



Preventing Employee Infections

Basics of Infection Prevention

2-Day Mini Course

May 2018





OBJECTIVES

At the conclusion of this presentation, participants will be able to:

- Discuss vaccines offered to healthcare workers in long-term care
- Describe the relationship between Infection Prevention and Employee Health
- Understand the implications of drug diversion with regard to infection transmission and outbreaks
- Discuss two risks associated with unsafe injection practices
- List three safe injection practices
- List two bloodborne pathogens and two ways to protect healthcare workers
- Discuss two risk strategies to prevent the spread of aerosol transmissible diseases



EMPLOYEE HEALTH





HEALTHCARE WORKERS

Carrier of
Infection to
Residents

The diagram consists of two red arrows pointing in opposite directions, connected at their tails. The left arrow points left and contains the text "Carrier of Infection to Residents". The right arrow points right and contains the text "Recipient of Infection from Residents".

Recipient of
Infection from
Residents



INFECTION PREVENTION AND EMPLOYEE HEALTH

Goal



Safe



Free of
Infection

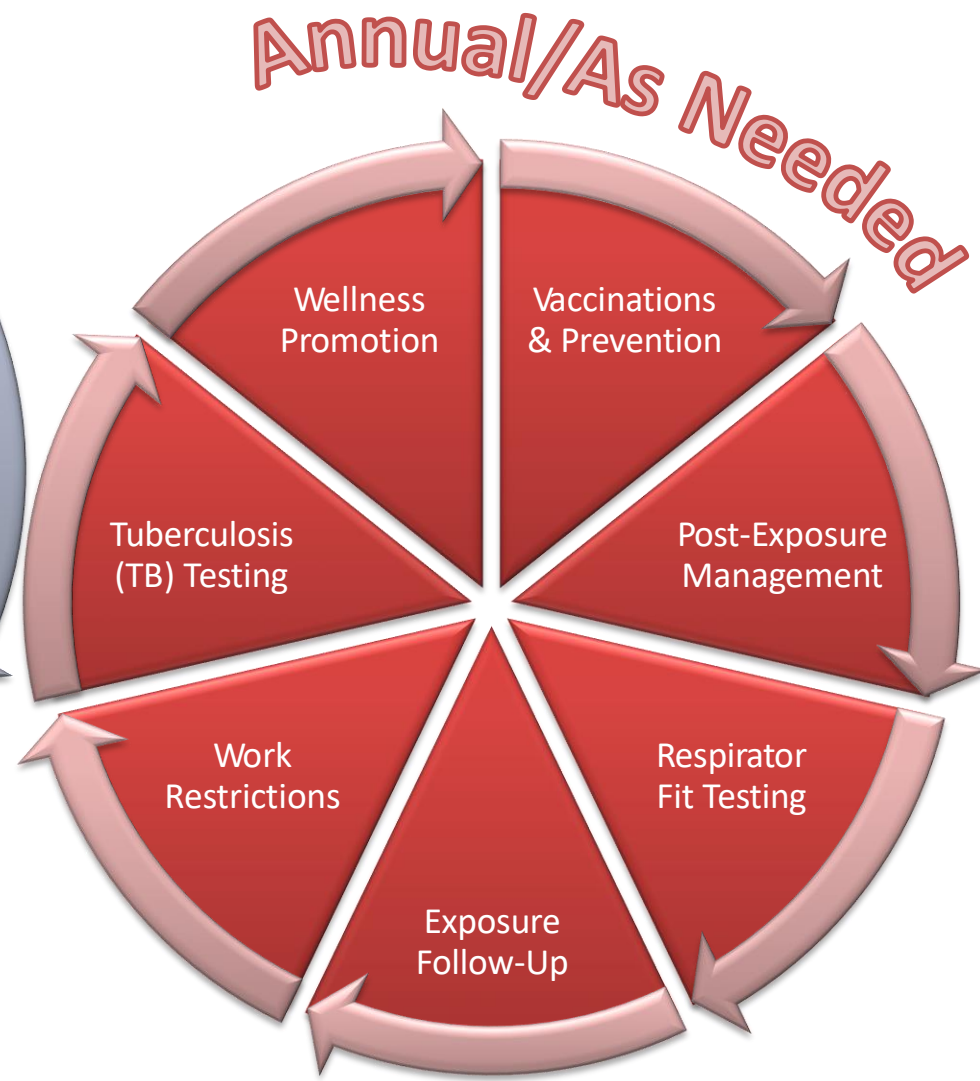
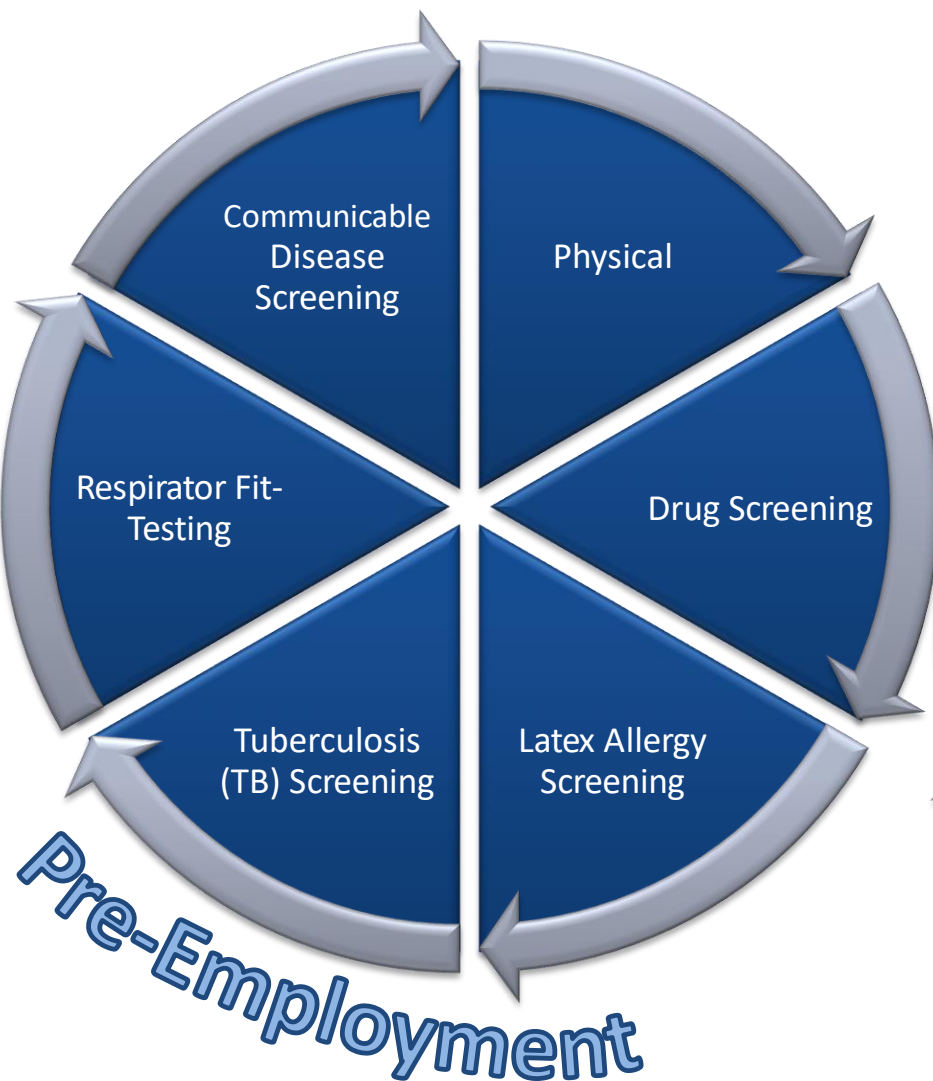


