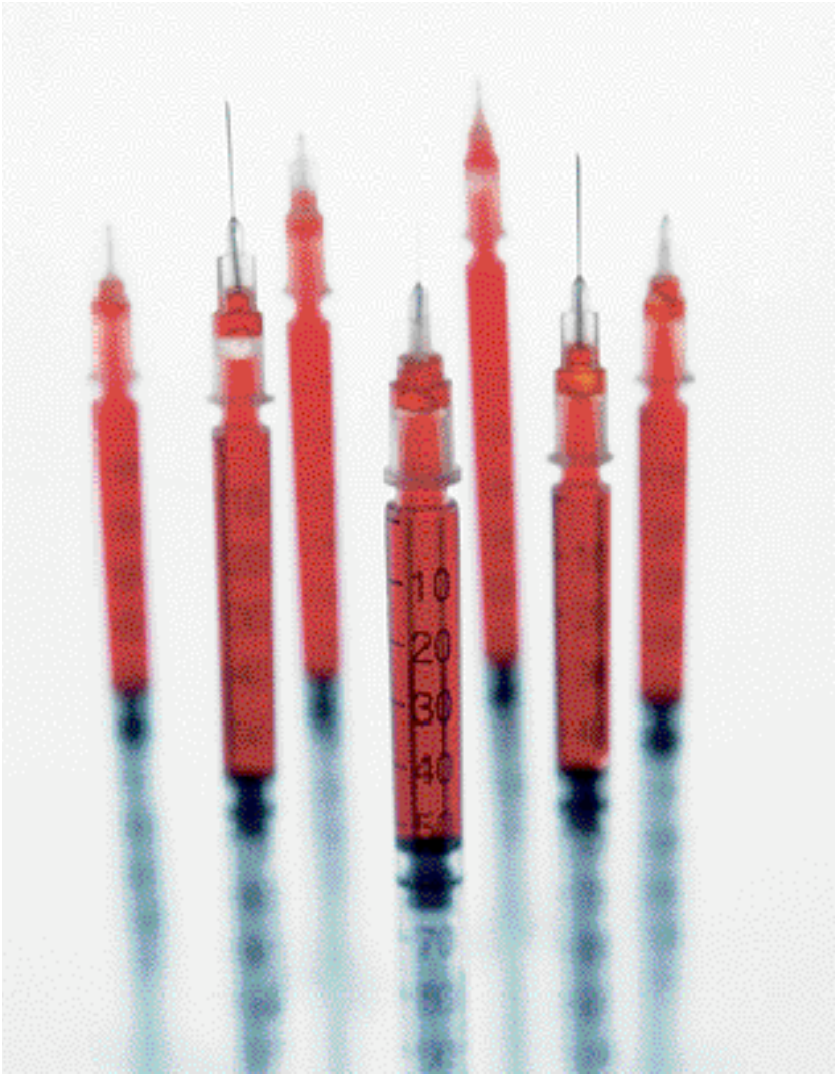
Eliminating Needlesticks

CREATING A SAFER ENVIRONMENT FOR BOTH PATIENT AND CAREGIVER

by Gail J. Callas, BSN, RN, MS

The clinical operations and compliance department of Cook Children's Physician Network (CCPN) in North Texas asks three questions in determining its policies, guidelines and changes to current safety procedures: 1) What is safest for the patient; 2) What is safest for the caregiver; and 3) What does OSHA say?



One specific area of safety in which OSHA, patients and staff share equal concern is that of needlestick safety and exposure to bloodborne pathogens. In the pediatric environment, parents in particular expect a high degree of safety in our care of their children, and often perceive this is part of the overall "quality" of their encounter.

Prior to the implementation of the federally mandated Needlestick Safety and Prevention Act on April 18, 2001, CCPN clinical operations and compliance reported on data collected on both patient and employee exposure to bloodborne pathogens, including contaminated needlesticks. Even though our overall rates were low, this data indicated that we could do better—and should.

Thus began our "quest" to find the safest needles, syringes and blood collection devices on the market.

