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An historic 'Never Event':

How can we prevent others?

There is nothing to disclose

Evelyn V McKnight, AuD
Thomas A McKnight MD

www.HONOReform.org

Learning Objectives

***Learners will be able to*:**

List causes of unsafe injections

List methods to foster a safety culture

Describe a way to mitigate unsafe technique

List current safety incentives

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Our story

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What happened?

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What happened to the victims?

99 cases of HCV

6 deaths

89 lawsuits

$12M from NELF

Mailliard et al. Outcomes of a patient to patient transmission of Genotype 3A. *Hepatitis C. Hepatology* 2009; 50; 361-368.

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What happened to the doctor?

- *Elected to Punjab province legislature*
- *Currently petitioning for re-licensure in New York*

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What happened to the nurse?

- *At last word, was working at an Omaha hospital; no direct patient contact*
- *Petitioned for licensure reinstatement; denied*

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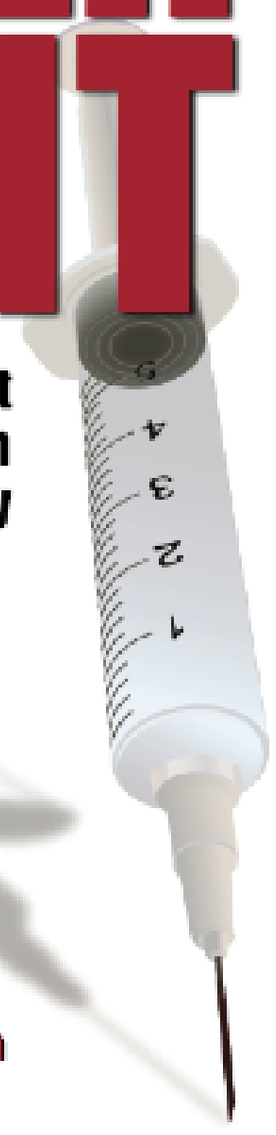
"Patient turns a harsh light on dangerous medical error."
—as seen in *USA Today*

A NEVER EVENT



Exposing the Largest Outbreak of Hepatitis C in American Healthcare History

Evelyn V. McKnight
and Travis T. Bennington

ANeverEvent.com

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Disease Transmission in the US

“Healthcare-Associated Hepatitis B and C Outbreaks Reported to the CDC in 2008-2013”
www.cdc.gov/hepatitis/Outbreaks/HealthcareHepOutbreakTable.htm

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Still happening in 2018

Syringe reuse incident in St. Paul rare but concerning

Misconceptions and cost savings still drive some providers to reuse.

By **Jeremy Olson** Star Tribune | MARCH 17, 2018 — 10:47PM

CARLOS GONZALEZ, STAR TRIBUNE

A national survey last year found that 12 percent of physicians believed that syringes had been reused in their facilities.

An unnerving case of a St. Paul nurse practitioner reusing syringes and exposing 161 patients to infection risk shows that unsafe injection practices still occur in U.S. health care. But the reasons remain a mystery.

http://www.startribune.com/syringe-reuse-incident-rare-but-concerning/477179573/

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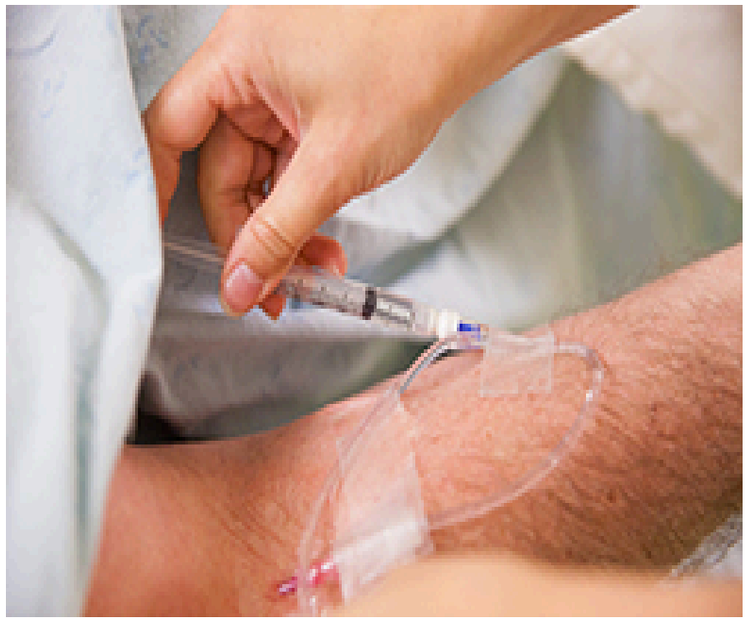
Still happening in 2018

Did Hospital Reuse HIV Patient's Syringe to Administer Anesthesia?

