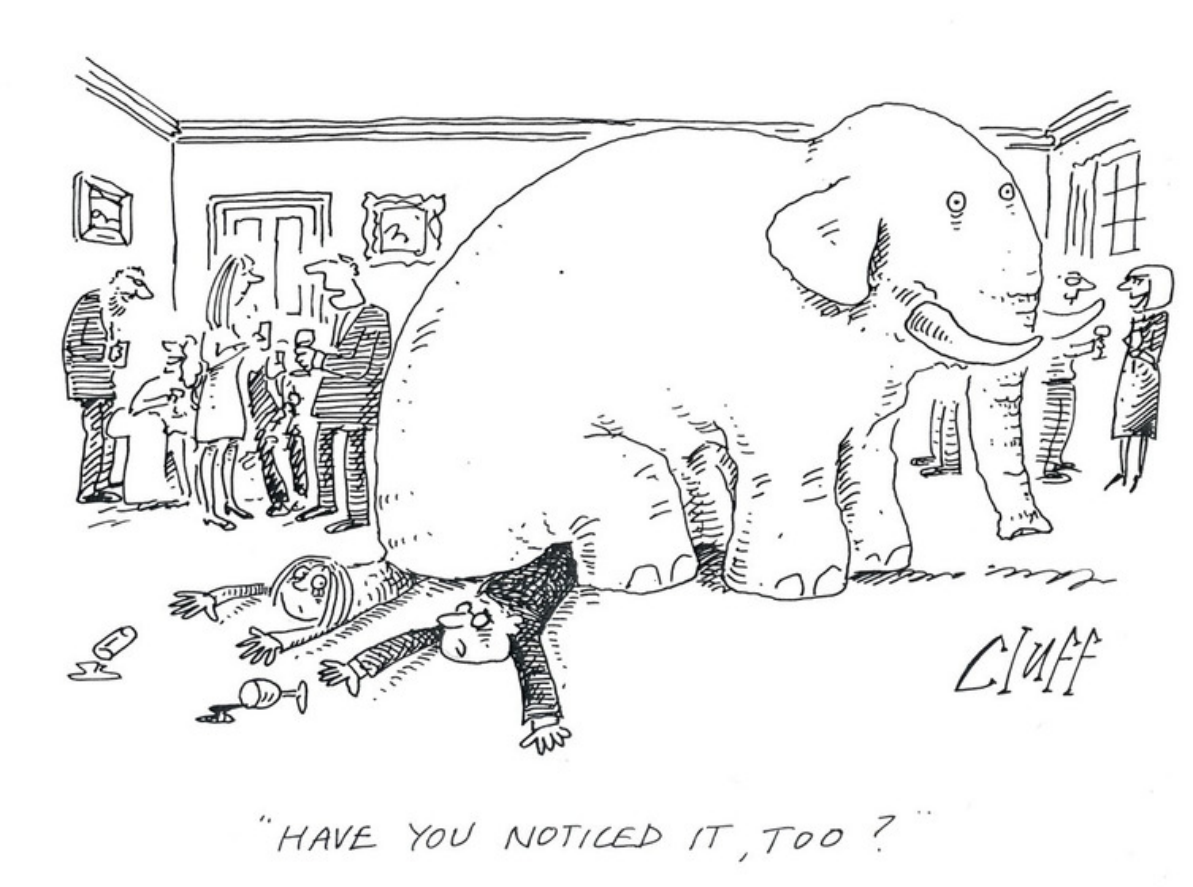
STAFF SAFETY: WHY DO WE NEGLECT IT?

And What Is The Cost?

OVERVIEW

1. Why do we neglect our own safety?
2. What is the risk of sharps safety for your and your family?
3. What are the current rules and guidelines?
4. Safe Sharps Management

SHARPS SAFETY:
THE ELEPHANT IN THE ROOM



WHY WE IGNORE SHARPS SAFETY: REASON #1

SELF BLAME OR BLAME WORTHY STAFF CULTURE

VS.