Employee
Health

Infection
Prevention

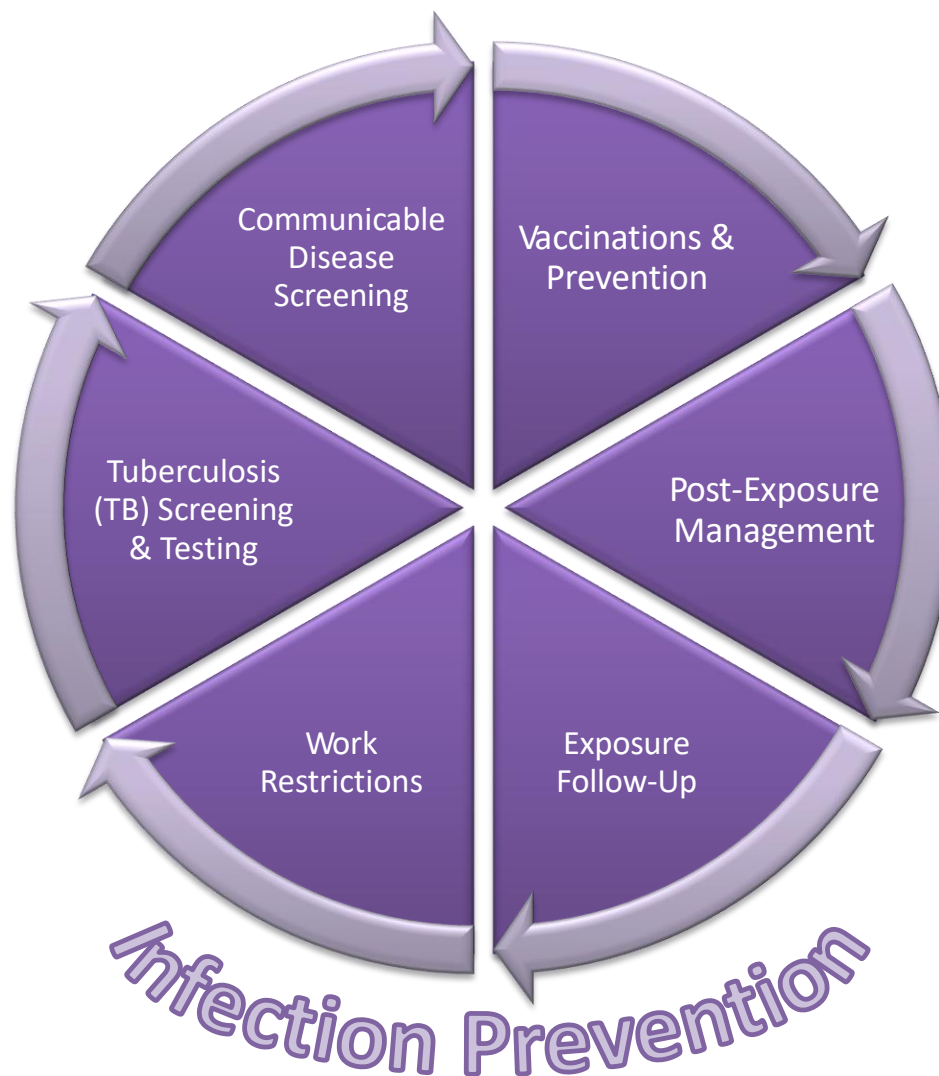


EMPLOYEE HEALTH RESPONSIBILITIES





EMPLOYEE HEALTH RESPONSIBILITIES





IMMUNIZATIONS



**KEEP
CALM
AND
VACCINATE**



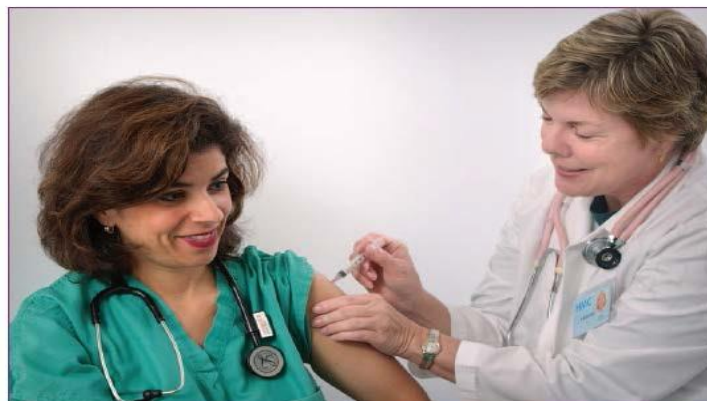
HEALTHCARE WORKER (HCW)* IMMUNIZATION

*ALSO REFERRED TO AS HEALTH CARE PERSONNEL (HCP)

Centers for Disease Control and Prevention
MMWR
Recommendations and Reports / Vol. 60 / No. 7

Morbidity and Mortality Weekly Report
November 25, 2011

Immunization of Health-Care Personnel Recommendations of the Advisory Committee on Immunization Practices (ACIP)



Continuing Education Examination available at <http://www.cdc.gov/mmwr/cme/conted.html>.





VACCINATIONS FOR EMPLOYEES

According to Section 5199 of Title 8³:

- All employees with potential occupational exposure to ATDs will be offered appropriate vaccinations at no cost to the employee upon hire or 10 working days prior to performing tasks determined to be at risk
- Vaccinations are to be given to employee at a time and place convenient to the employee
- Facilities to cover the cost of employee vaccinations



HEALTHCARE WORKER (HCW) IMMUNIZATION

VACCINE	INDICATIONS	SCHEDULE
Hepatitis B	No documented evidence of a complete Hep B vaccine series, or no up-to-date blood test demonstrating immunity to Hepatitis B (i.e., no serologic evidence of immunity or prior vaccination)	<ul style="list-style-type: none"> • 3-dose series <ul style="list-style-type: none"> • #1 now • #2 in 1 month • #3 approximately 5 months after #2 • Anti-HBs serologic test 1-2 months after dose #3
Influenza	All employees	<ul style="list-style-type: none"> • 1 dose annually
MMR (Measles, Mumps, Rubella)	Employees born in 1957 or later and have not had the MMR vaccine or who don't have an up-to-date blood test indicating immunity to Rubella	<ul style="list-style-type: none"> • 1 dose
Varicella (Chickenpox)	Employees who have not had Varicella, Varicella vaccine, or who don't have an up-to-date blood test that shows immunity to Varicella (i.e., no serologic evidence of immunity or prior vaccination)	<ul style="list-style-type: none"> • 2 doses, 4 weeks apart
Tdap (Tetanus, Diphtheria, Pertussis)	Employees who have not received Tdap previously (regardless of when previous dose of Td was received)	<ul style="list-style-type: none"> • 1 dose • Td boosters every 10 years thereafter • Pregnant HCWs – 1 dose during each pregnancy
Meningococcal	Employees who are routinely exposed to isolates of <i>N. meningitidis</i>	<ul style="list-style-type: none"> • 1 dose

