

1 ONE NEEDLE,
ONE SYRINGE,
ONLY ONE TIME.



Safe Injection Practices Coalition
www.ONEandONLYcampaign.org

Injection Safety

Every Provider's Responsibility

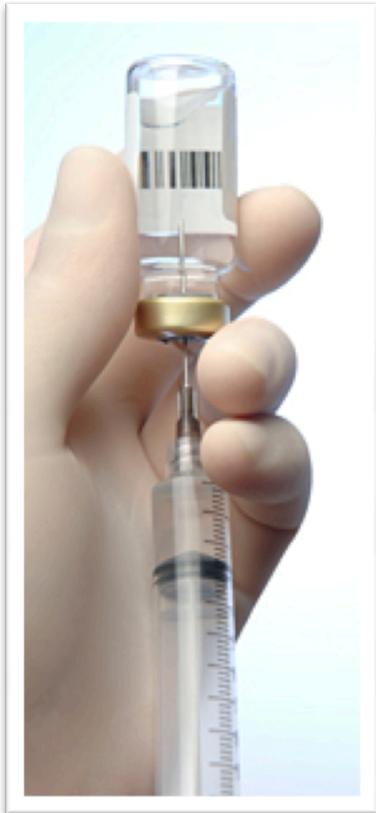


Outline

- Safe Injection Practices
- The ONE and ONLY Campaign
- Outbreak History
- Mistaken Beliefs
- A Call to Action
- Resources and Information



Why Unsafe Injection Practices Are Unacceptable



- Injection safety is part of Standard Precautions
- Healthcare practices should not provide a pathway for transmission of life-threatening infections
- Patient protections regarding injection safety should be on par with healthcare worker safety



Three Things Every Provider Needs to Know About Injection Safety

1. Needles and syringes are single use devices. They should not be used for more than one patient or reused to draw up additional medication.
2. Do not administer medications from a single-dose vial or IV bag to multiple patients.
3. Limit the use of multi-dose vials and dedicate them to a single patient whenever possible.

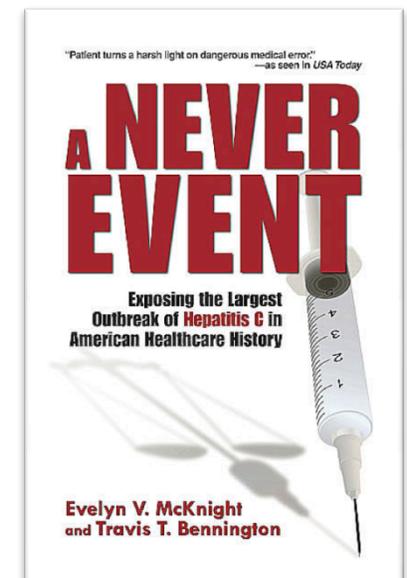


Evelyn McKnight's Story

Dr. Evelyn McKnight, mother of three, was battling breast cancer and was infected with hepatitis C during treatment because of syringe reuse to access saline flush solution.

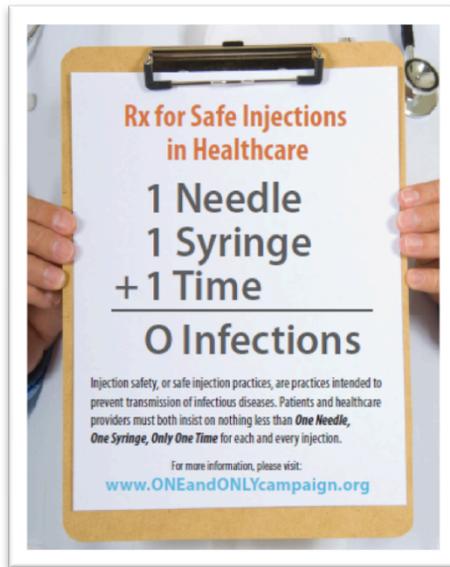
Along with Evelyn, a total of 99 cancer patients were infected in what was one of the largest outbreaks of hepatitis C in American healthcare history.

Evelyn co-founded HONORreform, a foundation dedicated to improving America's injection safety practices, and was the catalyst of the formation of the Safe Injection Practices Coalition.