A patient is suing a Chicago hospital, claiming that during his surgery staff members reused a syringe that had been used on an HIV-positive patient.

The patient, who remained anonymous and was only listed as John Doe in the Jan. 17 complaint, says he went to Northwestern Memorial Hospital in Chicago, Ill., in February 2017, for a hernia repair. During his procedure, a staff member at the hospital, who is unnamed in the suit, gave him anesthesia with a used syringe, according to a copy of the lawsuit. The syringe had been used before on a patient who was "known to be HIV-positive," the suit says.



CONTAMINATED The patient argues the hospital staff put him at risk by reusing a needle that had been used on someone who was HIV-positive.

http://www.outpatientsurgery.net/newsletter/eweekly/2018/01/23#2

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Still happening in 2018

Puyallup hospital links nurse to 2 patients infected with hepatitis C; 2,600 patients urged to seek testing

BY SEAN ROBINSON
sean.robinson@thenewstribune.com

April 30, 2018 03:57 PM
Updated May 01, 2018 02:39 PM

A nurse suspected of stealing injectable drugs and infecting at least two patients with hepatitis C at Puyallup's MultiCare Good Samaritan Hospital was "surprised" to learn that she had contracted the disease herself, hospital leaders said Monday.

The linkage between the emergency department nurse and the patients, identified in late March after an internal investigation, led the hospital to announce a safety alert and a recommendation that 2,600 patients who might have interacted with the nurse seek treatment. How the disease might have been transmitted to the two patients is an open question.

http://www.thenewstribune.com/news/local/article210158984.html

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But why?

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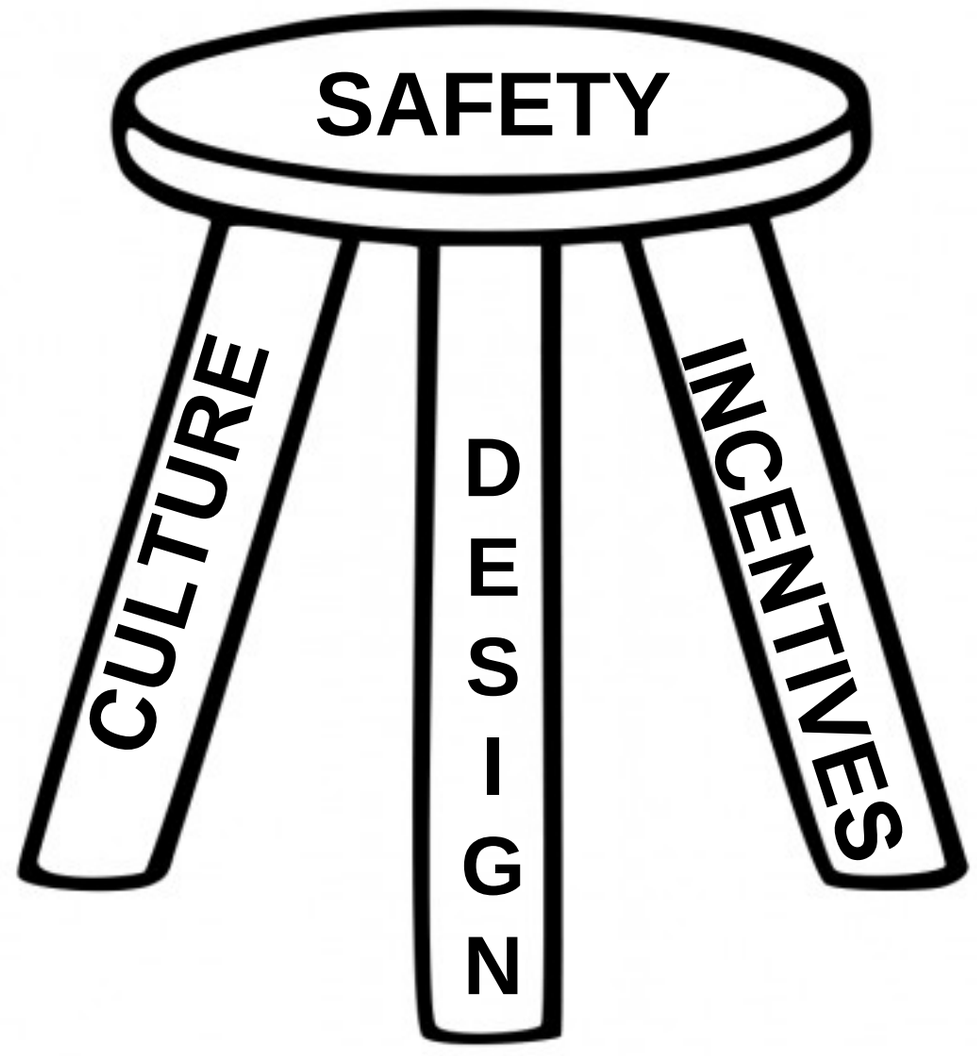
Improving patient safety