HEALTHCARE WORKER (HCW) IMMUNIZATION: HEPATITIS B



Hepatitis B

Hepatitis B

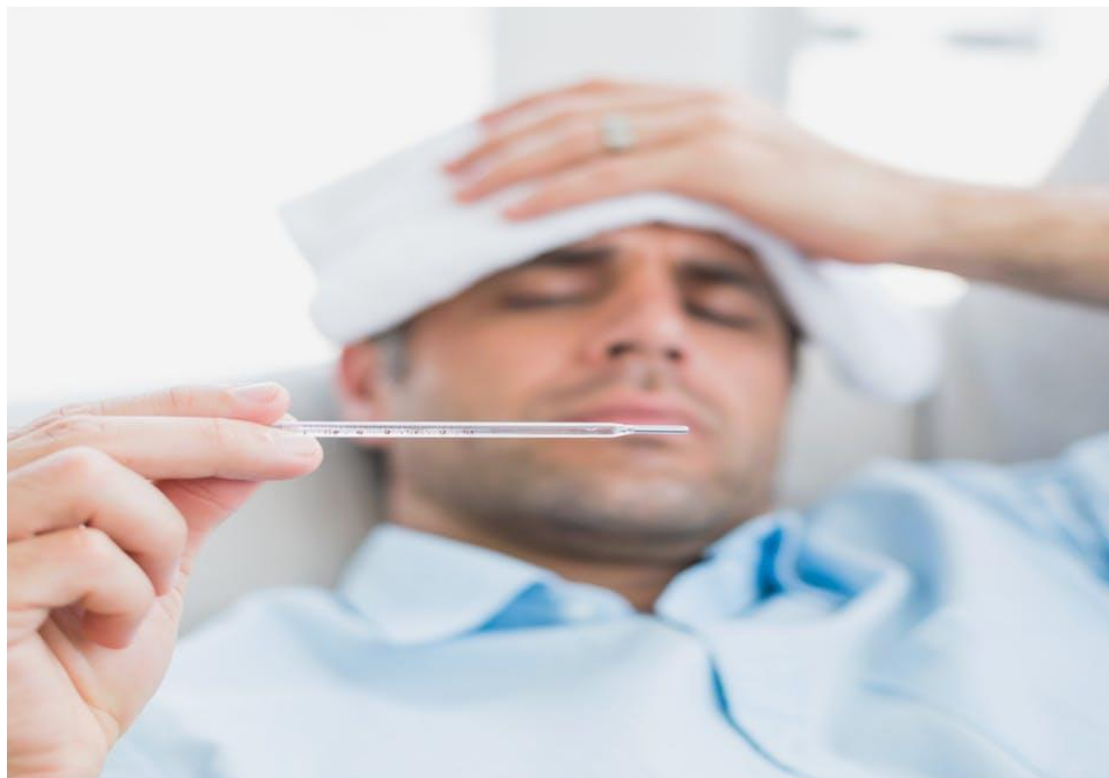
- Serious disease
- Caused by Hepatitis B virus (HBV)
- Attacks the liver
- Can cause chronic illness, cirrhosis of liver, liver cancer, liver failure, death
- Spread by blood-to-blood contact
- Symptoms:
 - Jaundice
 - Yellowing of eyes
 - Dark urine
 - Abdominal pain, nausea
 - Fatigue

Prevention

- Hepatitis B vaccine
 - 3 doses



HEALTHCARE WORKER (HCW) IMMUNIZATION: INFLUENZA



Influenza

Influenza (flu)

- Very contagious respiratory illness
- Caused by Influenza viruses
 - Infect nose, throat, lungs
 - Cause mild to severe illness, sometimes death
- Spread by droplets
- Symptoms:
 - Fever
 - Chills
 - Cough
 - Sore throat
 - Runny or stuffy nose
 - Headache
 - Muscle or body aches
 - Tiredness
 - Vomiting and/or diarrhea

Prevention

- Annual flu vaccine
- Safe; minimal side effects

HEALTHCARE WORKER (HCW) IMMUNIZATION: MEASLES, MUMPS, RUBELLA (MMR)



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Measles

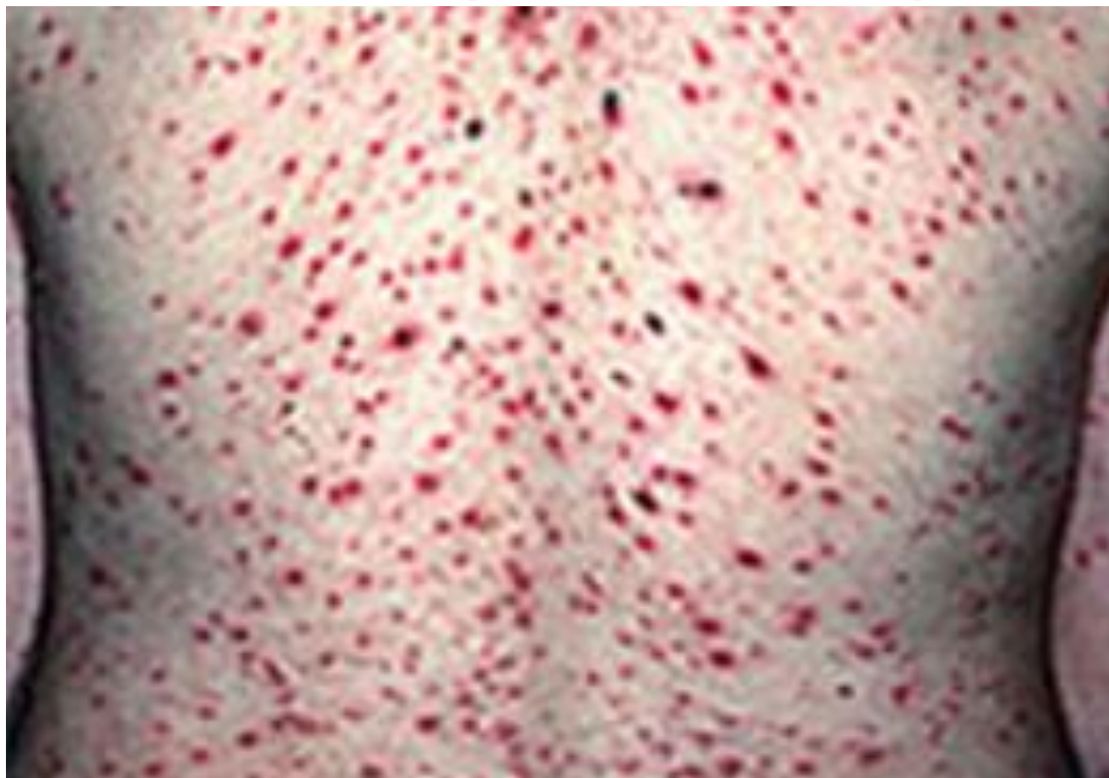
Measles

- Very contagious disease
- Caused by Measles virus
- Spread by aerosols from coughing, sneezing
- Symptoms:
 - Fever
 - Cough
 - Runny nose
 - Red eyes
 - Rash (starts at head)

Prevention

- MMR vaccine (Measles, Mumps, Rubella)
- Safe and effective
- 2 doses - 97% effective
- 1 dose - 93% effective

HEALTHCARE WORKER (HCW) IMMUNIZATION: VARICELLA (CHICKENPOX)



Varicella

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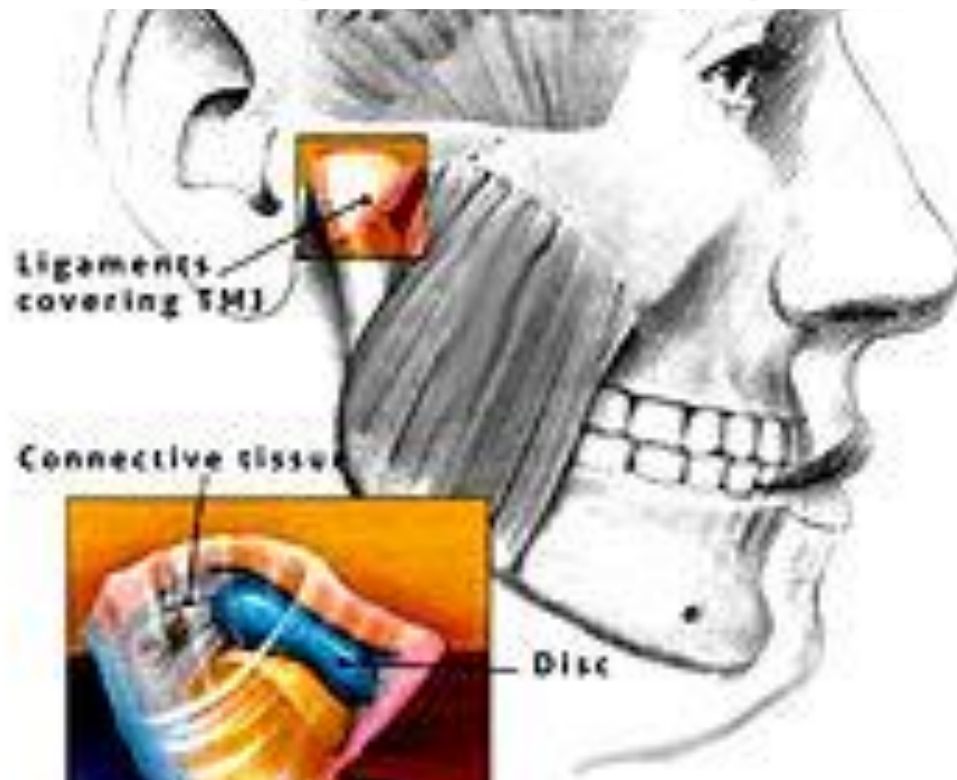
Varicella