The Quest

Over the next two years, per OSHA regulations, our frontline clinical staff (those who actually give immunizations and other injections during our 419,000 annual primary care visits) systematically piloted and recommended several safety-engineered devices. Chosen brands were implemented; all requiring that the user actually activates the safety control after the procedure.

While results in 2002 indicated we were making a positive difference as compared with previous years (see Table 1), 2003 showed an alarming increase in needlesticks. Further review

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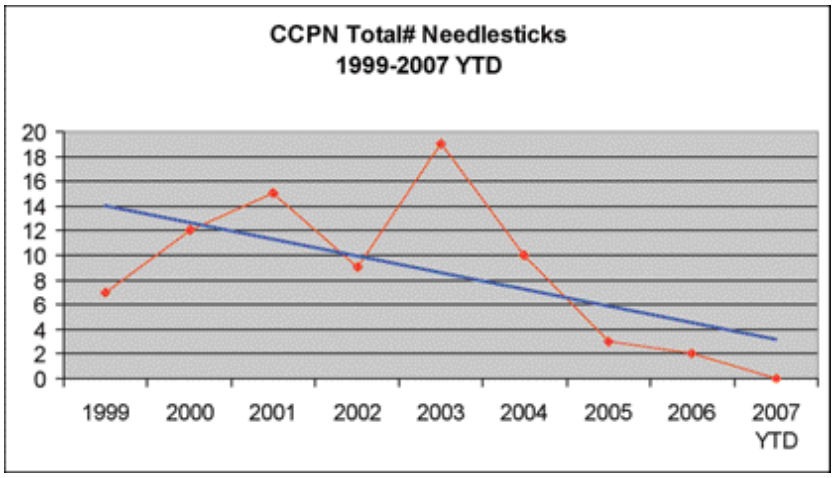
indicated that most of these sticks occurred just before activation or as the employee was attempting to activate the safety control. Pediatric patients are well known for their ability to grab and squirm, even when held appropriately, and both patients and staff were being stuck due to the delay in activating the safety control. This was simply unacceptable.

We knew that we hadn't accomplished our quest; we wanted our contaminated needlestick rate to be zero.

Table 1.



In 2004, we contacted Retractable Technologies Inc. and asked for a demonstration of their retractable devices. As their VanishPoint® safety device "self-activates" without any effort required of the user, it instantly appeared that we were on the right path.

Again, a team of frontline users piloted the devices, critiquing their use and patient response. As a result of this user pilot, CCPN clinical operations and compliance made the decision to implement the VanishPoint retractable safety needle as our product of choice.

In partnering with Retractable Technologies, training was provided to all 35 primary care locations, and the product was in place as of May, 2004. As evidenced in Table 1, our contaminated needlesticks for 2004 were reduced by 50 percent from 2003.

However, one location resisted implementation, continuing to use the user-activated needles, and this lone practice accounted for all of the contaminated needlesticks within CCPN for 2005. After retraining, this practice has now fully implemented the VanishPoint product, and we have now mandated its consistent use throughout all of our practices.

2006 data reveals that our quest has at last been successful: Cook Children's Physician Network practices have a *zero percent* contaminated needlestick rate. (Note: The two sticks in 2006 were not from syringes with needles, but from a scalpel and a blood collection device, which has now been changed to a retractable product.)

Staff feedback has been very positive. While change is never easy, many now tell us they would never want to work in an environment where these retractable devices aren't in place. Parents recognize the VanishPoint product as a safer device for both their child and caregiver as well. Children's Medical Center, Dallas, is now following our lead and our 500-plus affiliate physicians have taken notice as well.

In standardizing its use throughout our primary care practices, we are confident the VanishPoint product is the safest for both the patient and the caregiver. As for OSHA; well, we don't plan to ask—but we're betting they'd be quite pleased with our results! ✛

Gail J. Callas, BSN, RN, MS, is the assistant vice president and chief nursing officer in the clinical operations and compliance department at Cook Children's Physician Network (CCPN), the largest pediatric physician group practice in North Texas. A recipient of the 2007 International Sharps Injury Prevention Award, Ms. Callas is a champion of sharps safety.