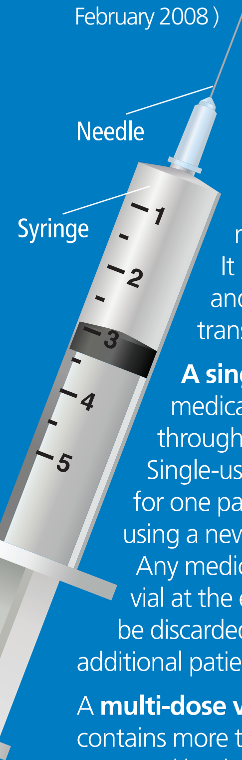
A Patient Safety Threat – Syringe Reuse

(Source: Division of Healthcare Quality Promotion (DHQP), Centers for Disease Control and Prevention (CDC), February 2008)



Healthcare providers (doctors, nurses, and anyone providing injections) should **never reuse a needle or syringe**. Use one needle for only one patient. Never put a used needle into a shared vial. Both needle and syringe must be discarded. It is also never safe to change the needle and reuse the syringe - this practice can transmit diseases.

A single-use vial is a bottle of liquid medication that is given to a patient through a needle and syringe. Single-use vials should only be used for one patient, for one procedure, using a new, clean needle and syringe. Any medication remaining in the vial at the end of the procedure must be discarded and may not be used on additional patients.

A **multi-dose vial** is a bottle of liquid medication that contains more than one dose of medication and is approved by the Food and Drug Administration (FDA) for use on multiple persons. A new, clean needle and syringe should always be used to access the medication in a multi-dose vial. The reuse of needles or syringes to access multi-dose vial medication can result in contamination of the medicine with germs that can be spread to others when the medicine is used again.

CDC recommends that single-use vials be used whenever possible and that multi-dose vials of medication be assigned to a single patient to reduce the risk of disease transmission.

Reusing a needle or syringe puts patients in danger of getting hepatitis C virus (HCV), hepatitis B virus (HBV), and HIV. When it is discovered that reuse of a needle or syringe has occurred, patients who may have been affected should be notified.

Healthcare providers should always adhere to **Safe Injection Practices** under **Standard Precautions** to prevent disease transmission from needles, syringes, or vials of medication.

About the Safe Injection Practices Coalition

The Safe Injection Practices Coalition was established in 2008.
The following organizations are members of the Coalition: Accreditation Association for Ambulatory Health Care (AAAHC), American Association of Nurse Anesthetists (AANA), Ambulatory Surgery Foundation, Association for Professionals in Infection Control and Epidemiology, Inc (APIC), BD (Becton, Dickinson and Company), Centers for Disease Control and Prevention (CDC), CDC Foundation, Covidien, HONOReform Foundation, Hospira, National Association of County & City Health Officials (NACCHO), Nebraska Medical Association (NMA), Nevada State Medical Association (NSMA) and Premier Safety Institute.

For more information, please visit our website at:

www.ONEandONLYcampaign.org

Some Things Should Never Be Reused

A Patient's Guide to Injection Safety

www.ONEandONLYcampaign.org

About the One and Only Campaign

Be informed:

Healthcare should not be a vehicle for infection transmission. However, in 2002, unsafe injection practices in an outpatient oncology clinic in Fremont, Nebraska, led to one of the largest outbreaks of hepatitis C virus (HCV), ever to occur in the United States. Unfortunately, this tragedy is far from an isolated case. Because new cases are usually without symptoms and only manifest several weeks after exposure, cases and outbreaks are difficult to detect and investigate. Nonetheless in the past 10 years:

- More than 35 outbreaks involving 400 patients with HBV or HCV infections from unsafe injection practices have been investigated.
- In those outbreaks more than 60,000 patients at potential risk of HBV or HCV infections from failure to follow basic infection control needed to be notified and screened for HBV, HCV and HIV.

In all of these events, HBV and HCV was transmitted from patient-to-patient because of a failure of healthcare personnel to follow basic standards of infection control.

Be involved:

To help increase awareness about these events and to help reinforce to patients and providers the level of care that should ALWAYS be provided, the Hepatitis Outbreaks National Organization for Reform (HONORerform) and the CDC Foundation co-convened the Safe Injection Practices Coalition (SIPC) to develop an education and awareness campaign to eradicate outbreaks resulting from unsafe injection practices.

Remember:

ONE Needle, **ONE** Syringe, ONLY **ONE** Time.

Ask Your Healthcare Provider Questions

I've heard of hepatitis outbreaks from providers reusing injection equipment across the country.

- Will there be a new needle, new syringe, and a new vial for this procedure or injection?
- Can you tell me how you prevent the spread of infections in your facility?
- What steps are you taking to keep me safe?

Glossary

Vial = A small container or bottle that holds medicine.

Transmission = Transfer, as of an infection from one patient to another.

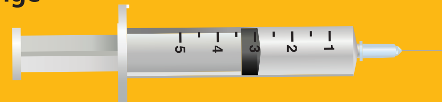
Dose = A portion of drug taken at one time.

Hepatitis B = A liver disease caused by the hepatitis B virus (HBV). HBV is transmitted through contact with infectious blood, semen, and other body fluids from having sex with an infected person, sharing unclean needles to inject drugs, or from an infected mother to her newborn.

Hepatitis C = A liver disease caused by the hepatitis C virus (HCV). HCV is transmitted through contact with the blood of an infected person.

Needle = A sharp pointed object used for injection or removal of fluid from the body.

Syringe =



Healthcare provider = Doctors, nurses or anyone providing injections.

Injection = Forcing a fluid into the body by means of a needle and syringe.

Patient Frequently Asked Questions

(Source: Division of Healthcare Quality Promotion (DHQP), Centers for Disease Control and Prevention (CDC), March 2008)

What is injection safety?

Injection safety, or safe injection practices, are practices intended to prevent transmission of infectious diseases between one patient and another, or between a patient and healthcare provider, and to prevent harms such as needlestick injuries.

What are some of the incorrect practices that have resulted in transmission of disease?

Practices that have resulted in transmission of HCV and/or HBV include the following:

- Using the same syringe to give medication to more than one patient, even if the needle was changed;
- Using the same medication vial for more than one patient, and entering the vial with a syringe that has already been used;
- Using a shared bag of saline (salt solution) or other IV fluid for more than one patient, and entering the bag with a syringe that has already been used.

For what types of procedures have these incorrect practices been identified?

Unsafe injection practices that put patients at risk for HCV, HBV and other infections have been identified during various types of procedures. Examples include the following:

- Administration of anesthetics for outpatient surgical, diagnostic, and pain management procedures;
- Administration of other IV medications for chemotherapy, cosmetic, or radiology procedures.