- Very contagious disease
- Caused by Varicella-zoster virus
- Spread by aerosols from coughing, sneezing
- Symptoms:
 - Blister-like rash
 - Itching
 - Tiredness
 - Fever
- Serious complications

Prevention

- Varicella vaccine
 - Varivax
 - ProQuad (MMRV)
 - Children only

HEALTHCARE WORKER (HCW) IMMUNIZATION: TETANUS, DIPHTHERIA, PERTUSSIS (TDAP)



Tetanus, Diphtheria, Pertussis (Tdap)

Tetanus

- Caused by *Clostridium tetani* bacteria
- Spread by spores entering body through broken skin (e.g., needlestick)
- Symptoms:
 - Jaw cramping
 - Muscle spasms, often in stomach
 - Trouble swallowing
 - Seizures
 - Headache
 - Fever and sweating

Prevention

- Tdap vaccine (Tetanus, Diphtheria, Pertussis)

HEALTHCARE WORKER (HCW) IMMUNIZATION: MENINGOCOCCAL



Meningococcal

Meningococcal

- Caused by *Neisseria meningitidis* bacteria
- Spread by exchange of respiratory and throat secretions
- Illnesses are often severe and deadly
- Infections of
 - Lining of the brain and spinal cord
 - Bloodstream

Prevention

- Meningococcal vaccine
 - Meningococcal conjugate
 - Serogroup B meningococcal



EMPLOYEE EXPOSURE INVESTIGATIONS

Warranted when staff are exposed to infectious diseases

- Unprotected inadvertent exposure
- Evaluate type of exposure and risk of transmission
- Contact list of exposed staff
- Evaluate need for post-exposure management – dependent on infection or disease
 - Prophylaxis
 - Vaccination
 - TB skin testing
- Determine if local public health or state should be notified



DIVER_xSION





WHAT IS DRUG DIVERSION?



DRUG DIVERSION

IN HOSPITALS BY

Professionals

*the illegal distribution or abuse of
prescription drugs or their use
for unintended purposes*



Drug Diversion is a Multi-Victim Crime

Employee Risks:

- Health - morbidity and death
- Progression to illicit substances
- Risky behaviors
- Incarceration
- Loss of employment
- Revocation of license



Patient Risks:

- Lack of pain control
- Infection risk
- Care by an impaired employee

Health System Risks:

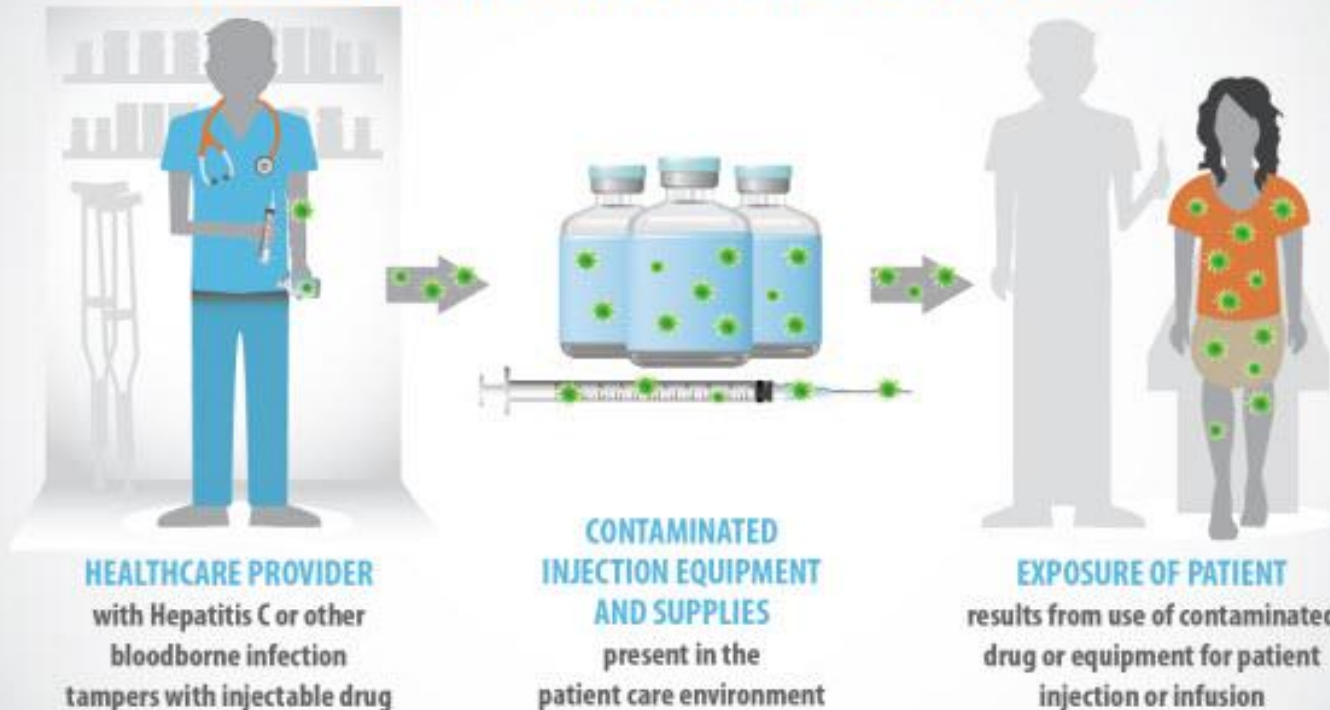
- Patient harm -- *CDC estimates ~30,000 people exposed to Hep C in last decade by infected hospital workers using narcotics intended for patients.*
- Civil and regulatory liability
- Reputation and brand at risk

*



DRUG DIVERSION AND INFECTION

DRUG DIVERSION* SPREADS INFECTION FROM HEALTHCARE PROVIDERS TO PATIENTS



*Drug diversion occurs when prescription medicines are obtained or used illegally by healthcare providers.