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Major causes of harm in the outbreak

- *Silo Culture*
- *Unsafe Technique*
- *Few Policy Incentives for Safety*

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Silo culture → Safety culture

- *"team behaviors improves safety culture…provides ability to adapt and learn"**
- ***AHRQ's TeamSTEPPS:*** *Strategies & Tools to Enhance Performance & Patient Safety*

*"I am **C**oncerned, I am **U**ncomfortable, This is a **S**afety Issue"*

*Jones, et al., *BMJ Quality & Safety,* 2013;22:394-404.

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Unsafe technique → Safety by design

- *mitigate unsafe technique*
- *focus in US has been on provider safety (needlestick prevention), but also fosters patient safety*

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Few incentives → Safety incentives

- *Private physician offices currently have less oversight than hospitals*
- *Sticks - only regulatory oversight is provider licensure*
- *Carrots - for ‘safe practices, malpractice insurers reduce premiums, third party payers increase reimbursement, PQRS*

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The only national advocacy organization dedicated to safeguarding the medical injection process

Our vision is a world in which healthcare providers always follow fundamental injection safety

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What we do -

- ***Educate Healthcare Providers and Patients***

- ***Advocate for injection safety policies at the local, state and federal level***

- ***Share Survivor Stories (HONOReform.org/blog)***

- ***Respond to Outbreaks***

- ***Promote the One and Only Campaign***

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www.ONEandOnlycampaign.org

Most accessed CDC Campaign in 2016
Bloodborne Pathogens Training Activity
Injection Safety Checklist
Injection Safety Training Videos
Infection Prevention Checklist for Outpatient Settings
Infection Control Plan for Outpatient Oncology
Resources to prevent Drug Diversion

www.cdc.gov/injectionsafety/

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SAFETY STEPS

FOLLOW THESE INJECTION SAFETY STEPS FOR SUCCESS!

BEFORE THE PROCEDURE

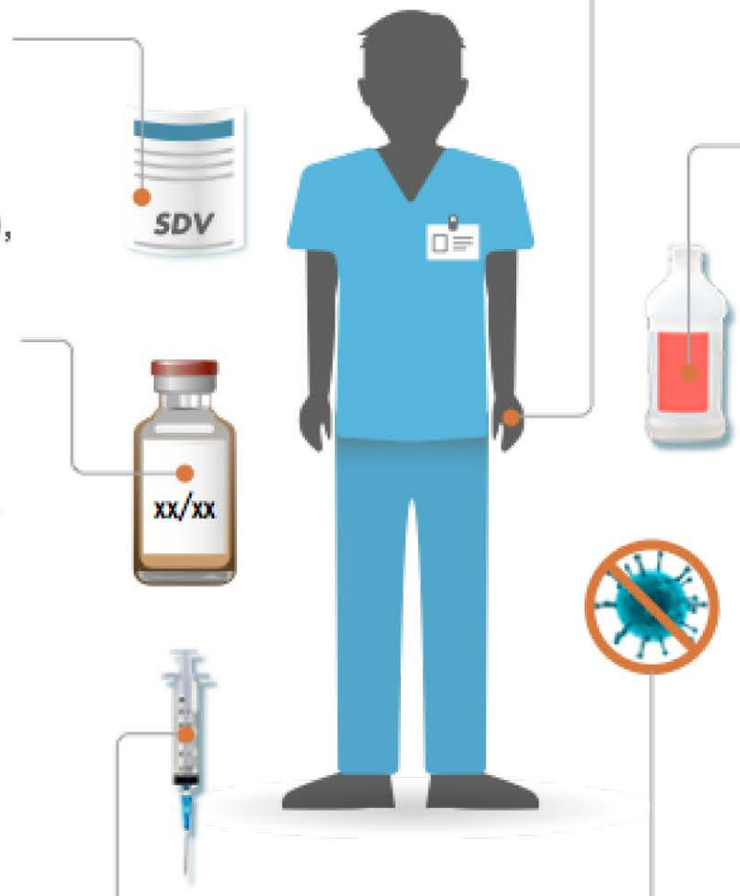
Carefully ***read the label*** of the vial of medication.

