

EXAMINATION AND LESSONS OF A LARGE OUTBREAK OF HEPATITIS C THROUGH HEALTHCARE TRANSMISSION

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DESCRIPTION

The authors are survivors of the largest outbreak of Hepatitis C through healthcare transmission in US history. Evelyn was infected with hepatitis C while battling breast cancer in 2000. In total, 99 patients of the oncology clinic became infected with HCV when a nurse reused syringes while administering chemotherapy. Here are our recommendations for prevention of healthcare transmission of viral hepatitis based on the causes of our outbreak.

PUBLIC HEALTH IMPACT

Healthcare providers in all types of settings have reviewed and followed safe injection best practices. Nonetheless, the “unthinkable” still happens, with significant impact on patients and providers. The CDC estimates that there have been more than 150,000 patient in the US who have been notified of potential exposure to viral hepatitis in the past decade due to reuse of needles, syringes or medication vials.

WHY IS THIS INNOVATIVE?

By examining the largest single source outbreak in United States history, and promoting its lessons, healthcare providers and consumers learn methods to prevent healthcare transmission of disease.

Those methods are:

1. Culture of safety
2. Safety designed devices
3. Strong incentives for safety

Culture of Safety



Teamwork and good communication reduce medical error

Safety Designed Devices



Reuse prevention syringes mitigate unsafe technique

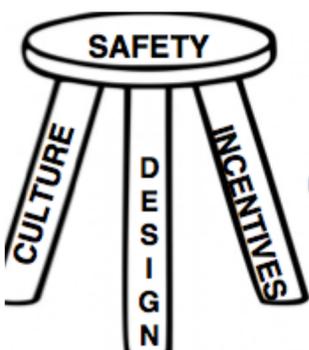
Incentives for Safety



Regulatory oversight and financial incentives foster safe practices

CONCLUSIONS

Fostering a culture of safety, the use of safety designed syringes, and incentives for safety will prevent healthcare transmission of viral hepatitis



REFERENCES

The One & Only Campaign
www.oneandonlycampaign.org/about/the-campaign
 AHRQ TeamSTEPPS: Team Strategies & Tools to Enhance Performance & Patient Safety.
ahrq.gov/teamstepps/index.html

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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