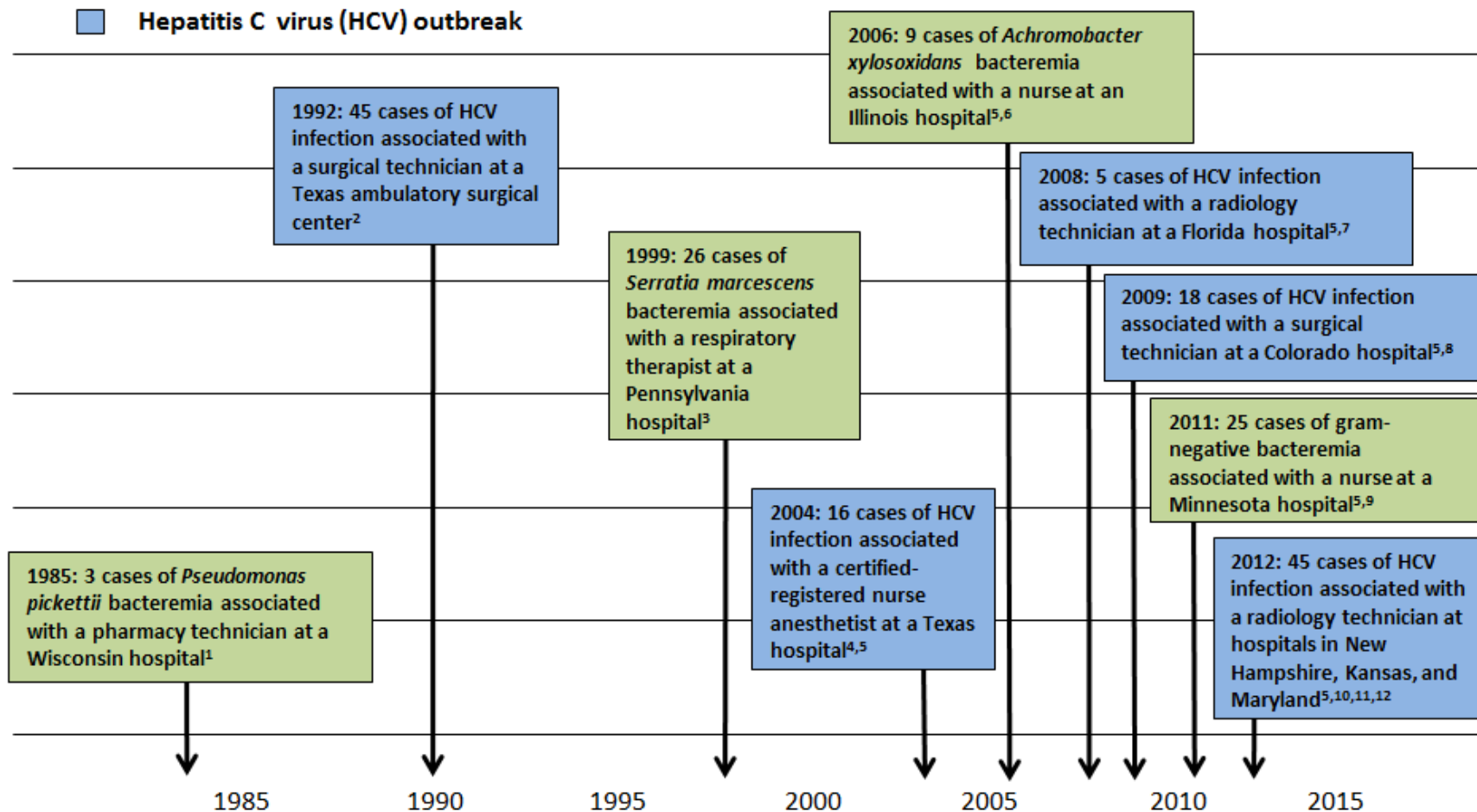
FOR MORE INFORMATION, VISIT [CDC.GOV/INJECTIONSAFETY/DRUGDIVERSION](https://www.cdc.gov/injectionsafety/drugdiversion)





U.S. OUTBREAKS ASSOCIATED WITH DRUG DIVERSION BY HEALTHCARE PROVIDERS, 1983-2013

- Bacterial outbreak
- Hepatitis C virus (HCV) outbreak





THREE STORIES

Nursing home worker accused of drug theft Suspect diverted painkilling medications from patients, Altoona police say

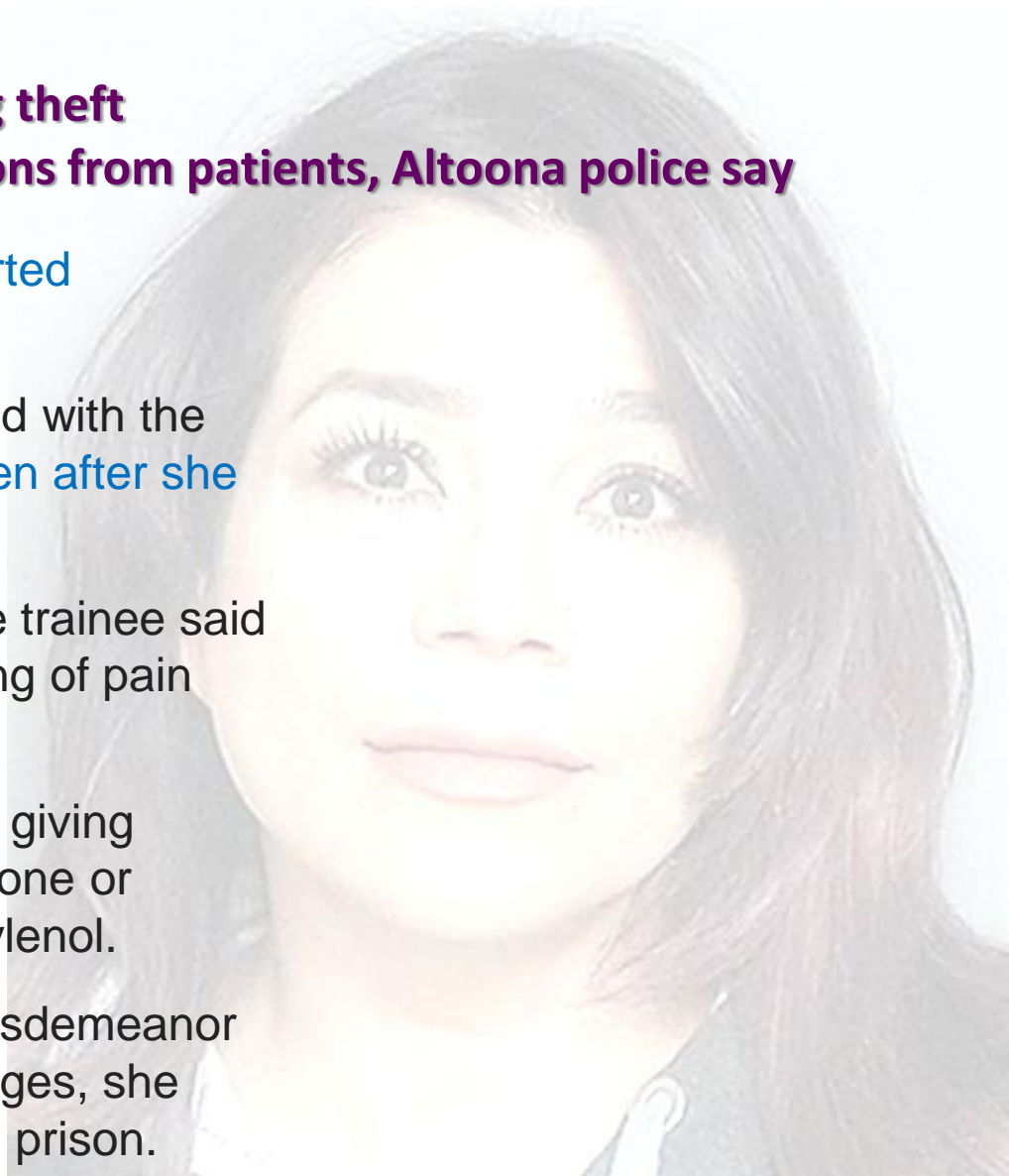
An astute nurse-trainee ultimately reported healthcare provider drug diversion.

The nurse trainee said when she worked with the nurse, residents complained of pain even after she gave them their medication.

But when training with other nurses, the trainee said the same residents were not complaining of pain after receiving pain medication.

An investigation showed that instead of giving residents scheduled doses of hydrocodone or Percocet, the nurse was giving them Tylenol.

She was charged with 11 felony and misdemeanor charges. If convicted of the felony charges, she could be sentenced to up to 16 years in prison.





THREE STORIES

ROAD TO RUIN: A NURSE'S STORY OF ADDICTION



“It just happened. But once it did, it was full-blown. There’s no other way to describe it,” he said of his addiction.”

To extract the drugs, he stole syringes from the hospital, and filled them from drug vials. To cover up his theft, he smeared Krazy Glue over the hole in the container’s packaging, according to court testimony. He said he didn’t get high at work — that came later, in private.

Court testimony revealed that he would use his personal password to gain access to the machine, take the drugs, and replace them with saline solution using a syringe.