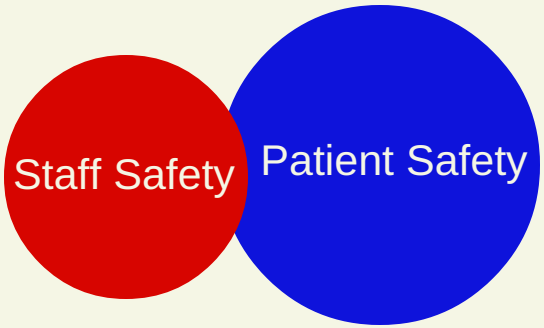
NO BLAME CULTURE FOR PATIENT SAFETY

WHY WE IGNORE SHARPS SAFETY: REASON #2

“IT WILL NEVER HAPPEN TO ME” ATTITUDE.

Take home message:

Staff safety and patient safety are no longer mutually exclusive.



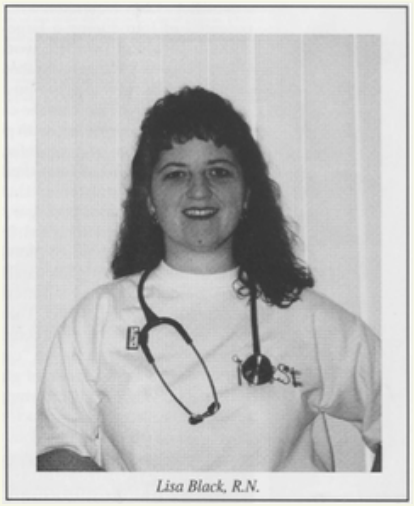
TODAY'S THINKING

TOMORROW'S THINKING

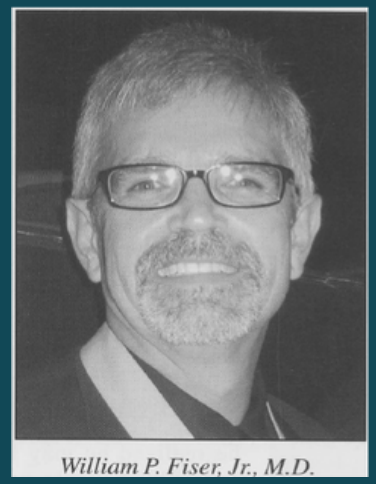
What is the WORST thing that can happen to you from a sharps injury?

Diane Mawyer
Virginia RN
Diagnosed Hep C: 1993

Lisa Arnold
Pennsylvania RN
Diagnosed HIV: 1993



Lisa Black
Nevada, RN
Diagnosed HIV & Hep C: 1998



William Fisher
US Surgeon
Diagnosed Hep C: 2002

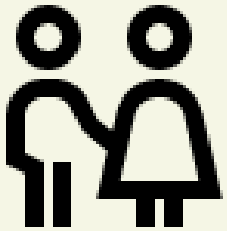
What is the LEAST WORST thing that can happen to you from a sharps injury?

THE UNCOMPLICATED INJURY

COST

The cost of even an uncomplicated injury could range from $500 to $2,000.

