

American Nurses Association – Independent Study Module Needlestick Safety and Prevention

ABSTRACT

Every day, health care workers are exposed to dangerous and deadly bloodborne pathogens through contaminated needlesticks, sharps, or splash exposures. It is one of the greatest risks faced by the frontline health care worker. Yet, these exposures have often been considered “part of the job.” The Needlestick Safety and Prevention Act was signed into law in November 2000 and became effective in April 2001. The passage of this federal needlestick legislation was part of a plan by the American Nurses Association (ANA) and other health care worker advocates to achieve an amendment to the federal Occupational Health and Safety Administration (OSHA) Bloodborne Pathogens Standard. The purpose of this Independent Study Module is to inform nurses about the law, the additional protections it provides, and present other strategies the nurse can use to reduce occupational exposure to bloodborne pathogens.

OBJECTIVES

1. Identify five key components of the Needlestick Safety and Prevention Act of 2000.
2. Discuss the impact of safe practice/safe needle devices on nurses’ health and well being.
3. Explain the key elements of the OSHA Compliance Directive for the Bloodborne Pathogens Standard and strategies for identifying and reporting non-compliance.
4. Explore proactive strategies for promoting a culture of safety in the workplace.
5. Describe ANA activities to promote health and safety in the workplace for nurses.

AUTHORS

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INTRODUCTION

Work-Related Bloodborne Pathogen Exposure: The Risks for Health Care Workers

Every percutaneous needlestick and sharps injury carries a risk of infection from bloodborne pathogens. Yet, these exposures often have been considered “part of the job.” Health care workers primarily are exposed to these pathogens via contaminated needlestick and sharps injuries. You probably know at least one colleague who has sustained an injury, or perhaps you have been stuck yourself. It is important that you and your colleagues fully understand these risks.

The Facts About Occupational Infection:

Every year, health care workers experience between 600,000 and 800,000 exposures to blood (United States Department of Labor-Occupational Safety and Health Administration [USDOL-OSHA], 2001). Registered nurses working at the bedside sustain an overwhelming majority of these injuries (Perry, Parker, & Jagger, 2003).

These exposures carry the risk of infection with Hepatitis B (HBV), Hepatitis C (HCV), and Human Immunodeficiency Virus (HIV), the virus that causes AIDS. Each of these viruses poses a different risk if a health care worker is exposed. More than 20 other infections can be transmitted through needlesticks, including syphilis, malaria, and herpes (Centers for Disease Control and Prevention [CDC], 1998a). At least 1,000 health care workers are estimated to contract serious infections annually from needlestick and sharps injuries (International Health Care Worker Safety Center, 1999).

According to the National Institute of Occupational Safety and Health (NIOSH), the design of the device can increase the risk of injury. Specific features make certain devices more dangerous. These include: (National Institute for Occupational Safety and Health [NIOSH], 1999).

- Devices with hollow-bore needles.
- Needle devices that need to be taken apart or manipulated by the health care worker-like blood-drawing devices that need to be detached after use.
- Syringes that retain an exposed needle after use.
- Needles that are attached to tubing-like butterflies that can be difficult to place in sharps disposal containers.

The highest risk of injury is from blood-filled hollow-bore needles. They accounted for 63% of the needlestick injuries from June 1995-July 1999 (NIOSH, 1999). Ninety

percent of the Centers for Disease Control and Prevention (CDC) documented cases of health care workers who contracted HIV from needlestick injuries involved injuries with hollow-bore, blood-filled needles (CDC, 1998a).

This data may appear to be “old”, dating back five or six years. It continues to have relevance when discussing the 2000 Needlestick Safety and Prevention Act since it was the science available at the time the law was debated, and ultimately, passed. This data proved to be very persuasive, and helped make the case for the law. Current data suggest that improvements in the design and distribution of equipment are making a positive impact on the incidence of needlesticks. Many references are provided that will direct the reader to data that is continuously updated and reflects current science. Some of the websites cited are continuously monitoring the epidemiology of these injuries and should be used in current discussions of the subject.

Figure 1. Hollow-bore needles and other devices associated with percutaneous injuries in CDC surveillance hospitals, by % total percutaneous injuries (n=4,951), June 1995-July 1999.

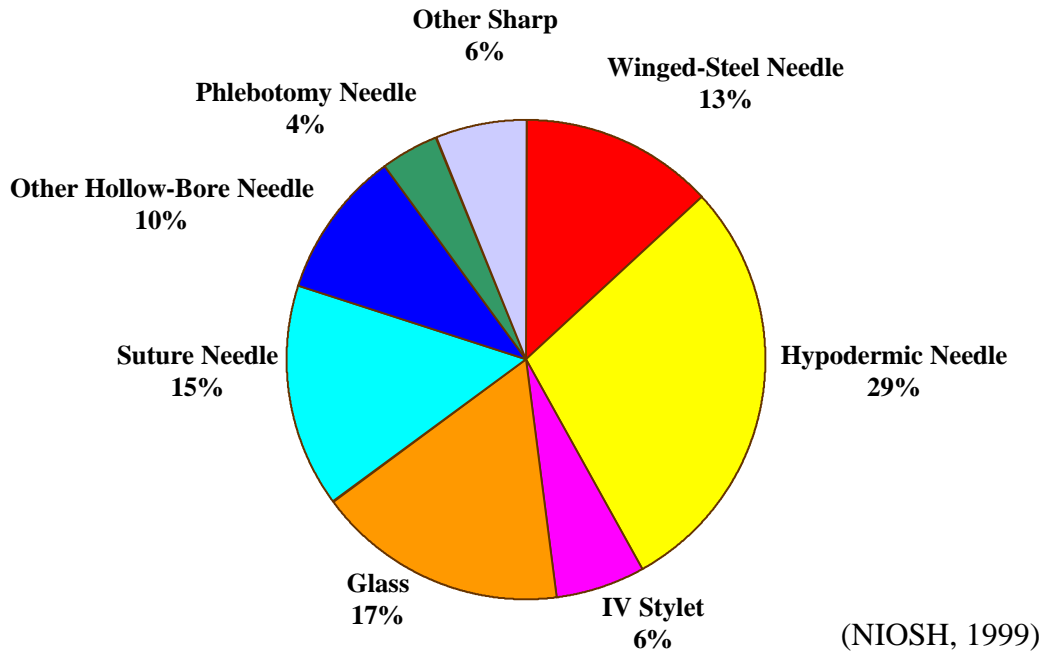
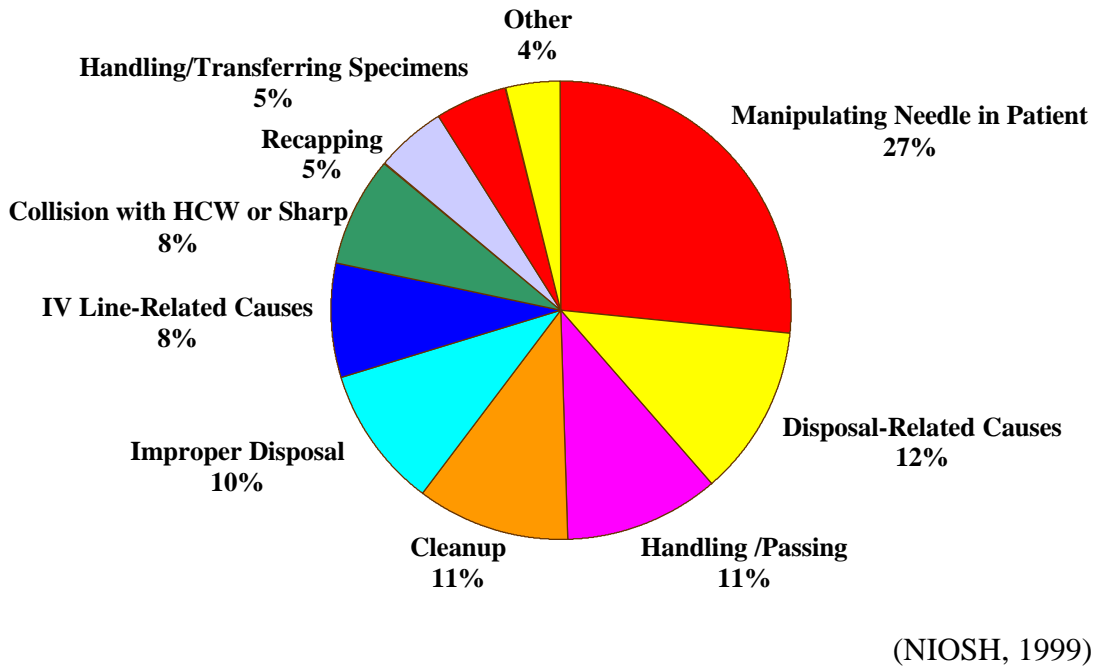


