It's Real. It's Recent. It Could Become YOUR Problem.

A 2010 survey of healthcare professionals found that:

1% "sometimes or always" reuse a syringe on a second patient after changing the needle

◦

1% reuse a syringe to enter a multidose vial and then save that vial for use on another patient

◦

6% "sometimes or always" use single-dose/single-use vials for more than one patient

Pugliese G, Gosnell C, Bartley JM, Robinson S. Injection practices among clinicians in United States health care settings. Am J Infect Control. 2010; 38:789-98.

Since 2001, more than 130,000 patients in the United States have been notified of potential exposure to hepatitis B virus (HBV), hepatitis C virus (HCV), and HIV due to lapses in basic infection control practices.

From 2008-2011, 31 outbreaks of viral hepatitis related to unsafe injection practices in healthcare settings were reported to CDC, including one involving both hepatitis B and C.* Twenty-nine (94%) occurred in non-hospital settings. Many of these lapses involved healthcare providers reusing syringes, resulting in contamination of medication vials or containers which were used then on subsequent patients. Of those occurring in LTC facilities, the vast majority were a result of the improper use and sharing of blood glucose monitoring equipment.

Unsafe Injection-Related Hepatitis B and Hepatitis C Outbreaks Reported to CDC, 2008-2011

	Outbreaks*	Notifications	Cases	Comments
Hepatitis B				
National outbreaks (summary)	19	>10,190	>150	• 15 outbreaks occurred in LTC facilities • 80% (12/15) of LTC outbreaks were associated with infection control breaches during assisted monitoring of blood glucose (AMBG)
North Carolina outbreaks	A	87	8	• Use of fingerstick devices for >1 resident • Use of blood glucose meter for >1 resident without cleaning and disinfection
	B	116	6	• Unclear mode of transmission
	C	109	6	• Specific mode of transmission not identified at the time of the investigation • AMBG and insulin injection were associated with illness in case-control study
Hepatitis C				
National outbreaks (summary)	13	80,649	102	• 7 outbreaks occurred in outpatient facilities • 5 outbreaks occurred in hemodialysis settings
North Carolina outbreaks	A	1,200	5	• Syringe reuse contaminating multi-dose vials of saline solution used for >1 patient

Table adapted from: http://www.cdc.gov/hepatitis/Outbreaks/HealthcareHepOutbreakTable.htm

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