NO SEXUAL INTIMACY



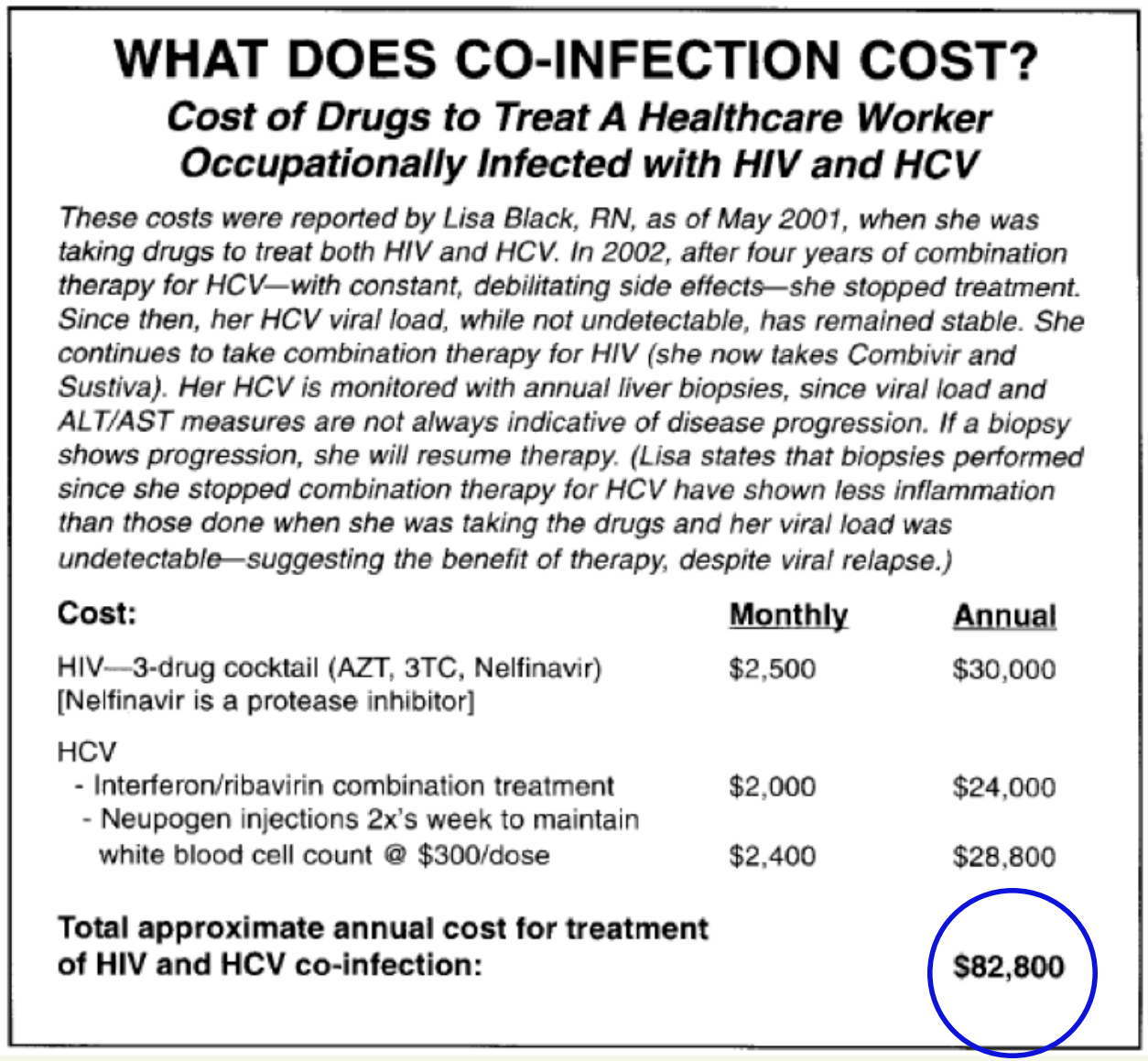
FOR 3 MONTHS.

SEVERED TENDON, ARTERY OR NERVE

If the injury requires microsurgery, it might cost as much as $100,000 and requires up to three months of rehabilitation.

Cost of an infection.

HOW CONFIDENT ARE YOU THAT THE HOSPITAL WILL PAY?