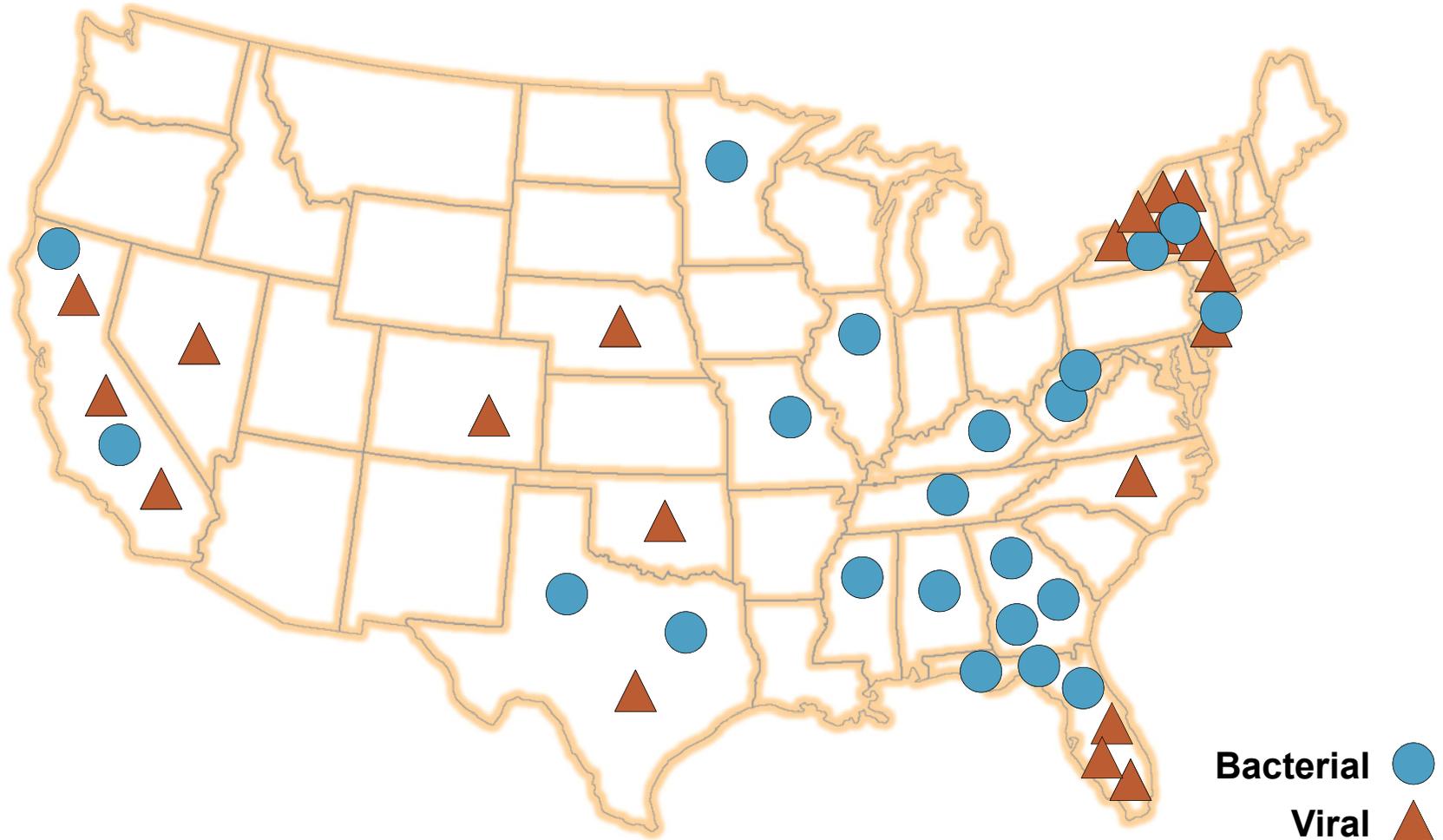


The ONE and ONLY Campaign



- Launched in response to outbreaks resulting from unsafe injection practices
- Led by the Centers for Disease Control and Prevention (CDC) and the Safe Injection Practices Coalition
- Goals
 - Increase understanding and implementation of safe injection practices among healthcare providers
 - Ensure patients are protected each and every time they receive a medical injection

