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PROFESSION

Coalition pushes for safe injection practices

Reuse of syringes has led to outbreaks of infectious diseases such as hepatitis C.

By KEVIN B. O'REILLY, amednews staff. *Posted May 11, 2011.*

More education and research and superior product designs are needed to end unsafe injection practices that have led to 30 infectious-disease outbreaks in the last 10 years, said a coalition of physicians, nurses, manufacturers and government officials.

In the last decade, more than 125,000 patients have been notified about potential exposure to infectious diseases such as hepatitis C due to reuse of syringes, according to the Safe Injection Practices Coalition, which was formed in 2008. Along with Premier, an alliance of more than 2,500 U.S. hospitals, the coalition co-sponsored an April 26 meeting in Washington, D.C., to discuss the problem (**www.premierinc.com/quality-safety/tools-services/safety/topics/safe_injection_practices/meeting.jsp**).

"These are largely preventable medical errors -- they are not so different from wrong-side surgery," said Joseph Perz, DrPH, who leads the prevention team in the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention, a member of the coalition.

"Safe injection practices are something that we should all be able to take for granted. The health care system should be able to guarantee safety in this regard."

Nearly 30% of 68 ambulatory surgery centers studied in Maryland, North Carolina and Oklahoma had safety lapses in medication handling and injection practices, according to a June 9, 2010, study in *The Journal of the American Medical Association* (**www.jama.ama-assn.org/content/303/22/2273.short**).

Six percent of nurses and other health professionals said they "sometimes or always" use single-use or single-dose vials for more than one patient, contradicting CDC guidelines, according to a survey of 5,446 health professionals reported in the December 2010 *American Journal of Infection Control* (**www.ncbi.nlm.nih.gov/pubmed/21093696/**). About 1% said they reuse a syringe but change the needle for the second patient, which experts say is unsafe because the syringe can become contaminated.

In May 2010, as part of its "One and Only Campaign," the coalition launched an educational video to address misconceptions among health professionals about injection safety (**www.oneandonlycampaign.org/videos/**). CD copies of the video can be ordered for free. But coalition officials said injection safety should be taught earlier, in medical, nursing and other health professions schools. Also, more research is needed to understand why health professionals do not always heed guidelines.

Safer syringes

Making injection products more mistake-proof is part of the solution, Perz said.

"We need to acknowledge that humans are prone to error," he said. "How can we take human error out of the equation? How can we promote innovations in product design, marketing, packaging and appropriate selection of devices?"

For example, one participant in the coalition meeting was Star Syringe, a British firm that makes a syringe that is automatically disabled when the medication dose is delivered.

Also needed, officials said, is a way to help organizations calculate the costs of quality mishaps to help confront syringe reuse as a money-saving strategy.

"In some facilities, cost becomes a huge issue," said Susan Dolan, RN, an epidemiologist at Children's Hospital in Denver and a representative of another member of the coalition, the Assn. for Professionals in Infection Control and Epidemiology. "We need to change those misperceptions, because that's when some unsafe practices can occur."

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