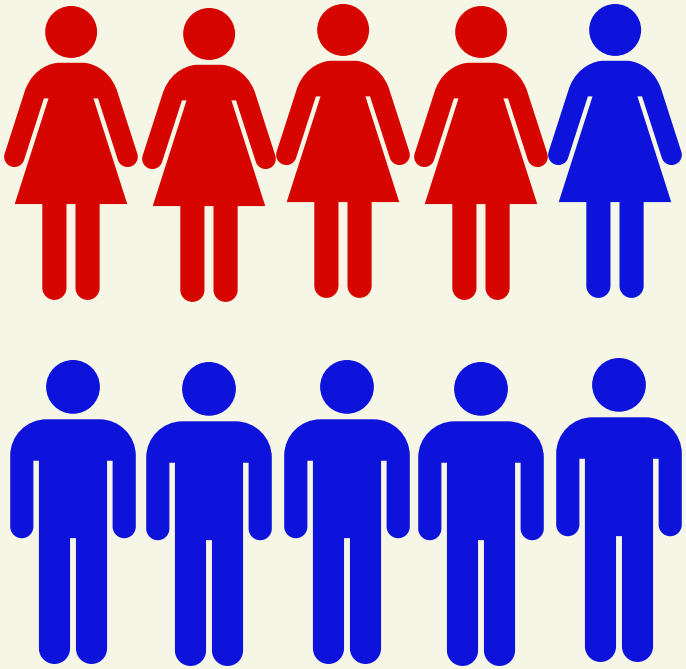


WHAT DOES CO-INFECTION COST?

Cost of Drugs to Treat A Healthcare Worker Occupationally Infected with HIV and HCV

These costs were reported by Lisa Black, RN, as of May 2001, when she was taking drugs to treat both HIV and HCV. In 2002, after four years of combination therapy for HCV—with constant, debilitating side effects—she stopped treatment. Since then, her HCV viral load, while not undetectable, has remained stable. She continues to take combination therapy for HIV (she now takes Combivir and Sustiva). Her HCV is monitored with annual liver biopsies, since viral load and ALT/AST measures are not always indicative of disease progression. If a biopsy shows progression, she will resume therapy. (Lisa states that biopsies performed since she stopped combination therapy for HCV have shown less inflammation than those done when she was taking the drugs and her viral load was undetectable—suggesting the benefit of therapy, despite viral relapse.)

Cost:	**Monthly**	**Annual**
HIV—3-drug cocktail (AZT, 3TC, Nelfinavir) [Nelfinavir is a protease inhibitor]	$2,500	$30,000
HCV		
- Interferon/ribavirin combination treatment	$2,000	$24,000
- Neupogen injections 2x's week to maintain white blood cell count @ $300/dose	$2,400	$28,800
Total approximate annual cost for treatment of HIV and HCV co-infection:		**$82,800**



44%

NURSES ARE MOST AT RISK OF SHARPS INJURY

INJURY FREQUENCY

sharps injuries reported per year.

Sharps injuries go unreported. Means the actual figure could be 3 millions.

Sharp injuries occur after use and prior to disposal of a sharp device

SCALPEL BLADE INJURIES

Scalpel blade injuries are the second most common type of sharps injury, second only to suture needles

FREQUENCY VS. INCIDENCE SCALPEL VS. NEEDLESTICK

scalpel incidences / 100,000 scalpel blades

Syringe & loose needle incidences / 100,000 Disposable syringes and loose needles.

A study conducted by Eisenstein and Smith showed that the incidence rates of scalpel blades is much higher than disposable syringes and loose needles when compared to their respective volume

RISK OF INFECTION FROM SCALPEL INJURIES

1 in 3 contract Hepatitis B. Post-exposure prophylaxis with hepatitis B immunoglobulin and initiation of hepatitis B vaccine is highly effective in preventing infection

RISK OF INFECTION FROM SCALPEL INJURIES

1 in 30 contract Hepatitis C.
Currently no vaccine for HCV.

New treatment is very expensive approximately £55,000 / treatment.