Figure 2. Causes of percutaneous injuries with hollow-bore needles in CDC surveillance hospitals, by % total percutaneous injuries (n=3,057), June 1995-July 1999⁹(NIOSH, 1999).



HIV/AIDS

HIV Transmission From Infected Patients to Health Care Workers:

While the transmission rate of occupationally acquired HIV remains very low, AIDS is a debilitating and ultimately fatal disease, making each potential exposure a frightening experience. Many nurses throughout the world are living with occupationally acquired AIDS, and many have died from it. Concerns about HIV contaminated blood led to the 1991 OSHA Bloodborne Pathogens Standard and CDC's Universal Precautions.

- The transmission rate of occupationally acquired HIV after an exposure is 0.3% (1 in 300). In other words, if a health care worker is stuck by a needle or cut by a sharp that is contaminated with the blood of an HIV patient, there is a 1 in 300 chance that she or he will be infected with HIV.
- As of June 2001, there were 57 CDC-documented cases of health care workers with occupationally acquired HIV and at least 137 cases of possible transmissions (CDC, 2003).
- Based on the prevalence of HIV, 35 new cases of occupationally-acquired HIV are estimated to occur annually (International Health Care Worker Safety Center, 1999).
- Health care workers primarily have been infected with HIV after needlestick and sharps injuries or, rarely, after infected blood gets into a worker's open cut or a mucous membrane (for example, the eyes or inside the nose).
- The majority of infections have resulted from injuries from hollow-bore, blood-filled devices. Less frequently, workers have been infected via solid sharps (like suture needles or scalpels) and splash exposures (NIOSH, 1999).
- The body fluids of most concern for HIV transmission are: blood, semen, vaginal fluid, breast milk, and other body fluids containing blood.
- Other body fluids that may transmit the virus include: cerebrospinal fluid surrounding the brain and the spinal cord, saliva transmitted in dental procedures, synovial fluid surrounding bone joints, and amniotic fluid surrounding a fetus.

Transmission of HIV From Infected Health Care Workers to Patients:

- This remains a serious concern for all health care professionals and for the public. No health care worker would intentionally harm a patient. The studies in the United States have shown only one instance of patients being infected by a health care worker, but this must be constantly tracked and evaluated. Investigations have been completed involving more than 22,000 patients of 63 HIV-infected physicians, surgeons, and dentists, and no other cases of transmission were identified in this study.
- Infected workers should seek counsel from an expert panel to review and modify their practice based on the best available scientific information.
- There are no data to indicate that infected workers who do not perform invasive procedures pose a risk to patients (CDC, 1998).

The Disease:

- The CDC estimates that at the end of 2000, approximately 800,000-900,000 people were living with HIV and AIDS in the United States.
- There have been 448,060 reported deaths caused by AIDS.
- There are approximately 40,000 new HIV infections occurring in the US every year.
- HIV destroys CD4+ T cells, which are crucial to the normal function of the human immune system. Loss of CD4+ T cells in people with HIV is also a predictor of the development of AIDS.
- Most people infected with HIV carry the virus for years before enough damage is done to the immune system for AIDS to develop. However, recently developed sensitive tests have shown a strong connection between the amount of HIV in the blood, decline in CD4+ T cell numbers and the development of AIDS. Reducing the amount of virus in the body with anti-HIV drugs can slow this immune system destruction.
- In addition to occupational exposure, HIV is spread by sexual contact with an infected person, by sharing needles and/or syringes (primarily for drug injection) with someone who is infected, or, less commonly (and now very rarely in countries where blood is screened for HIV antibodies), through transfusions of infected blood or blood clotting factors.
- Babies born to HIV infected women may become infected before or during birth or through breast-feeding after birth.

Treatment:

There is currently no HIV vaccine. While aggressive research continues in the U.S. and around the globe, a vaccine is still years and probably decades away. New medications, including antiretroviral drugs, can slow the development of HIV/AIDS. For the latest information on drug guidelines, contact the U.S. Department of Health and Human Services AIDS Info, which is included in the Internet Resource List. The OSHA Bloodborne Pathogen Standard requires employers to evaluate and treat health care workers in accordance with the latest post-exposure assessment, prophylaxis, and treatment guidelines that are posted on the CDC website (see Internet Resource page). Those guidelines are continuously updated and can be very effective. Post-exposure prophylaxis (PEP) can greatly reduce the risk of transmission and should be started within two hours of exposure.

Hepatitis C

Lately, Hepatitis C, caused by HCV, has become a great concern for nurses. Hepatitis C is a serious disease of the liver and can be fatal. HCV was not identified until 1989; before that it was referred to as non-A, non-B hepatitis virus. Since the method to test for Hepatitis C in blood products was not developed until 1992, people who received blood products before 1992 might have been exposed to HCV. Testing for Hepatitis C after

needlestick injuries was not recommended by the CDC until 1998 (CDC, 1998). Even after that, many health care workers were unaware of the need to be tested for Hepatitis C. There could be thousands of nurses with occupationally-acquired Hepatitis C who simply do not know it. It is a silent epidemic.

Transmission:

- HCV is primarily spread by exposure to infected blood, via IV drug use, occupational needlestick and sharps injuries, or having received a blood product prior to 1992. Transmission can also occur from an infected mother to her baby during birth.
- HCV also can be sexually transmitted, but this is rare.
- Hepatitis C is the most frequent infection resulting from needlestick and sharps injuries with a transmission rate of 2.7%-10% (CDC, 1998).

The Disease:

- Hepatitis C can lead to liver failure and liver cancer. It is the leading cause of liver transplants in the U.S. A liver transplant costs hundreds of thousands of dollars.
- Hepatitis C is the most common chronic bloodborne infection. The CDC estimates that almost four million Americans are infected with HCV, whereas less than one million are infected with HIV.
- Eighty percent of people infected with HCV are asymptomatic, but symptoms can include jaundice, fatigue, dark urine, abdominal pain, loss of appetite, and nausea.
- Seventy percent of chronically infected persons develop chronic liver disease.