U.S. Outbreaks Associated with Unsafe Injection Practices, 2001-2011





Over 125,000 patients were notified as a result of incidents and outbreaks involving unsafe injections practices



City alerts 450 patients of Hylan Boulevard clinic to hepatitis C Concern

June 17, 2011



Nurse accused of stealing pain meds gets probation

September 20, 2011

MailOnline

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

April 13, 2011



NJ doctor loses license after hepatitis B outbreak

September 15, 2011



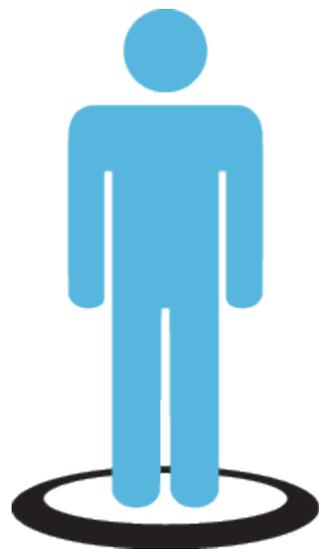
Injection Practices Among Clinicians in United States Health Care Settings

- Survey of 5,500 U.S. healthcare professionals
- 1 percent “sometimes or always” reuse a syringe on a second patient
- 1 percent “sometimes or always” reuse a multidose vial for additional patients after accessing it with a used syringe
- 6 percent use single-dose/single use vials for more than one patient



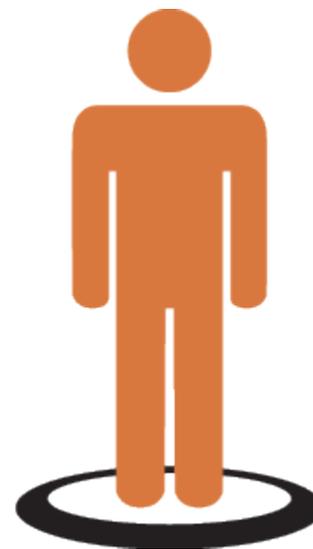
When Safe Practices are Used...