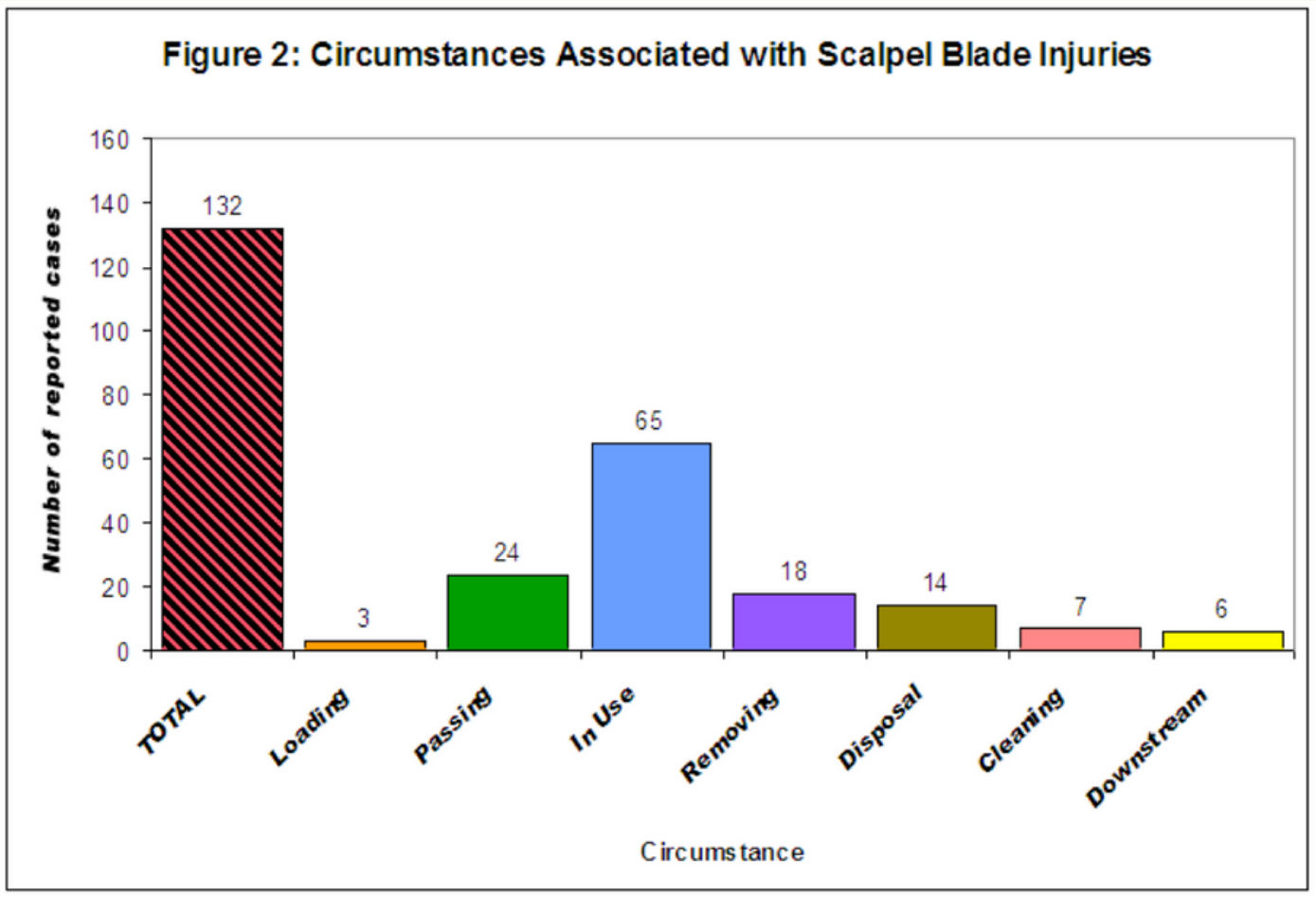
Of those infected with HCV, 85% develop an infection,

70% of whom develop liver disease which often leads to cirrhosis and liver transplants

RISK OF INFECTION FROM SCALPEL INJURIES

1 in 300 develop HIV.
Currently there is no vaccine or treatment available to either prevent or cure HIV.

HOW MANY SCALPEL INJURIES ARE PREVENTABLE? UP TO 50%.



Adapted from Fuentes et al “Scalpel Safety”: Modeling the effectiveness of different safety devices’ ability to reduce scalpel blade injuries. The International Journal of Risk & Safety in Medicine 2008; 20(1-2):83-89.