Treatment:

- There is no vaccine for Hepatitis C.
- There is currently no approved post-exposure prophylaxis (PEP) for HCV.
- Interferon monotherapy or combination therapy with ribavirin are the current treatments.
- Combination therapy is currently the preferred treatment and has been shown to be effective in 40% of infected persons.
- These drugs can cost thousands of dollars per month.
- Alcohol use can make the disease worse.

Hepatitis B

Hepatitis B, caused by Hepatitis B Virus, is now preventable due to the vaccine that must be offered to all health care workers and is given to children at birth. After the 1991 Bloodborne Pathogens Standard required that the vaccine be offered to all health care employees, cases of hepatitis B in health care workers dropped from 17,000 annually to 400 annually, and continues to drop (Mahoney, Steward, Hu, Coleman, & Alter, 1997).

ANA strongly recommends that all health care workers be vaccinated since it is the best means of prevention. Current public health recommendations also suggest that health care workers have blood titers drawn to assess vaccination status. Those recommendations were made by the US Public Health Service in 2001 (CDC, 2001).

Who is at risk?

- Health care and public safety workers
- People with multiple sex partners
- Men who have sex with men
- IV drug users
- Infants born to infected mothers
- Hemodialysis patients

The Disease:

- About 30% of infected people demonstrate no symptoms. Symptoms can include jaundice, fatigue, abdominal pain, loss of appetite, nausea, vomiting, and joint pain.
- Death from liver disease can occur in 15-25% of chronically infected people.
- Transmission occurs via blood and body fluids and is spread via unprotected sex with an infected partner, IV drug use, and mother-child transmission.
- There are approximately 1.25 million chronically infected people in the U.S., 20-30% of whom acquired their infection during childhood.
- The highest rate of disease occurs among 20-49-year-olds.

Treatment:

- Alpha interferon and lamivudine are used to treat chronic hepatitis B. They are effective in up to 40% of patients.
- These drugs should not be used in pregnant women.
- Alcohol use can make liver disease worse.

SHARPS INJURY PREVENTION

While exposure to bloodborne pathogens is one of the most deadly hazards that nurses face on a daily basis, it is also one of the most preventable. Over 80% of needlestick injuries can be prevented with the use of safer needle devices (CDC, 1997), which, in conjunction with worker education and work practice controls, can reduce injuries by over 90% (Jagger, 1996).

The first safer needle designs were patented in the 1970s. In 1992, the Food and Drug Administration (FDA) (1992) issued an alert to all health care facilities to use needleless IV systems wherever possible. That alert was merely a recommendation, and it took another eight years for it to be required by law. Despite FDA approval of hundreds of

safer devices, less than 15% of U.S. hospitals used safer needle devices and systems prior to the implementation of state and federal laws (McCormick, 1999).

With the rapid development of technology and engineering controls, prevention is becoming easier and easier. By using safer devices, your institution will not only protect workers, but will also save money. Safer needle devices can cost from cents to dollars more than standard devices, but prices continue to decrease with increased market competition and technology.

Prevention is cost-effective. The cost of follow-up for an exposure is almost \$3,000 per needlestick injury, even when no infection occurs (Jagger, Bentley, & Juillet, 1998). According to the American Hospital Association (AHA), one case of serious infection by bloodborne pathogens can soon add up to \$1 million or more in expenditures for testing, follow-up, lost time, and disability payments (Pugliese & Salahuddin, 1999). A liver transplant due to Hepatitis C costs hundreds of thousands of dollars. Other costs from needlestick and sharps injury include workers' compensation, overtime, and expenses related to recruitment and training of staff to replace a worker who becomes ill. While there are no financial calculations to cite here, there should be a cost applied to the replacement of nurses and other health care workers who chose to leave the care environment due to concerns about needlesticks. And what is the cost of those workers we never recruit into health care, because of those fears?

Hierarchy of Controls

You can work with your health care facility to reduce preventable exposures by identifying, as a starting point, the highest risk procedures and devices and implementing the most effective control measures. Standard occupational health principles to control hazards are usually discussed in terms of the hierarchy of controls (American Nurses Association [ANA], 2001). The list, below, demonstrates how to apply the hierarchy of controls framework to bloodborne pathogen hazards. In addition to eliminating sharps, using safer needle devices is one of the best ways to prevent injuries.

Hierarchy of Controls (from most effective to least effective)

Most Effective

- **Elimination of Hazard** – substitute injections by administering medications through another route, such as tablet, inhaler, or transdermal patches, for example. Remove sharps and needles and eliminate all unnecessary injections. Jet injectors may substitute for syringes and needles. Other examples include the elimination of unnecessary sharps like towel clips and using needleless intravenous (IV) systems.
- **Engineering Controls** – such as needles that retract, sheathe, or blunt immediately after use.
- **Administrative Controls** – policies aimed to limit exposure to the hazard. Examples include allocation of resources demonstrating a commitment to health care worker safety, a needlestick prevention committee, an exposure control plan, removing all unsafe devices, and consistent training on the use of safe devices.
- **Work Practice Controls** – examples include no re-capping, placing sharps containers at eye-level and at arms reach, remember that most nurses are women, and some of the placement practices of disposal containers have not taken that into consideration), emptying sharps containers before they're full, and establishing the means for safe handling and disposing of sharps devices before beginning a procedure.
- **Personal Protective Equipment (PPE)** – barriers and filters between the worker and the hazard. Examples include eye goggles, face shields, gloves, masks, and gowns.

Least Effective

Safer Devices

There is solid evidence that devices with safety features significantly reduce needlestick injuries (NIOSH, 1999):

- Needleless or protected-needle IV systems decreased needlestick injuries related to IV connectors between 62-88%.
- Phlebotomy injuries were reduced by 76% with a self-blunting needle, 66% with a hinged needle shield, and 23% with a sliding-shield, winged-steel (butterfly-type) needle.
- Phlebotomy injuries were reduced by 82% with a needle shield, but a recapping device had minimal impact.
- Safer IV catheters that encase the needle after use reduced needlestick injuries related to IV insertion by 83% in three hospitals.

Excitement has spread among advocates for safer needle design as they read the results of the 2001 data as reported by Dr. Janine Jagger, a pioneer researcher in the epidemiology of needlestick injuries and the originator of EPINet, and internet based data base that collects and analyzes trends. When compared to the 1999 data from facilities that voluntarily report injury data, there was a reduction in percutaneous injuries (PI) by 51%. And, the investigators believe that it is due to a combination of factors: the introduction of safer needle devices over the last decade, greater staff education on safer practices and use of safer devices, and major changes in the way intravenous lines are accessed and a reduction in the use of needles (Jagger, 2003).

THE NEEDLESTICK SAFETY AND PREVENTION ACT OF 2000 (Public Law 106-430)

How the Law Was Enacted: Nurse Power and a Three-Pronged Approach

Through the diligent work of the nurses in ANA, other health care workers, and unions representing health care workers, a tremendous victory was achieved when Congress passed the Needlestick Safety and Prevention Act of 2000 which President Clinton signed on November 6, 2000 (visit the OSHA website for more information on rights and protections contained in the law listed in the Internet Resources page). ANA had launched the campaign for federal legislation to provide more protection from needlestick and sharps injuries. ANA's Safe Needles Save Lives campaign laid the groundwork for a multi-pronged approach.

One special aspect of this campaign was the expert testimony of nurses who had been injured by needlesticks. They contributed a personal face to the statistics of workplace injuries, and convinced many in Congress that prevention of these injuries was the right thing to do for both humane and business reasons. Members from both parties of the U.S. House of Representatives and the U.S. Senate embraced the proposal to amend the 1991 OSHA Bloodborne Pathogens Standard by specifically addressing the safety of devices used and worker involvement in selecting the devices. This was another example of the long-standing effectiveness of ANA working with Congress and federal agencies. In all assessments, it was the credibility of nurses providing the personal and professional perspective that overcame the long-standing reluctance to expand OSHA-related regulations of any kind.