Most of his friends didn’t know he’d become addicted, nor did his wife, even when he suffered withdrawals as he attempted to become sober shortly before he was found out.



THREE STORIES

MY STORY: HOW ONE PERCOCET PRESCRIPTION TRIGGERED MY ADDICTION

“It all started with a Percocet prescription 4 years ago” following a lumbar puncture.

He was an experienced nurse and was not questioned when [asking another nurse to witness a narcotic waste](#) in Pyxis – after which he pocketed the excess medication.

Eventually he moved to stronger oral opioids as the Percocet was not longer giving the same feeling, and when those no longer helped then eventually to injectable narcotics. He needed greater amounts and became reckless with his diverting. **“I became preoccupied with obtaining opioids, and [patient care took a back burner.](#)”**

He became even more reckless knowing he would soon be found out – and he was. He was called into his manager’s office; his lies and excuses were not believed and he was terminated and reported to the state board of nursing.

“It was at this point that the slippery slope became a lot steeper. I was crippled with fear of losing my nursing license, family, friends, and girlfriend.”

He got another job – before the board caught up with him – and began diverting opioids, moving from Morphine to Dilaudid in quantities he knew would be discovered but without caution, and he was caught.

The [self-deception](#) includes [thinking his patients were not harmed](#), either by his impaired behavior at work, lack of receiving the pain medication they needed or contamination of the medication.



STRATEGIES TO PREVENT DRUG DIVERSION

Drug diversion monitoring program

- Include a narcotic log
- Monthly statistical comparison
- Anomalous number of one-time orders for a particular drug recorded by single user

Train staff

- Requirements to report misconduct
- What constitutes “significant loss” of medication

Establish environmental controls

- Medication storage
- Who has access
- How to handle unused medications

Do not turn a blind-eye

- Staff don't want to get a colleague in trouble
- Remember the consequences: Inaction can lead to permanent harm or death



STRATEGIES TO PREVENT DRUG DIVERSION – EARLY DETECTION

Look for the red flags before the narcotics counts are “Off”

- Train staff to know the signs and behaviors of impairment
 - Unusual behavior by colleagues
 - Forgetful, unpredictable behavior
 - Lack of concentration
 - Frequent illness or physical complaints
 - Elaborate excuses for things
 - Picking up extra on-call shifts
 - Labile mood with unexplained anger and overreaction to criticism
 - Increase in unexplained tardiness or absenteeism
 - Reports of items, e.g., sharps containers, being out of place
 - Large numbers of rejected verbal orders
 - Complaints of unrelieved pain by residents

If you see something, say something!

Preventing Drug Diversion: Best Practices

Staff Prevention Strategies:

- Only remove medications for your assigned patients
- Only remove current dose of medication for your patient
- Properly document medication administration and pain scores
- All wastes of medications must have a documented witness
- Don't be a "virtual witness" to medication wasting
- Don't loan your ID badge or pass-codes to anyone
- Return unused medications according to procedure
- Report medication discrepancies promptly to pharmacy (on-line reporting available)
- Report attempted inappropriate access to medications to pharmacy
- Report witnessed or suspected medication diversion to pharmacy





RESPONSE TO DRUG DIVERSION EVENTS

Assess harm to residents

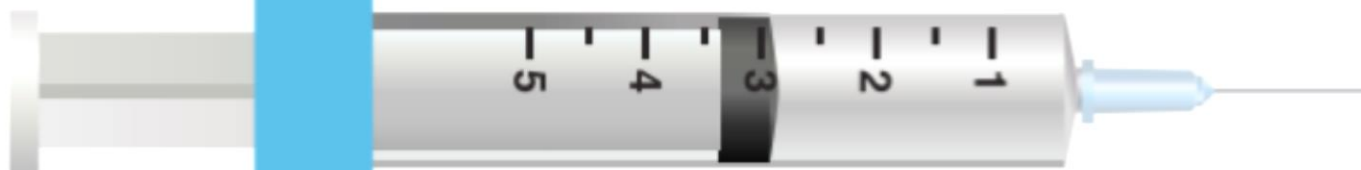
- Consult with public health officials when tampering with injectable medication is suspected
- Promptly report event to law and other enforcement agencies (DEA, FDA)



SAFE INJECTION PRACTICES



**ONE NEEDLE,
ONE SYRINGE,
ONLY ONE TIME.**



Safe Injection Practices Coalition

www.**ONEandONLY**campaign.org

DISCUSSION QUESTIONS

- What do you think “safe injection practices” means?
- What would you describe as an unsafe injection practice?
- What do you think could be the result of unsafe injection practices?
- What unsafe practices have you seen in your workplace that could cause infection?
- What should you do if you observe an unsafe injection practice at work?



HEPATITIS B AND C OUTBREAKS DUE TO UNSAFE INJECTION PRACTICES

- 44 hepatitis outbreaks reported to CDC
 - From 2008-2014
 - Non-hospital settings
- Six of the outbreaks were in California
 - Two skilled nursing facilities
 - Two assisted living facilities
 - Pain clinic
 - Dialysis clinic
 - 2678 people sent notices and tested
 - 27 new cases of hepatitis B or C



CAUSE OF CALIFORNIA HEPATITIS OUTBREAKS

- California outbreaks occurred because of injection safety breaches
 - Reuse of syringes on more than one patient
 - Contaminated medication vials used for more than one patient
 - Use of single-dose vials for more than one patient

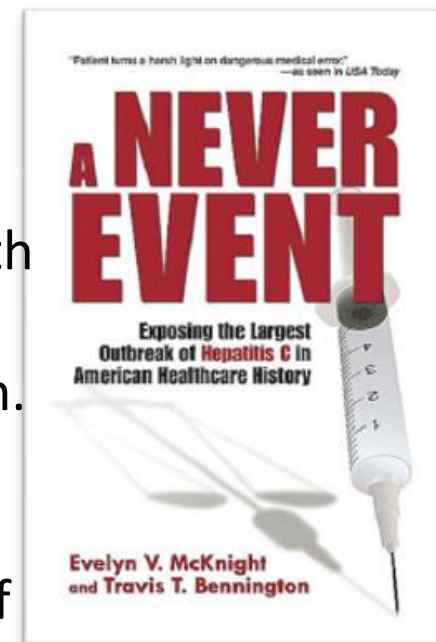
**1 ONE NEEDLE,
ONE SYRINGE,
ONLY ONE TIME.**

Safe Injection Practices Coalition
www.ONEandONLYcampaign.org

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



1 ONE NEEDLE,
ONE SYRINGE,
ONLY ONE TIME.

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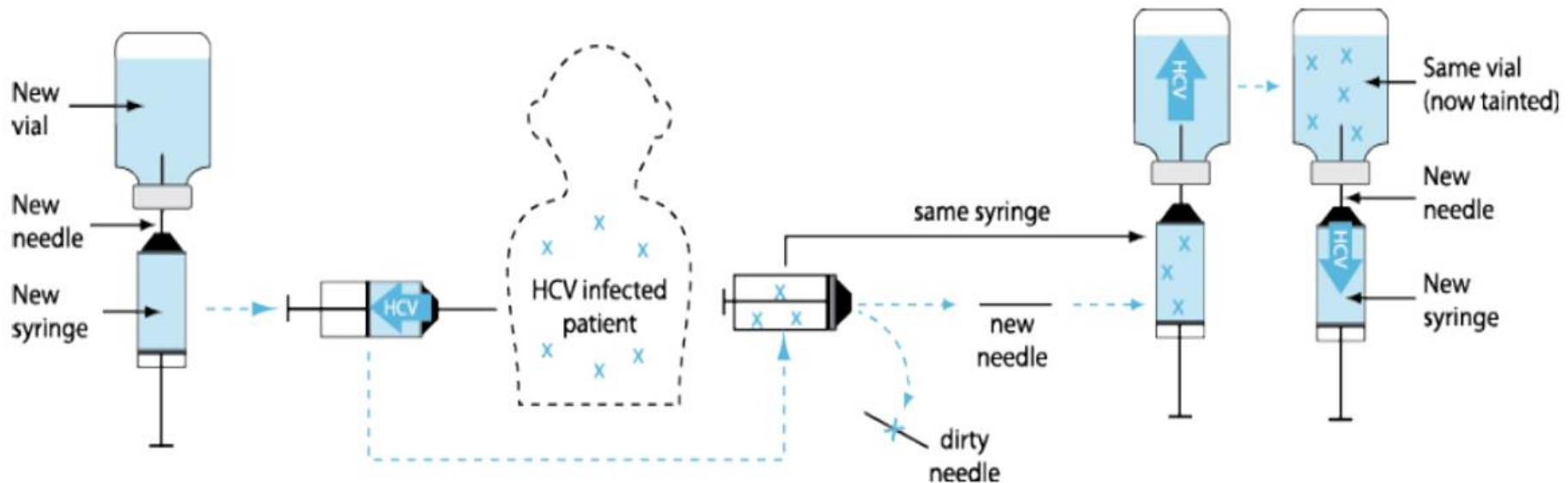
LAS VEGAS, NEVADA OUTBREAK, 2008