Each Patient is an Island



SOURCE

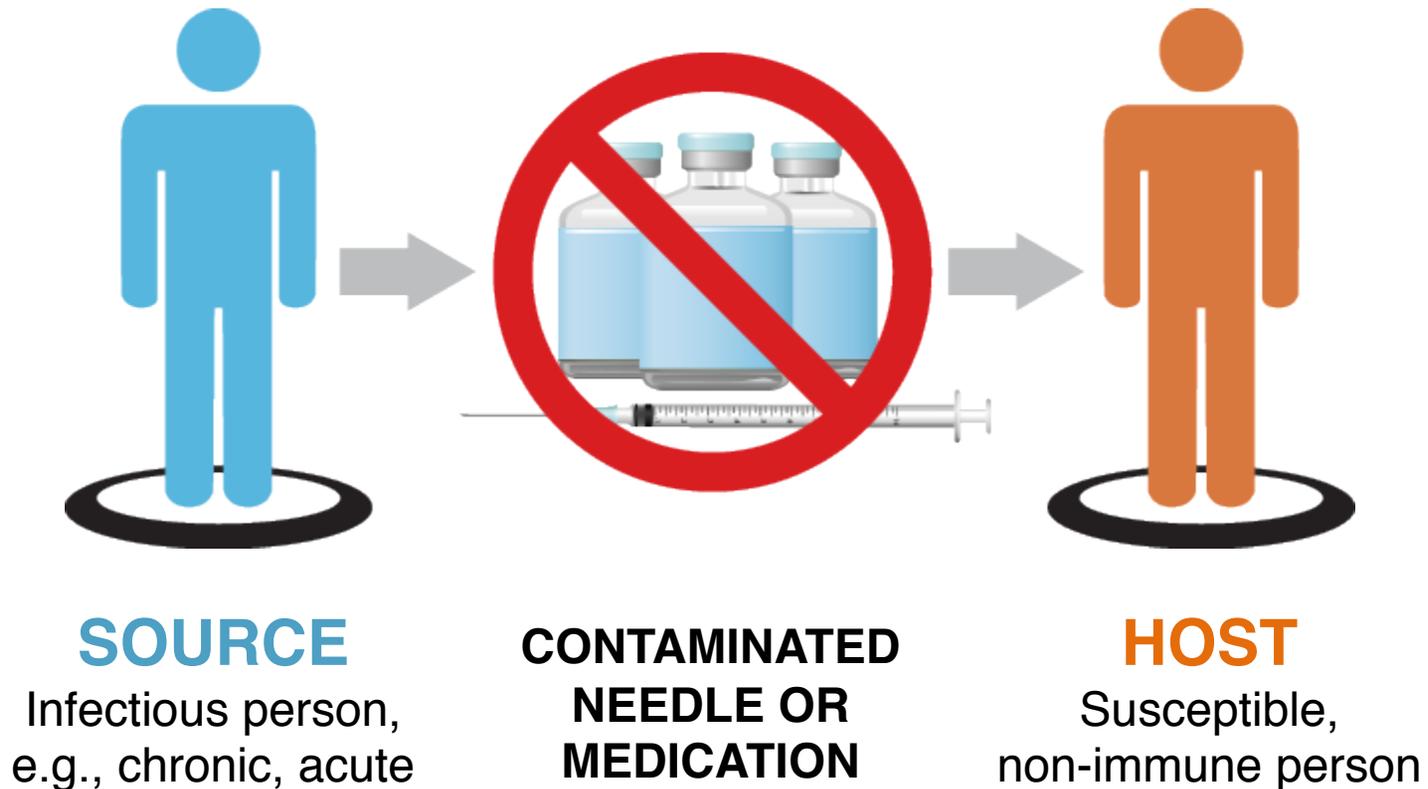
Infectious person,
e.g. chronic, acute



HOST

Susceptible,
non-immune person

Unsafe Injection Practices Can Lead to Transmission of Life-Threatening Infections



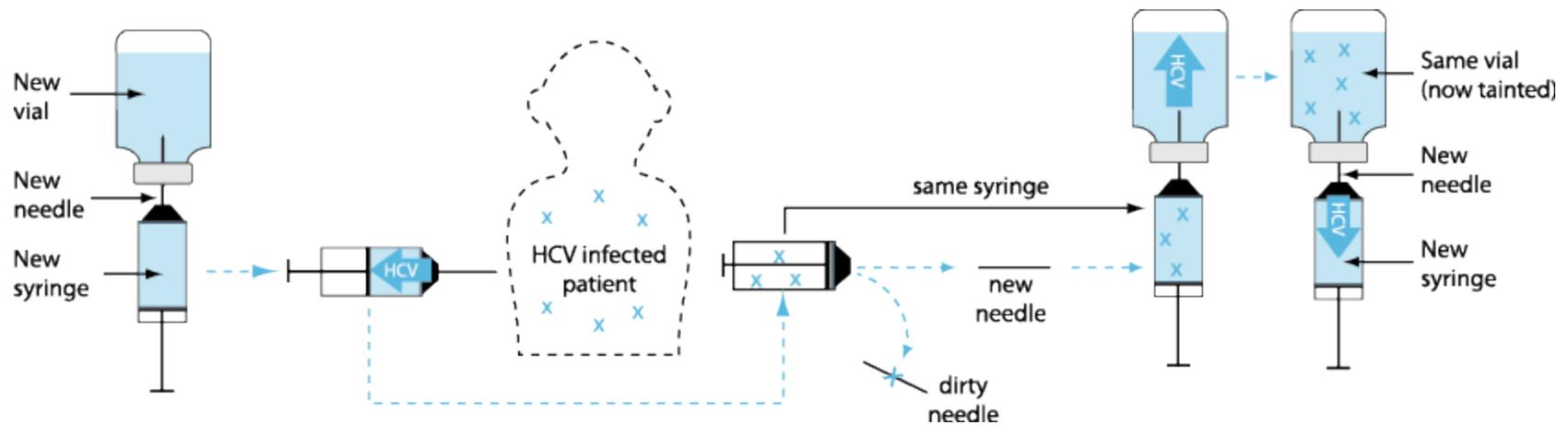
LIMIT OR ELIMINATE REUSE



Las Vegas, Nevada Outbreak, 2008

- Cluster of three acute HCV infections identified in Las Vegas
- All three patients underwent procedures at the same endoscopy clinic during the incubation period
- Two breaches contributed to transmission:
 - Re-entering vials with used syringes
 - Using contents from these single-dose vials on more than one patient