Once the groundwork had been laid, ANA's expert lobbying staff met with dozens of congressional members and staffs. Nurse constituents by the thousands communicated with their members of Congress and convinced them this issue was important to the quality of nurses' lives across the country. The momentum to pass a federal law also resulted from the parallel success of the second prong: the rate at which state needlestick legislation was sweeping across the country. More on the state strategy, and the third prong, additional regulatory reform, follows later.

Three nurses who made the difference, and were the personal faces behind the injury statistics are nurse heroes, and are still working to prevent any other workers from being injured. Their stories are told with their permission, and stands as an example of their commitment to prevention.

The first nurse who became an activist after her injury is Lynda Arnold. Lynda was a new graduate, practicing for five months in a Pennsylvania hospital, when she received a needlestick after inserting an intravenous (IV) line in an HIV-infected patient. Lynda was wearing gloves: the recommended “safer” practice at the time. The device she used was not a safer device. She became infected with HIV and has battled years of illness and medication side effects. Lynda launched a campaign called the National Campaign for Health Care Worker Safety that asked hospitals to declare their commitment to the use of safer devices. While the campaign stimulated discussions within the hospital industry, it was evident that voluntary compliance with safer devices would not have sufficient impact to help health care workers across the country. The good news is, Lynda is now feeling well and has an active life with her husband and children. She continues to speak and write about her experiences, and is a tireless advocate for safety.

Karen Daley is the second nurse we consider one of our heroes. She was working in a busy Boston emergency room, and received her needlestick while she was disposing a butterfly needle device she had successfully inserted into a patient into a wall mounted needle box. She felt a sharp stab, and realized she had been stuck by an unshielded needle protruding from the top of the box. When she was called into the employee health office, and met by her manager and other administrators at the hospital, Karen realized she was not going to hear good news. She was infected with HIV and Hepatitis C. Karen channeled her emotions into public disclosure and advocacy efforts to make change happen. She was president of the Massachusetts Nurses Association and active in the ANA at the time of her injury. She held a press conference at the state house in Boston to announce what had happened to her, and lent support to the passage of safer needle device legislation in that state, which became law in August, 2000. That same year, Karen testified in Washington, DC and was invited to join President Clinton on November 6, 2000 as the federal Act was signed into law. Karen is doing very well and is pursuing her graduate degrees in Boston.

Lisa Black is our third nurse hero. She was injured in 1997 in a Nevada hospital. While flushing a blood-filled IV line with a syringe and a needle, she was stuck when the needle was jerked out of the port by an unanticipated movement by the patient. Lisa immediately followed the first aid advice after an injury and was placed on a regimen of antiretroviral medication and a protease inhibitor. Despite the prophylaxis, Lisa became ill over nine months after the needlestick and converted with both HIV and Hepatitis C. Lisa’s injury was 100% preventable. If the hospital had consistently used a needleless IV system, which existed by 1997 and was widely available, Lisa would not have been injured. Lisa has also dedicated her energies on behalf of helping others avoid these life-threatening injuries. She worked tirelessly to secure passage of the Nevada safety legislation and related workers’ compensation legislation (see section on state legislation for a more complete discussion of the Nevada law). Lisa is also doing well now, and is

serving as Executive Director of the Nevada Nurses Association and pursuing graduate degrees in nursing and health policy.

These three activists have helped make work safer for all of us. Hundreds of other workers have experienced illness, and death. And countless more suffer the anxiety and trauma that accompanies every injury as they complete months of testing and treatment. Thank you, Lynda, Karen, and Lisa. Be well!

MAJOR PROVISIONS OF THE NEEDLESTICK ACT OF 2000 RIGHTS AND PROTECTIONS: OSHA BLOODBORNE PATHOGENS STANDARD

The OSHA Blood Borne Pathogens (BBP) Standard, including the amendments from the federal Needlestick Safety and Prevention Act, requires health care facilities to implement the following:

1. Engineering controls, such as safer medical devices, which must be used to reduce or eliminate worker exposure.
2. Involvement of frontline health care workers in the selection of safety devices.
3. Additions to the exposure control plan, such as an annual review and update.
4. Other control measures, such as administrative, work practice, and personal protective equipment.
5. Enhanced recordkeeping and detail in a sharps injury log.

These amendments, and the 1991 Blood Borne Pathogens Standard, provide the following general areas. It is strongly encouraged that the reader and all employers research the federal and state requirements thoroughly. Many internet and print references will be listed at the conclusion of this module, and should serve as a starting point for more information on the occupational protections from bloodborne pathogens.

1. Engineering Controls

- Use “safer medical devices, such as sharps with engineered sharps injury protections and needleless systems,” and other engineering controls. These devices have built-in safety features that reduce the risk of injury and can include syringes with a sliding sheath, needles that retract into the syringe after use, shielded or retracting catheters, and IV systems that use a catheter port with a needle housed in protective covering. Needleless systems include IVs that administer medication and fluids through a catheter port using non-needle connections and jet-injection systems that deliver liquid medication beneath the skin or through a muscle.
- Make safer needles and other sharps with integrated safety features available in syringes, blood collection devices, IV access products, lancets, and blunt suture needles.

- Use puncture-proof containers to dispose of sharps and needles. Containers must be closed, puncture resistant, leak proof, color coded, and emptied routinely to prevent overfilling.

2. Frontline Health Care Worker Involvement and Training Requirements

- Include the involvement of frontline health care workers (non-managerial employees responsible for direct patient care) in device evaluation and selection, with evidence of this participation documented in the exposure control plan.
- Provide all employees at risk for occupational exposure with interactive training on the use of safer devices, work practices, and PPE from a knowledgeable person. Workers must receive training when hired and at least once a year, or whenever there is a modification of tasks or procedures. Training must be provided during working hours and at no cost to employees. Training records must be maintained for three years.

3. Exposure Control Plan

- Have a written exposure control plan (ECP) and make a hard copy of the ECP available to employees or their representatives within 15 working days of a request.
- Review and update the ECP annually or more frequently whenever new or modified procedures are adopted or whenever employee positions are revised in such a way that creates new potential exposures. This review must include an examination of the most recent technological advances.
- Inform workers of the location of the ECP and the procedures to follow if an exposure occurs.

4. Other Control Measures: Administrative, Work Practice, and Personal Protective Equipment (PPE)

- Provide within two hours access to post-exposure follow-up that conforms to CDC guidelines for testing and prophylaxis.
- Make the Hepatitis B vaccine available to employees at no cost and add titer verification as recommended.
- Make purchasing decisions based on the proven safety and efficacy of the product.
- Prohibit work practices of bending, re-capping, or removing needles unless required by a specific medical or dental procedure.
- Clean and decontaminate all work surfaces after contact with blood and other infectious body fluids following infection control guidelines (CDC, 1998a).
- Provide PPE including gloves, gowns, goggles, masks or face shields. This equipment must be in sizes that fit all workers, of good quality and readily available. Non-latex alternatives must be provided.