- If it says single-dose and it has already been accessed (e.g. needle-punctured), ***throw it away.***
- If it says multiple-dose, ***double-check the expiration date*** and the beyond-use date if it was previously opened, and visually inspect to ensure no visible contamination.
- When in doubt, throw it out.

DURING THE PROCEDURE

Use aseptic technique.

- Use a new needle and syringe for every injection.



- Be sure to clean your hands immediately before handling any medication.
- Disinfect the medication vial by rubbing the diaphragm with alcohol.
- Draw up all medications in a clean medication preparation area.

AFTER THE PROCEDURE

Discard all used needles and syringes and SDVs after the procedure is over.

MDVs should be discarded when:

- the beyond-use date has been reached
- doses are drawn in a patient treatment area
- any time vial sterility is in question

FAQs Regarding Safe Practices for Medical Injections:

www.oneandonlycampaign.org/content/healthcare-professional-faqs

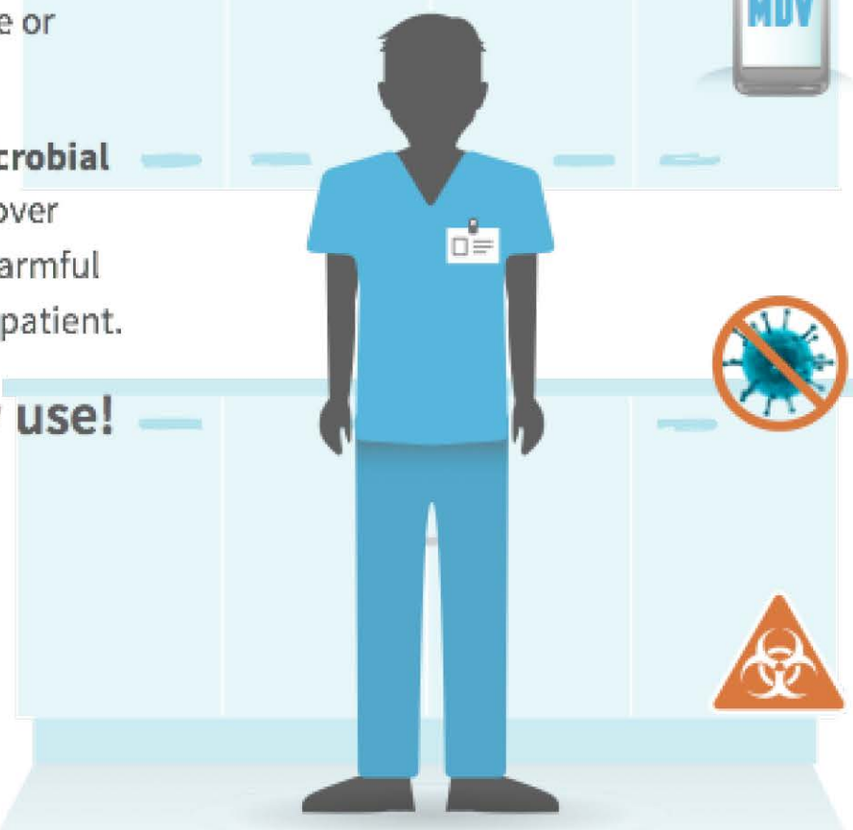
THE PROVIDER

DO YOU MULTI-DOSE?

A SINGLE-DOSE VIAL (SDV) is approved for use on a **SINGLE** patient for a **SINGLE** procedure or injection.

SDVs typically lack an antimicrobial preservative. Do not save leftover medication from these vials. Harmful bacteria can grow and infect a patient.

DISCARD after every use!



A MULTIPLE-DOSE VIAL (MDV) is recognized by its FDA-approved label.