REGULATORY
UPDATES

OSHA INTERPRETS BLOODBORNE PATHOGEN GUIDELINES 29 CFR 1910.1030(D)(1)(IV)(B) IN 2005

"... that no one medical device is appropriate for use in all circumstances and that it is important to safeguard both patients and employees during medical and surgical procedures. If the use of a particular engineering control, in this case a safety scalpel, compromises patient safety, its use would not be considered feasible. The employer, therefore, must determine what engineering and work practice controls effectively minimize hazards without unduly interfering with medical procedures. The standard also recognizes that market availability is another limiting factor in implementing the use of engineering controls and must be considered in both your choice of an engineering control and our enforcement of their use [29 CFR 1910.1030(d)(1)(iv)(B)]. However, please be aware, exposures have been determined and where engineering controls are commercially available and feasible, they must be used."

“The use of a single-handed scalpel blade remover meets these criteria”

OSHA UPDATES 2008

In 2008, OSHA clarifies further on this subject:

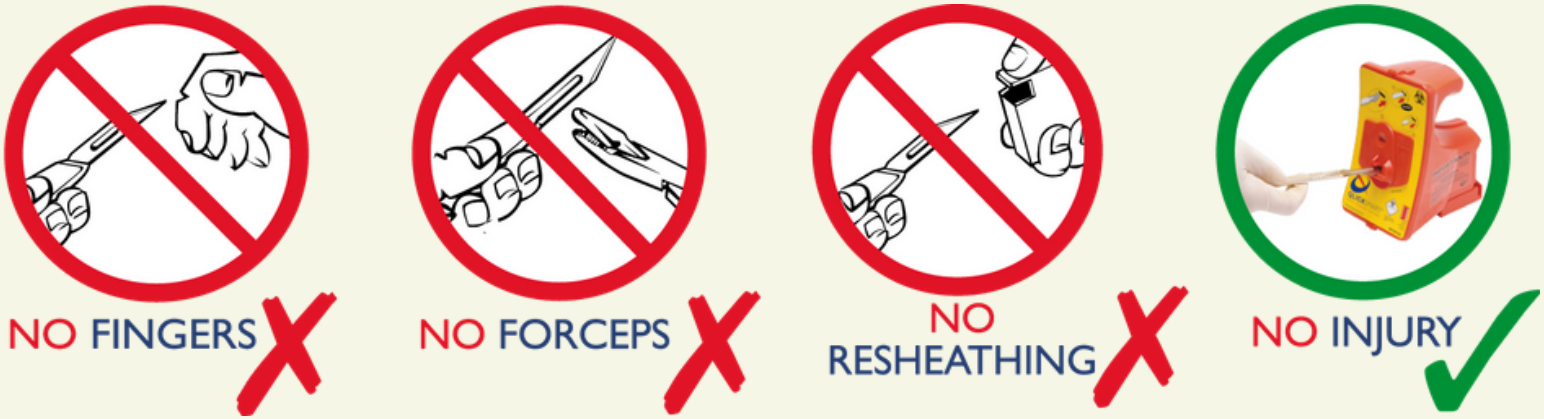
"... using fingers to remove a used scalpel blade does not meet the requirements of the standard."

"Some facilities use a two-handed procedure with hemostat as a mechanical device to remove scalpel blades... Hemostats have been used as a measure which was preferable to using fingers to remove a used scalpel blade. Employers are expected to consider and use safer and more effective measures when feasible."

"... suggestion that the BBP (bloodborne pathogen) standard be changed to require that if a mechanical device is utilized, it must be a 'one-handed use of a mechanical-device' is a very good recommendation and one that would improve worker safety."