5. Recordkeeping

The newly revised Bloodborne Pathogens Standard requires employers to “maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps.” The log must contain, at a minimum, the following information:

- Date of the injury
- Type and brand of the device involved
- Department or work area where the incident occurred
- Explanation of how the incident occurred

STATE LAWS THAT ADDRESS NEEDLESTICK INJURY PREVENTION: THE SECOND PRONG

There are some states (and territories) that have state OSHA plans, and have a designated state agency to enforce occupational safety and health standards. The current list of states with approved plans is available in Table 1. Further information on state plans can be found on the OSHA website, and that reference is listed on the Internet Resources page. The standards are set by the state and are required to be at least as stringent as the federal OSHA standards. States without state OSHA plans leave the responsibility for the development and enforcement of occupational safety and health standards to federal OSHA. The federal OSHA plan covers private employees. The coverage of private and public employees varies among the states, and it is best to review that information for your own state. Those laws are also undergoing continuous review and revision, and it would not be accurate for a summary to be provided in this module.

Table 1. State Occupational Safety and Health Plans.

Alaska	Kentucky	New York*	Vermont
Arizona	Maryland	North Carolina	Virgin Islands
California	Michigan	Oregon	Virginia
Connecticut*	Minnesota	Puerto Rico	Washington
Hawaii	Nevada	South Carolina	Wyoming
Indiana	New Jersey*	Tennessee	
Iowa	New Mexico	Utah	

*The Connecticut, New Jersey, and New York plans cover public sector (state & local government) employment only.

California was the first state to pass needlestick legislation. In September 1998, AB 1208 became law, revising the state’s bloodborne pathogen standard. The state nurses association, ANA/California, nurses unions, and other health care unions had been

working with state officials to convince them of the need for additional language addressing the safety of devices. After legislation passed, there was a rush by hundreds of facilities and manufacturers to implement the law by August 1999. In 2002 and 2003, the California Department of Health Services conducted evaluations of injury rates, record keeping, and evaluation practices subsequent to implementation of the law. Pre- and post-law safety device sales show dramatic changes in practices. Additional analysis from those studies will also identify strategies for success, or barriers, to safer device utilization.

Between 1998 and 2001, 17 states passed legislation that addressed needlestick injuries. State needlestick legislation passed prior to the federal act strengthens the OSHA standards that may exist in state OSHA plans, and further strengthens programs in two states that are covered by federal OSHA standards.

Since passage of the Federal Needlestick Safety and Prevention Act in 2000 some states continued to introduce and pass legislation to strengthen needlestick protections. As of June 2002, 21 states have needlestick legislation. Those without state OSHA plans have introduced legislation to cover state and municipal employees who are not covered by the federal Act. States with state OSHA plans have introduced legislation to strengthen the standard with additional requirements.

For example, legislation in Hawaii requires employers to record information related to needlestick injuries in addition to that required by federal law, and a law in Alaska requires a needlestick committee comprised of at least 50% frontline health care workers from all units and all specialties. Another law in Nevada illustrates the merit of additional protections. Passed in 2002, Nevada now provides “presumptive” eligibility coverage under workers’ compensation for reported occupational exposure. Because there is such a long interval between exposure and diagnosis of HIV and Hepatitis C, many health care workers are denied workers’ compensation benefits for their illness. This legislation presumes an infection stems from the injury at the employee’s job without the need for documentation of patient infection and the employee would be covered by workers’ compensation.

Other state variations are too numerous to mention in general terms, and it is strongly advised that you research your own state to be fully informed of the laws that affect you, or require your involvement to be successfully passed. Additionally, some specific information is provided from CDC-NIOSH (see website listed on the Internet Resources page). Table 2, below, lists a basic comparison of state legislation provisions.

Table 2. Comparison of state-by-state needle safety legislation (revised May 2001), source: CDC-NIOSH.

States	Safety Device List	Sharps Injury Log	Reporting Sharps Injury Log	Safety Device Selection Process	NIOSH Cited	Study Report
Alaska	X	X		X		
Arkansas						
California	X	X		X		
Connecticut						
Georgia	X	X		X	X	
Iowa					X	X
Maine						
Maryland		X		X		
Massachusetts	X	X		X		
Minnesota		X		X		X
Missouri	X	X			X	X
New Hampshire						
New Jersey		X	X	X		X
New York						X
Ohio	X	X		X	X	
Oklahoma	X	X		X		
Pennsylvania		X		X		
Rhode Island		X		X		
Tennessee	X					
Texas	X	X	X	X		
West Virginia	X	X	X			

THE OCCUPATIONAL SAFETY AND HEALTH BLOODBORNE PATHOGENS STANDARD: THE THIRD PRONG- REGULATIONS

After years of lobbying efforts by ANA and others starting in the 1980's, there are significant laws and regulations that provide nurses with rights and protections. This standard existed almost a decade before the latest amendments. In addition to the Occupational Safety and Health Act (OSHAct), health care workers are protected by OSHA's 1991 Bloodborne Pathogens (BBP) Standard. Although this standard made many improvements in the health care workplace, needlestick injuries continued to occur at an alarming rate. The OSHA Bloodborne Pathogens Standard applies to all occupational exposures to blood or other potentially infectious materials. The original standard certainly improved the health care environment regarding exposures to blood and body fluids as far as it went. The standard set forth requirements for employers with workers who may be exposed to blood or other potentially infectious materials. In order to reduce or eliminate the hazards, the employer must implement an exposure control plan for the worksite with details on employee protections measures. It adopted the concept of universal precautions, and required the employer to make available personal protective equipment, such as gowns, gloves, face shields, and other barriers to fluids. Disposal systems for sharps were designed and widely dispersed. Hepatitis B vaccine was made available to all employees who may be exposed to blood and body fluid exposures, as well as post-exposure testing and prophylaxis. Training in exposure prevention was required, and advisories about practice changes were issued, such as avoidance of recapping or bending of needles.

During the first ten years, OSHA intended to reduce the number of injuries that health care workers received from needles and other sharp medical objects. The agency issued and revised compliance directives (guidance to be used in the field) to reflect newer and safer technologies, and to increase the employer's responsibility to evaluate and use effective, safer technologies. The agency also proposed a requirement in recordkeeping that would have collected all needlestick injuries. In spite of these directives and the intent of the agency to strengthen the standard through their regulatory agenda, leaders in worker health and safety, such as ANA, chose to amend the rules with sweeping legislative improvements.

The OSHA Compliance Directive (CPL 2-2.69): Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens

OSHA issued an instruction that established policies and provides clarifications to ensure uniform enforcement of the Bloodborne Pathogens Standard (OSHA, 2001). The compliance directive is essential informational for employers and employees to better understand how the OSHA Bloodborne Pathogens standard and the Federal Needlestick Safety and Prevention Act of 2000 are interpreted. The directive is also used by compliance officers when conducting workplace visits. Inspections can be either programmed, or non-programmed. When inspections occur, the exposure control plan is

reviewed and employees will be interviewed to assess employer compliance with the standard.

The compliance directive strongly reinforced those additional areas of emphasis resulting from passage of the Needlestick Safety and Prevention Act. The critical role of non-managerial employee/patient care providers in the identification, selection, and evaluation of effective engineering and work practice controls is stated with great clarity within the directive. Frontline employee input, whether it be by surveys, participation in safety meetings, worksite inspections, or exposure incident investigations is highlighted.

Documentation and Recordkeeping:

1. Sharps Injury Log

The International Health Care Worker Safety Center at the University of Virginia has produced a form that serves as a sharps injury report. They created EPINet, a surveillance system that gives health care facilities a standardized system to track exposures and injuries. Facilities can use EPINet for free and adapt it to fit any specific needs.