- Cluster of three acute Hepatitis C Virus (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

**1 ONE NEEDLE,
ONE SYRINGE,
ONLY ONE TIME.**

Safe Injection Practices Coalition
www.CDC.gov/onecampaign.org

LAS VEGAS, NEVADA OUTBREAK, 2008





UNSAFE INJECTION PRACTICES IN THE U.S.

Common causes of hepatitis outbreaks

- Not properly disinfecting equipment between patients
- Using the same finger stick device on more than one patient
- Reusing a syringe on more than one patient
- Using single-dose vials for more than one patient
- Using a single saline bag for more than one patient



COMMON REASONS FOR UNSAFE INJECTION PRACTICES

- Lack of safe injection policies at healthcare facility
- Staff are poorly trained or unaware of safe injection practices
- Healthcare provider is rushed and takes a shortcut
- Healthcare provider learned safe injection practices at one time but has forgotten



UNSAFE PRACTICES THAT LEAD TO INFECTION

- Using the same needle on multiple patients
- Switching the needle in between patients but using the same syringe
- Reusing cartridges or reusing insulin pens
- Attempting to disinfect a needle with alcohol in between patients

WHAT ARE SAFE INJECTION PRACTICES?



Resident to
Provider



Provider to
Resident



Resident to
Resident

A set of measures to perform injections in an optimally safe manner for residents, healthcare providers, and others

SAFE INJECTION PRACTICES ARE PART OF STANDARD PRECAUTIONS

Hand hygiene



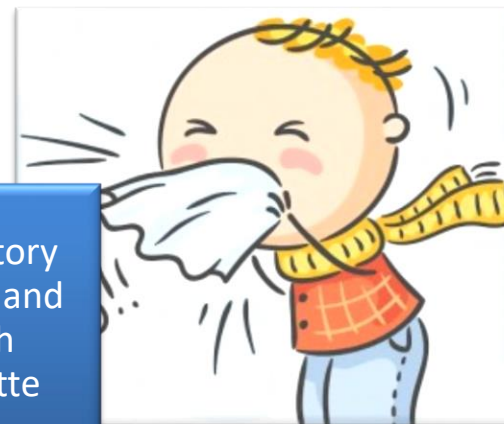
Personal protective equipment (gloves, gowns, masks)



Safe handling of soiled equipment or surfaces



Respiratory hygiene and cough etiquette





“SAFE INJECTION = NO INFECTION”

Injection safety includes

Safe production

Sterile medications from manufacturer

Safe preparation

Prepare in a clean area

Safe Administration

Follow standard precautions

Safe disposal

Minimize risks to the resident and healthcare provider



ASEPTIC TECHNIQUE FOR PREPARING INJECTED MEDICATIONS

- Perform hand hygiene
- Draw up medications in a clean medication area
 - The designated medication area should **not** be near areas where contaminated items are placed

NEEDLES AND SYRINGES: ONE TIME USE ONLY

- Use **needles** for only one resident/patient
- Use **syringes** only one time
 - Including manufactured prefilled syringes
- Use cartridge devices for only one resident/patient
- Use insulin pens for only one resident/patient



**Rx for Safe Injections
in Healthcare**

**1 Needle
1 Syringe
+ 1 Time**

0 Infections

Safe injection practices prevent transmission of infectious diseases. Patients and healthcare providers must insist on nothing less than **One Needle, One Syringe, Only One Time** for each and every injection.

For more information, please visit:
OneandOnlyCampaign.org

The *One & Only Campaign* is a public health effort to eliminate unsafe medical injections. To learn more about safe injection practices, please visit OneandOnlyCampaign.org.

For the latest news and updates, follow us on Twitter @injectionsafety and Facebook/OneandOnlyCampaign.

**1 ONE NEEDLE,
ONE SYRINGE,
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Safe Injection Practices Coalition
www.ONEANDONLYcampaign.org



SPECIAL CONSIDERATIONS FOR DIABETIC RESIDENTS

- Diabetic residents use needles frequently in the care and management of their disease
- Never allow reuse of insulin pens on more than one resident
 - It is not safe to change the needle on insulin pens for use on more than one resident
- Lancets used for blood glucose testing are designed for one resident only
 - Using lancets on multiple residents can lead to infections

INJECTION SAFETY FOR DIABETIC RESIDENTS



Insulin pens that contain more than one dose of insulin are meant for only one person



For glucose testing, clean the glucometer after every use

MEDICATION VIALS

- Always cleanse the diaphragm (tops) of medication vials using friction with 70% alcohol before entry
- Allow the alcohol to dry before inserting a needle or device into the vial

Note: Clean even if the vial comes with a hard lid or cap

- Manufacturers guarantee **medications and solutions** are sterile
- But they do not guarantee the **outside of the container** or **medication vial** is sterile



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SINGLE-DOSE VIALS: ONE RESIDENT & ONLY ONCE

- Use single-dose medications for only one resident
- Read the label on medication vials carefully! Determine if single use
- Never enter a medication vial with a used syringe or needle
- If the vial says single-dose, throw it away after it has been accessed
- Do not store single use medications for future use
- Discard unused single-dose medications when expired



When in doubt throw it out!

MULTI-DOSE (MULTIPLE-DOSE) VIALS

A multi-dose vial is recognized by its FDA-approved label





MULTI-DOSE (MULTIPLE-DOSE) VIALS

Limit the use of multi-dose vials

- When possible, dedicate multi-dose vials to a single resident

For multi-dose vials used for more than one resident

- Keep in a medication area
- Never take into a resident treatment area, resident room or cubicle

Date the multi-dose vial when first opened

- Discard within 28 days
 - Unless the manufacturer recommends a shorter expiration period

Any time the sterility of the vial is in question, throw it out



BAGS OF INTRAVENOUS (IV) SOLUTIONS SHOULD BE USED FOR ONE RESIDENT ONLY

Do not use bags of IV solution as a common source of supply for more than one resident

Everything from the medication bag to the resident's IV catheter is a single interconnected unit

DANGEROUS MISPERCEPTIONS

Here are some examples of dangerous misperceptions about safe injection practices.



Myth	Truth
Changing the needle makes a syringe safe for reuse.	Once they are used, both the needle and syringe are contaminated and must be discarded. A new sterile needle and a new sterile syringe should be used for each injection and each entry into a medication vial.
Syringes can be reused as long as an injection is administered through IV tubing.	Syringes and needles should never be reused. The IV tubing, syringe, and other components represent a single, interconnected unit. Distance from the patient, gravity, or infusion pressure do not ensure that small amounts of blood won't contaminate the syringe once it has been connected to the unit.
If you don't see blood in the IV tubing or syringe, it means that those supplies are safe for reuse.	Germs such as hepatitis C virus and staph or MRSA are invisible to the naked eye, but can easily infect patients even when present in microscopic quantities. Do not reuse syringes, needles, or IV tubing.
It's okay to use leftover medicine from use single-dose or single-use vials for more than one patient.	Single-dose or single-use vials should not be used for more than one patient regardless of how much medicine is remaining.