Although MDVs can be used for more than one patient when aseptic technique is followed, ***ideally even MDVs are used for only one patient.***

MDVs typically contain an antimicrobial preservative to help limit the growth of bacteria. Preservatives have no effect on bloodborne viruses (i.e. hepatitis B, hepatitis C, HIV).

Discard MDVs when the beyond-use date has been reached, when doses are drawn in a patient treatment area, or any time the sterility of the vial is in question!

SIZE DOES NOT MATTER!

SDVs and MDVs can come in any shape and size. ***Do not assume*** that a vial is an SDV or MDV based on size or volume of medication. ***ALWAYS check the label!***

FAQs Regarding Safe Practices for Medical Injections:

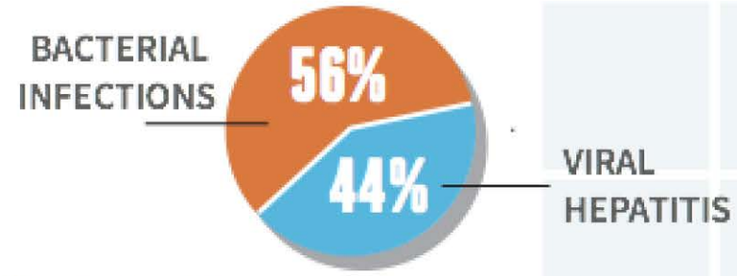
www.oneandonlycampaign.org/content/healthcare-professional-faqs

THE PATIENT

WE ARE ALL PATIENTS.

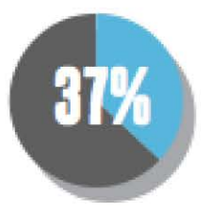
50 OUTBREAKS AND COUNTING

Since 2001, at least 50 outbreaks involving unsafe injection practices were reported to CDC

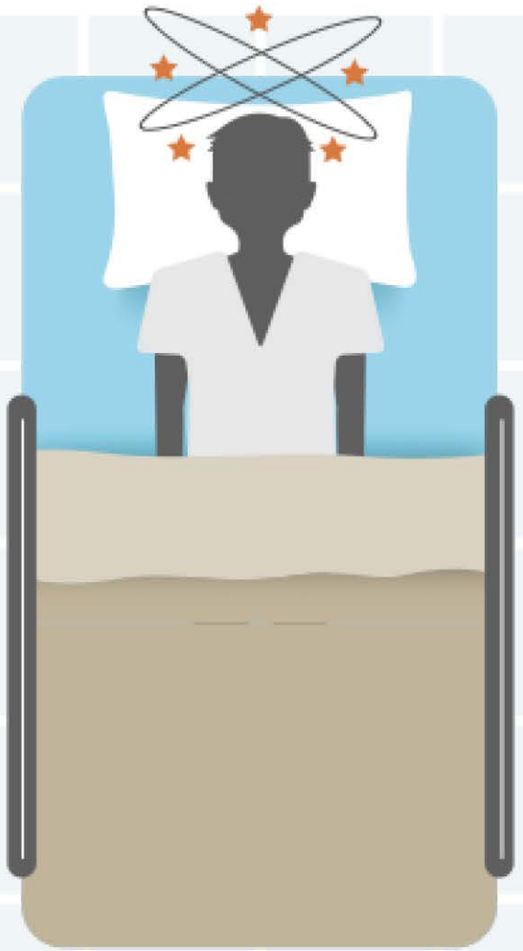


- 90% (n=45) occurred in outpatient settings
- Many hundreds of infected patients
- Over 150,000 patients notified and tested

6% of U.S. health professionals have admitted to using single-dose vials for ***more than one patient.***



A recent study showed that 37% of new hepatitis infections in older adults may be due to unsafe medical injections.



3 QUESTIONS EVERY PATIENT SHOULD BE ENCOURAGED TO ASK:

As a provider, be prepared to answer your patients' questions about safe injection practices.

Did you wash your hands?

Did you use a clean needle and syringe to draw up this medication?

Is this medication from a single-dose vial? Have you used this vial of medication on another person?

Thank you!

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HONOReform is a nonprofit organization working to safeguard the injection process for caregivers and patients.

How You Can Help:

Use resources at OneandOnlyCampaign.org

Sign up for e-newsletter at www.HONOReform.org

Follow us on Twitter, Like us on Facebook

Recommend us for a presentation

Recommend *A Never Event* to others

www.HONOReform.org

www.OneandOnlyCampaign.org

www.ANeverEvent.com