The data contained in the log can be used to:

- Analyze injury frequencies by specific attributes like work units, devices, and procedures.
- Identify high-risk devices and procedures.
- Identify injuries that could be prevented.
- Evaluate the efficacy of newly implemented safe devices.
- Share and compare information and successes with other institutions.

Needlestick and/or Safety Committees should regularly review the sharps injury log. (See section on Needlestick Committees). By learning which types of devices are involved in injuries, it is possible to determine which devices are not safe and must be replaced. While reviewing the log, certain departments or units may seem to have a high number of injuries. Armed with that information, interventions can be made within that unit to determine why they are sustaining so many injuries. Did nurses on that unit receive training on the use of safe devices? Is there a lack of safer devices available on that unit? Recognize that short staffing and other work organization issues might contribute to needlestick injuries. Adequate staffing might help prevent needlestick injuries (Aiken, Sloane, & Klocinski, 1997). Information from the log will help to identify specific interventions, such as increased training, stocking additional safer devices, and increased staffing.

As you analyze the log data, the committee should identify high priorities for action, especially to eliminate the highest risk devices and prevent the highest risk and most frequently occurring injuries. However, remember that according to federal law, the goal of the committee is to prevent all types of exposures and minimize all risks.

2. OSHA 300 Log

While your facility must record all information on the sharps injury log, they also still must record these injuries on the OSHA 300 Log. You should review the OSHA 300 Log and compare it with the information in the sharps log and make sure both are accurate. The OSHA 300 Log must be posted in a public place each year and employees are encouraged to track the information on the Log. Ask the following questions when reviewing the OSHA 300 Log:

- Are there needlestick and sharps injuries?
- When do they occur?
- What was the injury or illness?
- Are injuries and illnesses occurring in isolated cases or in groups of employees?
- Are injuries happening to employees in some job titles and not others?
- Were employees on restricted duty due to the injury or illness?
- Did employees take leave due to the injury or illness?
- Have these injuries led to illness?

Filing an OSHA Complaint:

Many employers are still learning about the federal Needlestick Safety and Prevention Act. Documenting the specifics of the amended Bloodborne Pathogens Standard (See Rights and Protections) and offering solutions can convince management to correct the hazards. Hopefully, you will either be able to establish a needlestick prevention committee or work with an already established committee to prevent injuries. Work with your facility's health and safety committee, labor-management committee, or whichever committee has the authority on this issue to make your employer aware of state and federal laws. Make it clear that employees are concerned enough to contact OSHA for an inspection if no action is taken.

If management refuses to correct problems and is violating the OSHA Bloodborne Pathogens Standard, employees have the right to file a complaint. A complaint is a notice of an alleged uncontrolled occupational hazard or a violation of the OSHAct or specific OSHA Standard given by a past or present employee or an employee representative, such as a union. Complaints can be filed anonymously.

It's your responsibility to report the hazard to a supervisor as an essential first step. When possible, you and your employer should work together to resolve the problem. You are not required to discuss concerns with your employer if you choose to file a complaint. If you are unionized, work with the union to file the complaint.

To file a complaint, fill out OSHA's official complaint form, including, if possible, the specific violation of either the OSHAct or the BBP Standard. OSHA recommends including the following information:

- The number of employees who work at the site and how many are at risk for exposure to the hazard.
- Details regarding the status of compliance, such as types of sharps used in all areas of the employment setting and whether safer devices are in place for all procedures requiring sharps.
- The units on which the use of safety devices has NOT been implemented.
- The number of needlestick injuries recorded in available needlestick logs.
- Whether or not frontline staff nurses and other health care workers were involved in the evaluation and selection of the safety devices.
- Data documenting the trials of safety devices and evidence regarding the decision to use the particular product.
- Examples of “near-misses” (e.g., sharps left in a bed).

It is against the law for an employer to discriminate against an employee for filing an OSHA complaint. Consult your local OSHA office or your state nurses association for assistance. For more information, complaint forms, and instructions, see OSHA’s website with details noted on the Internet Resources page.

WHAT EVERY NURSE CAN DO ABOUT SHARPS INJURY PREVENTION

How to Start, or Join a Needlestick Committee

Key Players in Committee Formation:

The strategies outlined in this module can be used by nurses in all settings and in all roles to advocate for themselves and their colleagues. The first step toward a comprehensive exposure control program and effective implementation of the law is the creation of a needlestick prevention committee. After gaining support and commitment to prevention from top-level administrators, establish a multidisciplinary needlestick and sharps injury prevention committee, required in some states, to bring together various departments, such as nursing, purchasing, housekeeping, infection control, employee health, risk management, and employee education and training. For the committee to be effective it must have power: the decision-makers in your institution should be represented. In some cases, it might be easier to work with an existing health and safety committee or infection control committee that already has the decision-making authority in this arena. It is required that some committees have the responsibility, and authority, to oversee implementation of the Needlestick Safety and Prevention Act of 2000. It is essential to be aware of the roles and levels of authority of all the related committees. If you face resistance in initiating safer devices, you may need to seek assistance from some of these committees.

Whether you are working with an existing committee or forming a separate needlestick prevention committee, make sure frontline health care workers with the greatest potential for injury and with the most experience using needles and sharps are represented on that committee. Because nurses use the majority of the equipment in extremely varied units,

and experience the majority of injuries, they must be actively involved in the committee, and must represent the wide variety of the units in which they work. Some states require that 50% of the committee be comprised of frontline health care workers (Perry, 2000). With frontline staff nurses involved, the most appropriate devices are more likely to be selected, and staffs are more likely to accept and use the new devices and practices. When committee meetings occur during patient care shifts (they should occur in the workplace during work hours), adequate nursing staff for patient care must be ensured for the frontline staff's full attention to the committee. The expertise of employees should not be provided without pay or offered at the expense of patients.

The committee will need access to data in a way that protects confidentiality. What the committee will need to know will be the specific devices involved and the environmental conditions in which each injury took place.

Role of the Committee:

The needlestick prevention committee should seek training on the principles of the industrial hygiene hierarchy of controls, product design features, and applying criteria for device evaluation to ensure a consistent knowledge level among device evaluators and for an effective selection process. The training should not be conducted by or in the presence of product representatives. Once a device is selected, the manufacturer can provide useful in-service education on the use of that device prior to implementation. In some institutions, unit-based committees may exist, and should be integrated with and representative to the overall committee. Language barriers should also be addressed, and in multi-language workforces adequate translation should be provided for committee representatives, and addressed in training protocols.

This committee's primary goals are to prevent needlestick and sharps injuries and to ensure that the hospital is adhering to state and federal standards. The committee should have clearly defined authority and not just serve in an advisory role. The committee should have authority to decide which devices are selected. The committee's responsibilities should include (Fisher, 1994):

- Defining bloodborne pathogen exposure problems.
- Developing strategies for improved needlestick injury reporting procedures.
- Overseeing the exposure control plan as mandated by OSHA, including post-exposure follow-up.
- Monitoring the post-exposure treatment program.
- Developing surveillance systems to monitor needlestick injuries.
- Reviewing the sharps injury log.
- Reviewing the OSHA 300 Log, which tracks all occupational injuries and illnesses.
- Obtaining and disseminating information about new devices as they develop.
- Evaluating, selecting, and implementing safe devices.
- Ensuring health care workers' input into product selection.
- Training on new safety devices.

- Documenting the committee’s work in meeting minutes.
- Informing and assisting those responsible for preparing for Joint Commission on Accreditation of Healthcare Organizations (JCAHO) inspections to demonstrate compliance with the Needlestick Safety and Prevention Act. JCAHO requires hospitals to comply with applicable local, state, and federal regulations including OSHA standards (Wilburn & Worthington, 2001).

