

## One and Only—Safe Injection Practices

Unsafe injection practices have led to outbreaks of hepatitis B, C and HIV across the United States. In response, the CDC and the Safe Injection Practices Coalition are promoting awareness of safe injection practices for all health care providers. Multiple studies indicate that unsafe practices are associated with increased risk of transmission to individuals and disease outbreaks. Also, providers who do not follow safe injection practices are frequently referred for disciplinary action, and some are sued for malpractice. Health care providers are well-positioned to promote safe injection practices and reduce the risk of disease transmission.

From 2008 – 2011, more than 250 cases occurred and more than 90,000 patients in the US were notified of potential exposures resulting from unsafe injection practices such as:

- reuse of blood glucose monitoring equipment among multiple patients,*
- reuse of contaminated syringes and other equipment, and*
- contamination and reuse of medication vials or other containers designed for use with single patients.*

Understanding the basics of microbial disease and transmission is part of health care provider education, yet outbreaks continue to occur because of improper practices.

Settings in which healthcare-associated infections are diagnosed include long-term care facilities, multiple services in hospitals, clinics, dialysis centers and individual homes. Eight-three percent of the outbreaks involved outpatient settings. There have been four large exposure events since 2007 with greater than 5,000 patient notifications per event. Highlights of more recently reported healthcare-associated hepatitis B and C outbreaks (2008-2011) follow. It is notable that many outbreaks were associated with Assisted Monitoring of Blood Glucose (AMBG).

### **Hepatitis B (19 outbreaks, 155 outbreak-associated cases, 10,318 persons notified for screening):**

- 15 outbreaks occurred in long-term care facilities, with at least 118 outbreak-associated cases of HBV and approximately 1,600 at-risk persons notified for screening. 80% (12/15) of the outbreaks were associated with infection control breaks during assisted monitoring of blood glucose (AMBG).
- 4 outbreaks occurred in other settings, including a free dental clinic in school gymnasium, an outpatient oncology clinic, a hospital surgery service, and a pain remediation clinic, with at least 37 outbreak-associated cases of HBV and approximately 8,722 at-risk persons notified for screening.
- Infection control breaks varied in these settings.

### **Hepatitis C (total 13 outbreaks, 102 outbreak-associated cases, 80,649 at-risk persons notified for screening):**

- 7 outbreaks occurred in outpatient facilities (including one outbreak of both HBV and HCV), with at least 30 outbreak-associated cases of HCV and >68,579 persons notified for screening.
- 5 outbreaks occurred in hemodialysis settings, with at least 46 outbreak-associated cases of HCV and 1,311 persons notified for screening.
- One outbreak occurred because of drug diversion by an HCV-infected surgery technician, with at least 24 outbreak-associated cases of HCV and 8,000 persons notified for screening.