Las Vegas, Nevada Outbreak, 2008



Adapted from MMWR (May 16, 2008 / 57(19);513-517)



Insulin Pen Reuse Incidents

- Reuse of insulin pens for multiple patients, reportedly after changing needles has resulted in large notifications
 - NY hospital, 2008: 185 patients notified
 - TX hospital, 2009: 2,114 patients notified
 - WI hospital and outpatient clinic, 2011: 2,401 patients notified





True or False?

“I’m preventing contamination and infection transmission as long as I’m...”

“...changing the needle between patients.”  **FALSE**

“...injecting through intervening lengths of intravenous tubing.”  **FALSE**

“...maintaining pressure on the plunger to prevent backflow of body fluids.”  **FALSE**

“...not able to observe contamination or blood.”  **FALSE**



Unsafe Injection Practices Result In...

- Patients placed at risk for life-threatening infections
- Referral of providers to licensing boards for disciplinary action
- Legal actions such as malpractice suits filed by patients
- CMS and The Joint Commission have begun assessing injection practices as part of facility inspections



A Call to Action

- Injection practices should not provide a pathway for transmission of life-threatening infections
- Injection safety is every provider's responsibility
- Safe injection practices should be discussed and reviewed frequently among colleagues





Injection Safety Checklist

INJECTION SAFETY CHECKLIST

The following Injection Safety checklist items are a subset of items that can be found in the CDC *Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care*.

The checklist, which is appropriate for both inpatient and outpatient settings, should be used to systematically assess adherence of healthcare personnel to safe injection practices. (Assessment of adherence should be conducted by direct observation of healthcare personnel during the performance of their duties.)

Injection Safety	Practice Performed?	If answer is No, document plan for remediation
Injections are prepared using aseptic technique in a clean area free from contamination or contact with blood, body fluids or contaminated equipment	Yes No	
Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens)	Yes No	
The rubber septum on a medication vial is disinfected with alcohol prior to piercing	Yes No	
Medication vials are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient	Yes No	
Single dose (single-use) medication vials, ampules, and bags or bottles of intravenous solution are used for only one patient	Yes No	
Medication administration tubing and connectors are used for only one patient	Yes No	
Multi-dose vials are dated by HCP when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial <small>Note: This is different from the expiration date printed on the vial.</small>	Yes No	
Multi-dose vials are dedicated to individual patients whenever possible.	Yes No	
Multi-dose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g., operating room, patient room/cubicle) <small>Note: If multi-dose vials enter the immediate patient treatment area they should be dedicated for single-patient use and discarded immediately after use.</small>	Yes No	

RESOURCES

Checklist: <http://www.cdc.gov/HAI/pdfs/guidelines/ambulatory-care-checklist-07-2011.pdf>
 Guide to Infection Prevention for Outpatient Settings: *Minimum Expectations for Safe Care*:
<http://www.cdc.gov/HAI/pdfs/guidelines/standards-of-ambulatory-care-7-2011.pdf>



www.oneandonlycampaign.org

www.cdc.gov/injectionsafety



Resources and Information

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Materials Available for Order

One & Only Campaign Materials For Order Via CDC-INFO



Safe Injection Practices DVD
Item 22-0087



Rx for Safe Injections Poster
Item 22-0696



It's Elementary Poster
Item 22-0697



Provider Brochure
Item 22-0702



Patient Brochure
Item 22-0701



Injection Safety Pocket Card
Item 22-0713



Logo Poster for Providers
Item 22-0700



Logo Poster for General Public
Item 22-0699



Injection Safety Dangerous Misperceptions Flyer
Item 22-1170



Injection Safety Healthcare Provider Checklist
Item 22-1176



Injection Safety Healthcare Provider Toolkit
Item 22-1177

How to Order



SCAN
Scan with your Smartphone to access the ordering page

CALL
1-800-CDC-INFO

CLICK
<http://www.cdc.gov/pubs/dhqp.aspx>

1-800-CDC-INFO