How to Assess Compliance Where You Work:

The first step for the needlestick committee is to identify and document where and why needlestick and sharps injuries are occurring. There are various tools to assist in this task including: the sharps injury log, the OSHA 300 Log, a survey, and a workplace walk-through.

Document! Document! Document! All nurses have a responsibility to document. Documentation is always the first step, and it is essential that you actively train employees to report and document every needlestick and sharps injury to:

- Ensure timely post-exposure follow-up, including testing and treatment.
- Ensure workers’ compensation payment and that all health expenses are charged to workers’ compensation and not to the individual’s health insurance.
- Collect data to evaluate the health and safety of your workplace.
- Collect data that can be used by the ANA and state nurses associations to lobby state and federal agencies for additional protections. Forward the data to the institutional bloodborne pathogen coordinator.

The importance of documenting cannot be overstated. Help your colleagues understand that documenting will improve their own health and safety. Promptly reporting a needlestick and starting PEP can protect you in the future. It is always in your best interest no matter how busy you are to document illnesses and injuries. While each health care facility must now keep a sharps injury log, they also must maintain the OSHA 300 Log, which tracks all occupational injuries like back injuries and illnesses, like latex allergy. So, document all injuries and illnesses, not just sharps injuries.

It is now strongly encouraged that a mechanism be established to collect and analyze information about “near misses.” Data about products that fail, or injuries that are averted but could have caused an injury, can be rich learning opportunities about devices and training needs.

Workplace Walk-Through. A walk-through, which is a workplace inspection, is a crucial way to identify workplace hazards. Walk-throughs should be regularly planned and conducted by the needlestick prevention committee, and in the absence of a needlestick committee, the safety committee. Frontline workers should participate in these walkthroughs. Every facility is required to have a standing safety committee. The walkthroughs should be conducted during work hours, during different shifts, and unannounced. Walk through all units and speak with supervisors and frontline health

care workers. Include all departments that use sharp devices, like the lab and radiology departments. You can use the following components to create a checklist to help you gather information:

- What kinds of sharps are available on the unit?
- What procedures require needles and sharps?
- What patient characteristics are present in these procedures`?
- Where is the procedure done?
- Who does the procedure?
- Are there alternative methods to perform the procedure that can eliminate the sharp? For example, is there an oral instead of an injectable administration or needleless IV connectors?
- Are safer devices for all categories of sharps available on the unit? Are they used? Why or why not?
- Are there legitimate uses of conventional devices, and, are there procedures that cannot use safer devices?
- Are unsafe devices still on the unit? If so, why and how can the use and access to these devices be monitored and controlled? What equipment is available in the supply closets?
- Are the sharps boxes available within arm's reach, in sight, and routinely replaced when full? Is there a proscribed procedure for the removal of full boxes that maintains safety precautions?
- What other conditions, such as short staffing, exist that may contribute to the risk of needlestick and sharps injuries?

Employee Survey. While every needlestick and sharps injury should be documented, many people do not report them. In addition, many health care workers simply are unaware of the laws that protect them or the policies already in place at their health care facility. When the safety or needlestick prevention committee begins its work, it will need to assess the situation in your workplace. A survey can help determine whether needlestick injuries are being reported, whether staff are using safer devices, and whether they are aware of the laws and policies in place. Often, increased attention to needlestick injury prevention will result in an initial increase in the number of reported injuries. If used for an initial assessment and follow-up annually, this survey will help the needlestick prevention committee determine whether a change in the number of needlestick injuries recorded is, for example, truly an increase in the number of injuries occurring or an improvement in the reporting of existing injuries.

Using Contract Language:

In those settings where health care workers are represented by a collective bargaining agreement, the contract can serve as a tool to address workplace safety strategies. You can work with your state nurses association to negotiate contract language specific to needlestick prevention. If you work in a public facility in a state without an OSHA-approved health and safety program, and therefore, are not covered by OSHA

regulations, you should negotiate contract language incorporating the OSHA Bloodborne Pathogens Standard. Contract language goals should include:

- Establishing a joint labor-management needlestick prevention committee with equal representation that has the authority and responsibility discussed at the beginning of the section on the Needlestick Committee.
- Presumptive compensability, which means that if a nurse is infected with HIV, hepatitis B virus, hepatitis C virus, or other infectious diseases, it shall be presumed to be work-related for the purposes of workers' compensation. In other words, if you become infected you will not have to prove that you became infected at work.
- Financial compensation for workers infected with a deadly virus like HIV.
- Paid administrative leave during the administrative waiting period for state workers' compensation.
- Accommodation for injury/illness, for example, if you are ill while taking PEP medications after an exposure to a bloodborne pathogen.
- Return-to-work guidelines and modified work assignments.
- Union access to needlestick injury data and "near miss" reports.

Your contract is a powerful tool that can be used to ensure worker safety. Even if you do not have specific language regarding needlesticks, almost all contracts have some general health and safety language. While your collective bargaining unit works toward negotiating the language goals above, make sure you administer your current contract. For example, if management is not sufficiently addressing needlestick prevention or not involving union representatives in this process, consider filing a grievance through your union.

Evaluation, Selection, and Implementation:

Evaluating, selecting, and implementing safer devices are among the most important tasks for the needlestick prevention committee since the federal Act expects health care workers to be continuously and seriously involved in device evaluation and selection. OSHA requires that institutions review their exposure control plan annually and evaluate the effectiveness of the control measures, including safer needle devices. New devices are entering the market at a rapid pace and even an annual evaluation could miss opportunities for innovations that might reduce injuries. Not all devices are alike or equally effective. Just because the manufacturer claims that a device is a safety device does not mean that it is safe.

Desirable Characteristics of Safety Devices

- The device is needleless.
- The safety feature is built into the device.
- The device works passively (i.e., requires no activation by the user). If user activation is necessary, the safety feature can be engaged with a single-handed technique, allowing workers' hands to remain behind the exposed sharp.

- The user can easily tell whether the safety feature has been activated. Some safety features have a sound, such as a click, indicating that the feature has been activated. That may not be an effective function in noisy settings. Others change color when the feature is engaged. In dim visibility, or with color-blind staff, that may not be an effective indicator.
- The safety feature cannot be deactivated and remains protective through disposal.
- If the device uses needles, it performs reliably with all needle sizes.
- The device is easy to use and practical.
- The device is safe and effective in patient care. (Does the use of the safety device impact the number of tries necessary to give the injection or start the IV? What is the impact on patient discomfort or bruising at the site? Is there any modification to the dosage administered because of the safety mechanisms?)

Health care facilities purchase equipment and supplies in a variety of ways, and the needlestick prevention committee needs to work within that system. It is important to learn the process for approval and purchasing of new devices in your workplace, particularly in the case of large health networks and group purchasing organizations (GPOs), which might have complex purchasing systems. The needlestick prevention committee should work closely with the purchasing department to ensure that safer devices are purchased. Find out who is responsible for new product purchases in your facility and schedule a meeting between the needlestick prevention committee and the identified contact persons. Share the changes in the OSHA regulation with them and ask what steps are necessary for bringing a new product into the facility. Ideally, someone from purchasing will be a member of the needlestick prevention committee. The purchasing department can provide a list of devices that already are included in your institution's formulary and can contact manufacturers to request samples of products for screening. Be aware of "narrowed down" selection procedures. Some facilities only offer products that have been pre-approved by purchasing or management personnel. These often are based on recommendations or limitations by GPOs. These "narrowed down" device choices often are only based on price and neglect the safety features. This is especially true in facilities that are owned and operated by nationwide corporations. OSHA requires the use of safe and effective devices. If a safe and effective device is not available from the GPO, an exception to the purchasing contract will be necessary.

