposure
- Discuss the impact on public health agencies
- Identify provider barriers to safe injection practices
- Identify means of empowering medical consumers (patients) to ask questions
- Explore ways the “One and Only Campaign” can help providers and patients attain safer injections

What is a Safe Injection?

A safe injection:

- Does not harm recipient
- Does not expose provider to avoidable risks

What Is Going Wrong?

- Direct transmission: Using the same syringe to administer medication to more than one patient even if the needle was changed or the injection was administered through an intervening length of intravenous (IV) tubing.

What is Going Wrong?

- Indirect transmission: Accessing a medication vial or bag with a syringe already used to administer medication to a patient, then reusing contents from that vial or bag for another patient

How Transmission Occurs

Unsafe Injection Practices and Disease Transmission

- 1. Intact needle and vial/packaging not damaged
- 2. All necessary medications contained within single vial
- 3. Needle/sharps are used and discarded properly
- 4. Proper waste disposal procedures and disposal of sharps

[Image]
Safe Diabetes Care

- Never share blood-testing equipment (lancets, lancet pens, insulin pens)
- These unsafe practices have been linked to transmission events
- Never share insulin vials

Why are there lapses in basic infection control?

- Lack of awareness
- Poor/insufficient training
- Economics
- Lax procedures

Outcomes

- Since 1999, over 125,000 patients in the U.S. have been notified of potential exposure to hepatitis B virus (HBV), hepatitis C virus (HCV) and HIV because of unsafe injection practices

Viral Hepatitis Outbreaks In Outpatient Settings (n=16) Due to Unsafe Injection Practices 2001-2010

<table>
<thead>
<tr>
<th>Location</th>
<th>Year</th>
<th>Virus</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY Private MD office</td>
<td>2001</td>
<td>HCV</td>
</tr>
<tr>
<td>NY Private MD office</td>
<td>2001</td>
<td>HBV</td>
</tr>
<tr>
<td>NE Oncology Clinic</td>
<td>2002</td>
<td>HCV</td>
</tr>
<tr>
<td>OK Pain Clinic</td>
<td>2002</td>
<td>HBV + HCV</td>
</tr>
<tr>
<td>NY Endoscopy Clinic</td>
<td>2002</td>
<td>HCV</td>
</tr>
<tr>
<td>NY Endoscopy Clinic</td>
<td>2006</td>
<td>HBV + HCV</td>
</tr>
<tr>
<td>NY Pain Clinic</td>
<td>2007</td>
<td>HCV</td>
</tr>
<tr>
<td>NV Endoscopy Clinic</td>
<td>2008</td>
<td>HCV</td>
</tr>
<tr>
<td>NJ Oncology Clinic</td>
<td>2009</td>
<td>HCV</td>
</tr>
<tr>
<td>CA Pain Clinic</td>
<td>2010</td>
<td>HCV + HBV</td>
</tr>
</tbody>
</table>

“One and Only Campaign”

Our story – one of 125,000 stories
What happened to the victims?
- 6 deaths from HCV, not cancer
- 33 antiviral therapy, 28 achieved SVR
- 1 sexually acquired HCV
- 89 lawsuits, $16M paid from NELF
- Conflict and complicated grief

What went wrong?

Emotional Impact

HONORenberg Foundation

- Educates regarding safe injection practices
- Advocates legislative/regulatory options
- SIPC has launched a health education campaign

These entities strive to prevent outbreaks

Three-pronged approach to safety

Alliance for Injection Safety
Compassionate Response Toolkit


Mission of “One and Only Campaign”

• Educate providers
• Empower medical consumers
• Both should insist on nothing less than “One needle, One syringe, Only one time.”

Parents’ horror as they are told to test their infants for HIV after flu vaccine mix-up

Injection Practices Among Clinicians in US Healthcare Settings

Pugliese G, Gosnell C, Bartley JM, Robinson S.
Injection practices among clinician in US hospitals.
American Journal of Infection Control Dec 2010
Download results at www.premierinc.com/injectionpractices

Acceptable Practices WITH Aseptic Technique

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you administer a medication in a syringe that was prepared by someone else?</td>
<td>71%</td>
<td>70%</td>
<td>34%</td>
</tr>
<tr>
<td>How often do you enter a single dose/single use vial more than once to obtain additional doses for same patient?</td>
<td>70%</td>
<td>30%</td>
<td>66%</td>
</tr>
<tr>
<td>How often do you use multi-dose vials for more than one patient?</td>
<td>34%</td>
<td>66%</td>
<td></td>
</tr>
</tbody>
</table>

Inappropriate practices NOT consistent with guidelines

<table>
<thead>
<tr>
<th>Practice</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use a single dose vial for more than one patient?</td>
<td>94%</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td>Administer medication to more than one patient using the same syringe but a new sterile needle for each patient?</td>
<td>99%</td>
<td>~1.0%</td>
<td>9%</td>
</tr>
<tr>
<td>Use a bag or bottle of intravenous solution as a source of supply or as a medication diluent for more than one patient?</td>
<td>94%</td>
<td>9%</td>
<td>91%</td>
</tr>
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Download at www.premierinc.com/injectionpractices
**Inappropriate practices** NOT consistent with guidelines

<table>
<thead>
<tr>
<th>Action</th>
<th>Never (85%)</th>
<th>Sometimes (15%)</th>
</tr>
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<tr>
<td>Reuse a syringe to obtain additional doses from SAME multi-dose vial for the SAME patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposition of vial by the 15% who reuse syringe to re-enter the vial for same patient</td>
<td></td>
<td></td>
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</table>

- **Discard vial** 93.5%
- **Leave for another patient** 6.5% (51)

**Mistaken beliefs about practices to prevent contamination and infection transmission**

- Changing the needle between patients (not the syringe)
- Injecting through IV tubing
- Maintaining pressure on the plunger to prevent backflow
- Lack of visible blood
- Large single-dose vials are ok for more than one patient

**Consumer Empowerment Barriers**

- Goes against traditional doctor/patient relationship
- Some don’t want to be challenged
- Patients are intimidated
- Patients have other pressing health concerns

**Impact on Public Health Agencies**

- Time/personnel
- Investigation
- Patient Notification
- Alerting Media

**Financial Impact on Public Health Agencies**

- In the 2008 Nevada outbreak, the estimated total public health cost including investigation, testing, and medical counseling was $16 million to $21 million.

**We need to change the culture**

- Perceptions of cost containment
- Culture of complacency
- Educate and dispel myths about sterile technique and risks
- Empower staff AND patients to “speak up”
CDC guidelines, education, training
www.cdc.gov/injectionsafety

Safe Injection Practices Coalition and the
One and only Campaign
www.oneandonlycampaign.org
• Education, outreach materials for patients and staff
• Brochures
• Training videos

Engineering “out” Human Error

Download brochures at
www.oneandonlycampaign.org

For More Information
• HONORem Foundation:
  http://www.honoreform.org/
• Premier healthcare alliance:
  http://www.premierinc.com/
• The One and Only Campaign:
  http://www.oneandonlycampaign.org
• CDC Injection Safety:
  http://www.cdc.gov/injectionsafety/
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*Thank you!*