



HISTORICAL

The serious and ongoing issue of needlestick in Australian healthcare settings



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Received 7 January 2013; received in revised form 1 June 2013; accepted 6 June 2013

KEYWORDS

Australia;
Needlestick;
Sharps;
Occupational health;
Infection prevention
and control policy

Summary Australian healthcare workers and especially nurses repeatedly have their safety and health jeopardized through occupational exposures to blood and body fluids. Percutaneous or needlestick injuries are especially concerning and consistent. The purpose of this article is to again draw attention to the serious and costly issue of needlestick injuries in Australian healthcare settings. Specifically it considers the context of needlestick injuries and safety engineered devices within Standard 3 of the Australian Commission on Safety and Quality in Health Care's National Standards reform agenda. Given that Standard 3 alone will likely be insufficient to reduce needlestick injuries, this article also discusses improvements and current challenges in international needlestick injury reduction in an attempt to stimulate key opinion leader consideration of Australia adopting similar strategies.

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Introduction

In 2008 without public access to any valid, reliable large aggregate datasets the author used published Australian Council on Healthcare Standards (ACHS) data to crudely estimate that approximately 18,700 reported needlestick injuries (NSIs) occurred in Australian hospitals annually (Murphy, 2008). Applying the same method of extrapolation using updated 2011 ACHS data in which 245 hospitals reported 3484 percutaneous exposures (The Australian Council on Healthcare Standards, 2012) a revised estimate

now suggests that approximately 19,355 NSIs may be reported in Australian hospitals each year. Again readers are cautioned that this estimate excludes non-reported NSIs as well as injuries occurring in non-hospital settings. One recent Australian study has demonstrated underreporting to be almost 40% (Australian Safety and Compensation Council, 2008).

Very recent and much needed reports of reported NSI data from state and local data collections confirm that NSIs are endemic within the Australian healthcare setting. Data published in 2011 of 1191 injuries sustained in twenty Queensland public hospitals revealed a rate of 2.86 percutaneous exposures per 100 full time equivalent staff (Queensland Health, 2012). Other recent reports highlight NSIs among pediatric, haemodialysis and even defence force healthcare delivery (Chenoweth, 2012; Holley, Weber, & Reade, 2012; Tomlinson & Metz, 2012). Data from a

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large New South Wales nurses study demonstrated that 6.5% of respondents sustained and reported a NSI (Guest, Kable, & McLeod, 2010). In a separate national study 11.2% of nurses reported having sustained at least one NSI or other sharps injury within the 12 months preceding the study (Australian Safety and Compensation Council, 2008). In Western Australia (WA) from July 2010 to June 2011 healthcare workers from 46 hospitals reported just under a thousand exposures. Those 993 exposures accounted for more than three-quarters of all exposures. Nurses reported the majority (52%) of parenteral exposures. The WA government concedes that the data indicates "unacceptable risks of blood borne virus exposure to healthcare workers (HCWs)" (Communicable Disease Control Directorate Department of Health, 2011).

In recent sweeping reform the Australian national government has deemed improving hand hygiene compliance, implementing systems of antimicrobial stewardship and measuring organism-specific cases including *Staphylococcus aureus* bacteraemia and *Clostridium difficile* infection prevention as priorities. Addressing these clinical challenges has included public policy reform, investment in related research and development of programs for surveillance and education (Grayson & Russo, 2009, 2012; Grayson et al., 2011). In comparison measuring, understanding and preventing NSIs among Australian healthcare workers has been afforded very limited government attention or support. Unrelenting government issued mandates now compel the Australian infection prevention community to focus on those conditions and outcomes included in publically accessible hospital-specific performance data. Collection or reporting of NSI data is neither mandated nor publically reported. As such it remains "hidden" Several deeply thinking members of the Australian infection prevention community have from time-to-time rightly questioned the strategic wisdom, priority, intent and return on investment associated with allocating precious infection prevention resources to those other specific initiatives (Grayson & Russo, 2012; Macbeth & Murphy, 2012; Russo, 2012; Stackelroth & Shaban, 2011; Worth, Thursky, & Slavin, 2012).

Given the high frequency, avoidable cost and serious harm associated with NSIs, as well as the repeated calls by respected national and international experts for the various state and national jurisdictional agencies to initiate sweeping practice and policy reform to reduce NSIs (Bi, Tully, Pearce, & Hiller, 2006; Hunt & Murphy, 2004; Jagger, 2002; Murphy, 2008; Peng, Tully, Boss, & Hiller, 2008; Smith, Smyth, Leggat, & Wang, 2006; Whitby, 2004; Whitby, McLaws, & Slater, 2008) it is frustrating for Australian healthcare workers to repeatedly have their safety and health jeopardized. The purpose of this article is to again draw attention to the serious and costly issue of NSIs in Australian healthcare settings. Specifically it considers the context of NSI and safety engineered devices (SEDs) within Standard 3 of the Australian Commission on Safety and Quality in Health Care's National Standards reform agenda (Australian Commission on Safety and Quality in Health Care, 2012). Given that Standard 3 alone will likely be insufficient to reduce NSIs, this article also discusses improvements and current challenges in international NSI reduction. The work of the *Alliance for Sharps Safety and Needlestick Prevention in Healthcare*

is described with the intent of provoking increased NSI prevention advocacy by Australian healthcare workers to begin a rapid and sustained reduction in NSIs through local application of proven solutions.

The Context of NSIs and Safety Engineered Devices Within Standard 3 of The Australian Commission On Safety and Quality in Health Care's National Standards Reform Agenda

The Australian Commission on Safety and Quality in Health Care (the Commission) has developed Australia's new 'National Safety and Quality Health Service Standards' primarily to protect the public from harm and to improve the quality of Australian health care (Smith, 2012). The extent to which these goals will be achieved is largely unknown (Brand et al., 2008). From 1 January 2013 under Standard 3 of the Australian Commission on Safety and Quality in Health Care's Standard 3: Preventing and Controlling Healthcare Associated Infections (Australian Commission on Safety and Quality in Health Care, 2012) all Australian healthcare organizations must implement systems to prevent and manage healthcare associated infections and communicate these to the workforce in order to achieve appropriate outcomes. Standard 3 stipulates that hospitals and day procedure services meet the requirements of 39 and 38 specific "core actions" respectively. Action 3.7 is mandatory in both settings and specifically requires organizations to "promote collaboration with occupational health and safety programs to decrease the risk of infection or injury to healthcare workers". The Commission's supporting documentation for Standard 3 suggests that the following tasks be undertaken as an implementation strategy for Action 3.7:

- "review occupational health and safety policies, procedures and protocols to include areas where risk of injury or infection can be reduced for healthcare worker safety";
- "quality activities that should be considered to demonstrate evaluation and management of risk including new product reviews or evaluations; and
- consideration of outputs including reports on occupational exposure data showing cases, management strategies used to support the introduction of safety devices and equipment to minimize risks to healthcare workers and patients.

Furthermore, 3.1.1 states that "A risk management approach is taken when implementing policies, procedures and/or protocols for prevention and management of occupational exposure to blood and body substances."

This recent advice from the Commission aligns with their earlier acknowledgment that much is needed to better understand and address occupational exposures to blood and body fluids, including NSIs among Australian healthcare workers (Cruikshank & Ferguson, 2008). Given the substantial success of international policy reform mandating the introduction and ongoing use of SEDs (Adams & Elliott, 2006; Elder & Paterson, 2006; Jagger, Perry, Gooma, & Phillips, 2008; Phillips, Conaway, & Jagger, 2012; Valls et al., 2007), and this new policy-based national imperative, Australian healthcare organizations are now obligated across the entire

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