The Training for the Development of Innovative Control Technologies (TDICT) Project developed the following four-step, user-based systems approach for the evaluation, selection, and implementation of safer medical devices. It is comprehensive in scope, geared to developing and maintaining an ongoing program, and is predicated on the involvement of those who use the devices: frontline health care workers.

The four steps are summarized here, but it is strongly encouraged that the TDICT website be used as a resource. There are many tools that will be helpful as the law is implemented.

The Four-Step User Based System from the TDICT Project

Step 1. Conduct a broad identification of all market-available devices.

The needlestick and/or safety committee should identify types, obtain samples, and screen all products available on the market in each category of device. Numerous sources exist to find the latest devices, such as manufacturer magazines, conferences and exhibits areas, and web sites. Two that are used by the TDICT Project are at the University of Virginia International Health Work Safety Center and the California Occupational Health Branch. Both websites are listed in the Internet Resources page.

Step 2. Perform a three-step selection process – initial screening of devices, clinical simulation and intermediate selection, and clinical pilot testing.

The initial screening is performed using evaluation forms, which can be found at the TDICT website and should involve a broad cross section of employees and unit representatives. Clinical simulation and scenarios are methods of “test driving” the device and assessing its application in a particular clinical situation without threatening the health and safety of either patients or health care workers. TDICT has created simulation variables, also available at their website. It is strongly encouraged that each facility create scenarios that are appropriate for unique patient needs and settings in your facility. Clinical pilot testing allows a test in “real use” situations before purchasing in large quantities and implementing the device throughout the health care facility. Pilot testing can identify potential problems prior to full implementation and can determine training needs and procedure changes that may be needed.

Step 3. Institutionalizing selected devices after the pilot testing is complete.

The needlestick prevention committee should work closely with the purchasing department to ensure that the product chosen is available in the required quantities. Training of all affected personnel must occur prior to implementation. One way to assure success is to find “champions” from the needlestick committee and other committed workers to perform the training and promote use of the new devices.

Step 4. Conduct ongoing surveillance for efficacy and for better devices.

Formal and informal feedback about the devices will help identify possible adverse effects of the device on worker safety or patient care. The law requires an annual review of the exposure control plan and review of the market for new and better products. This feedback process will assist in both the implementation of the law and constant improvement in the workplace.

WHAT EVERY NURSE CAN DO: THE WORK IS NOT FINISHED

The work that led to the original 1991 OSHA Bloodborne Pathogens Standard and the Needlestick Safety and Prevention Act of 2000 was remarkable. It does not mean that our work is finished, but rather, that the work to assure healthy and safe workplaces has just begun. In fact, the success of the Act will be judged on how many injuries are

prevented and how many frontline workers actually become involved in the implementation. The real difference in the law of 2000, and many of the state laws, lies in the active role of the frontline health care worker. In addition, many nurses and other health care workers, such as some public-sector employees, still do not have the benefit of being protected under federal or state regulations addressing needlestick/sharps injuries and exposure to bloodborne pathogens. The ANA and partnering nursing organizations will continue efforts to advocate for the passage and implementation of state laws and support the development of an OSHA state plan for states without one.

In summary, the following activities led to the successful passage of the original 1991 OSHA Bloodborne Pathogens Standard and the 2000 federal Needlestick Safety and Prevention Act to improve on the standard. These will hopefully serve as examples of work you can contribute to the life-saving movement that has begun.

Help to participate in the health care worker safety agenda by:

- Speaking out about the problems affecting health care workers regarding protection from bloodborne injuries.
- Participate in education about bloodborne pathogens and protection from these hazards.
- Work within your state to support current legislative activity, or initiate legislative activity, to protect more health care workers.
- Testify at hearings at the local and state levels to communicate your personal story and the stories of your co-workers. Real stories of dedicated health care workers exposed to injury on a daily basis can be the most compelling evidence.
- Build coalitions and grass roots support among other providers, health care representatives, and the public.
- Join your local facility committees, your specialty practice organization, and your state nurses association. The associations are working on your behalf at the state and national level. Help them do a better job by your active participation.

SUMMARY

You have completed the on-line ANA Independent Study Module for the Needlestick Safety and Prevention Act of 2000. In reviewing that information, you have learned about the changes in the OSHA standard that were achieved in 2000. You have also learned that bloodborne pathogen protections were not new, but that employers were required since 1991 to protect health care workers.

The legislative and regulatory protections that have passed to this date are effective, but more needs to be done. Please keep yourself and others safe by seeking more information and helping to make the environment as safe as we can all make it.

The work is not finished. Health care workers are still being injured. It is our collective responsibility to work toward safer environments. This module will serve to inform you

about the basic protections, and motivate you to seek additional information about your particular work site or interest group.

INTERNET RESOURCES

California Department of Health Services Sharps Injury Control Program.

Available at: <http://www.dhs.ca.gov/ohb/SHARPS/Default.htm> (accessed 9/26/03).

CDC National Center for HIV, STD, and TB Prevention

Available at: <http://www.cdc.gov/hiv/pubs/facts.htm> (accessed 9/26/03).

CDC National Center for Infectious Diseases – Hepatitis C Website

Available at: <http://www.cdc.gov/ncidod/diseases/hepatitis/c/index.htm>
(accessed 9/26/03).

CDC National Center for Infectious Diseases – Hepatitis B Website

Available at: <http://www.cdc.gov/ncidod/diseases/hepatitis/b/index.htm>
(accessed 9/26/03).

CDC-NIOSH Bloodborne Infectious Diseases: HIV/AIDS, Hepatitis B Virus, and Hepatitis C Virus. Available at: <http://www.cdc.gov/niosh/topics/bbp/>
(accessed 9/26/03).

CDC-NIOSH State-by-State Provisions of State Needle Safety Legislation (Revised June 2002) In Chronological Order.

Available at: <http://www.cdc.gov/niosh/topics/bbp/ndl-law-1.html> (accessed 9/26/03).

CDC-NIOSH Comparison of State-By-State Needle Safety Legislation

(Revised May 2001). Available at: <http://www.cdc.gov/niosh/topics/bbp/ndl-law-2.html>
(accessed 9/26/03).

OSHA – Bloodborne Pathogens & Needlestick Prevention.

Available at: <http://www.osha.gov/SLTC/bloodbornepathogens/index.html>
(accessed 9/26/03).

OSHA – Compliance Directive (CPL 2-2.69): Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens

Available at: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=DIRECTIVES&p_id=2570 (accessed 9/26/03).

OSHA – State Occupational Safety and Health Plans.

Available at: <http://www.osha.gov/fso/osp/index.html> (accessed 9/26/03).

OSHA – How to File a Complaint with OSHA

Available at: <http://www.osha.gov/as/opa/worker/index.html> (accessed 9/26/03).

International Healthcare Worker Safety Center, University of Virginia.

Available at: <http://www.med.virginia.edu/medcntr/centers/epinet/home.html>
(accessed 9/26/03).

Training for Development of Innovative Control Technologies Project.

Available at: <http://www.tdict.org/> (accessed 9/26/03).

U.S. Department of Health and Human Services AIDS Info

<http://www.aidsinfo.nih.gov/> (accessed 9/26/03).

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