AUSTRALIAN STANDARD

OSHA regulations are now equivalent to the Australian and New Zealand Standards (AS/NZS 3825:1998)



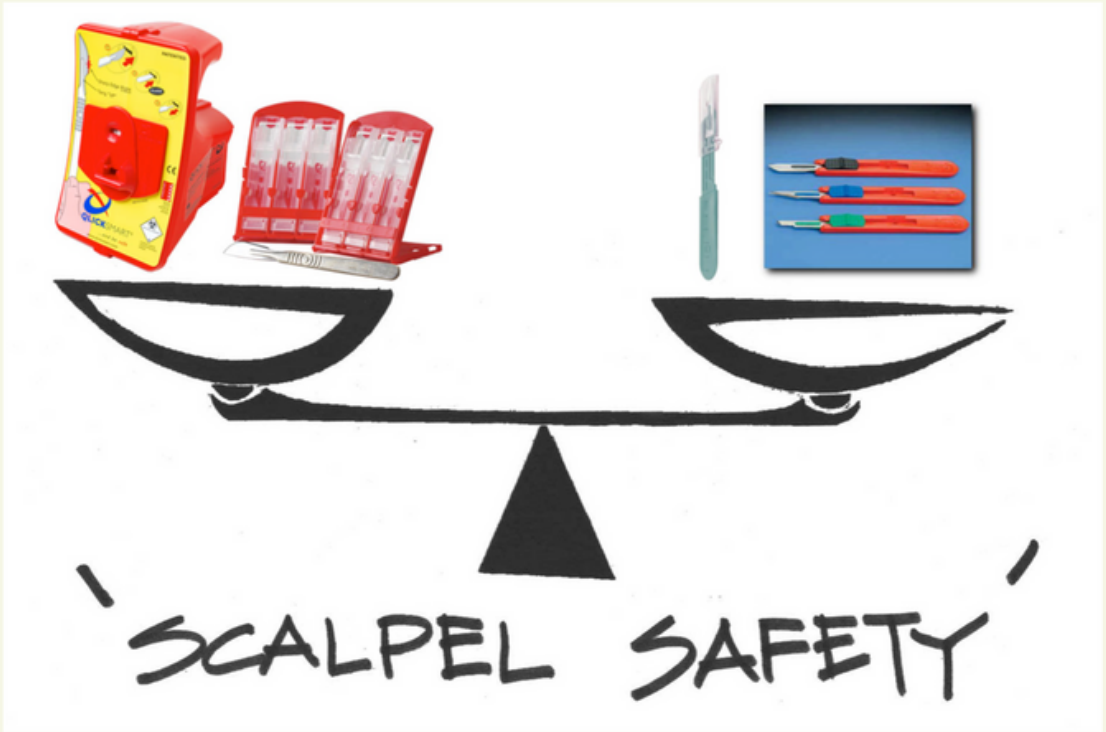
HOW CAN WE IMPROVE SHARPS SAFETY?

1

ACCEPT THE PROBLEM AND TAKE RESPONSIBILITY

2

PICK THE APPROPRIATE PRODUCTS



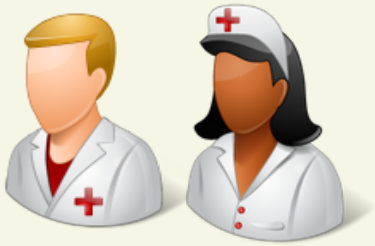
ACTIVE VS. PASSIVE SAFETY

Passive Safety is “automatic” safety
E.g. spring loaded safety syringe or single-handed blade remover.

Active Safety requires user to “manually” do something, w.g. sheath style safety syringe or safety scalpel. CDC studies show active safety devices were not activated in up to 90% of cases – failing to protect the staff using them.

PASSIVE SAFETY = SUPERIOR SAFETY

WIN: WIN: WIN



HEALTHCARE WORKERS

Safer for healthcare professionals

PATIENTS

Benefit from improved “safety culture”

HOSPITAL

Less risk of law suit
Less risk of OSHA fine?
Less staff turnover
Improved staff morale

IT'S NOT TOO HARD TO CHANGE, JUST CHANGE BEFORE IT'S TOO LATE!

THANKS FOR READING.

For enquiries, please contact Qlicksmart at mjs@qlicksmart.com.