Injection Safety is Every Provider's Responsibility!

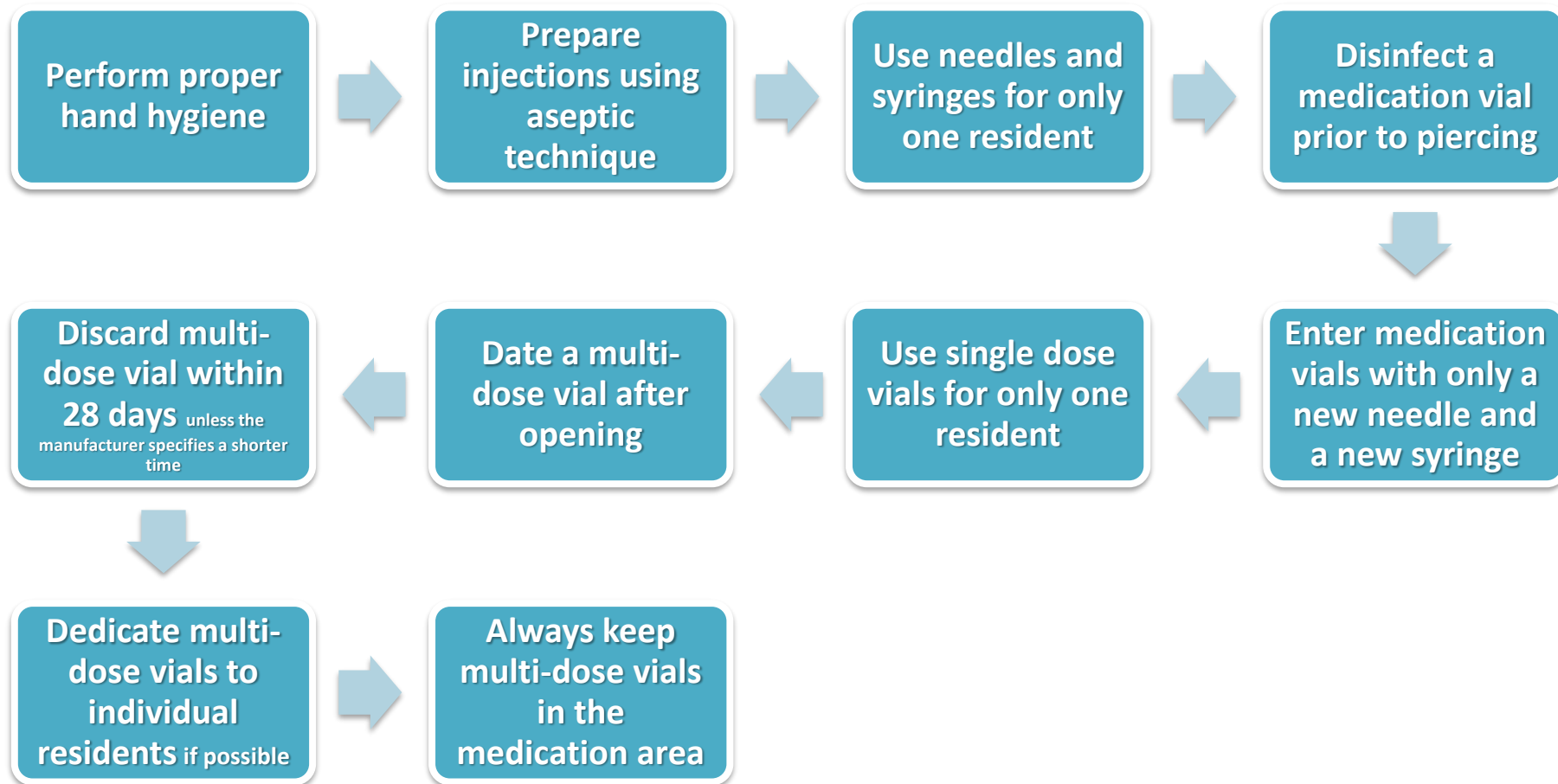
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KEY COMPONENTS TO SAFE INJECTION PRACTICES





SAFE INJECTION PRACTICES

HOW TO DO IT RIGHT VIDEO

Safe Injection Practices - How to Do It Right

OneandOnlyCampaign - 9 videos

8,382

20 0

Subscribe 52



THE INJECTION SAFETY CHECKLIST

- Used to assess your facility's injection safety practices
- Download and share the Injection Safety Checklist

www.cdc.gov/injectionsafety/PDF/SIPC_Checklist.pdf

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	

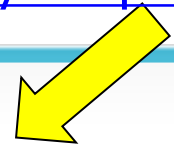
RESOURCES
 Checklist: <http://www.cdc.gov/HAI/pdfs/guidelines/ambulatory-care-checklist-07-2011.pdf>
 Guide to Infection Prevention for Outpatient Settings: *Minimum Expectations for Safe Care*:
<http://www.cdc.gov/HAI/pdfs/guidelines/standards-of-ambulatory-care-7-2011.pdf>

www.oneandonlycampaign.org



- About the Campaign
- Safe Injection Practices
- Healthcare Provider Information
- Patient Information
- Campaign Resources
- News
- Contact Us

California www.oneandonlycampaign.org/partner/california



News & Events

» Injection Safety Newsletter



Check out the *California One and Only Campaign* newsletter by [clicking here](#).

» Injection Safety is Everyone's Responsibility



The Centers for Disease Control and Prevention (CDC) estimate that in recent years, unsafe injection practices have affected more than 150,000 patients in the United States, including 11,500 in California. CDC recommends that healthcare providers NEVER administer medications from the same syringe to more than one patient, even if the needle is changed. It is your right to know that your provider will use a new syringe and new needle every time.

The California One & Only Campaign encourages healthcare organizations and individuals to promote public awareness of safe injection practices. To become a member of the California One & Only Campaign, [click here](#)

» Hepatitis B and C Outbreaks in California



CDC summarized 44 healthcare-associated outbreaks of hepatitis B and C in non-hospital settings from 2008-2014. Six of the outbreaks occurred in California; 2700 people were notified of possible exposure and 27 patients were found to be infected. The outbreaks occurred in two skilled nursing facilities, two assisted living facilities, a pain management clinic, and an outpatient dialysis clinic.

Unsafe injection practices that resulted in these infections included reusing

USE AN INJECTION SAFETY CHECKLIST



It is every patient's right to receive a safe injection. Are healthcare workers always following safe

injection practices at YOUR facility? Safe injection practices are a set of measures that define how to give injections in a safe manner for patients and healthcare providers. The California One & Only Campaign encourages healthcare workers to review and use the Injection Safety Checklist to assess their practices. The checklist, developed by CDC and the Safe Injection Practices Coalition, includes nine observations to help healthcare workers ensure they are adhering to safe injection practices during the care of patients. To download and share the Injection Safety Checklist, [click here](#)

WHEN IN DOUBT, THROW IT OUT!



Outbreaks of bloodborne infections have been associated with the reuse of single-dose vials or misuse of

multiple dose vials. As a team leader or a team member, it is important to make sure that every health worker uses single-dose vials only one time for one patient. If a healthcare



SUMMARY

- Infection Prevention and Employee Health – working together
- Healthcare workers are at risk of
 - Acquiring infections from residents
 - Transmitting infections to residents
- Appropriate screening and vaccinations help protect HCWs
- Drug diversion has caused serious harm to many patients/residents
 - Including transmission of organisms resulting in illness and death
- Safe injection practices reduce the risk of infections
 - They protect both residents and healthcare providers
- Evaluate your facility's injection safety practices
 - Use the injection safety checklist
- Always follow Standard Precautions
 - Every time
 - With every resident