Implementation of Guided Actions to Reduce Recurrence of Sharps Related Injuries

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Published In/Presented At

Walker, L., Kaszuba, J., Guanowsky, C., & Docherty, T. (2016, April 11). *Implementation of Guided Actions to Reduce Recurrence of Sharps Related Injuries.* Poster presented at: American Associatioof Occupational Health Nurses (AAOHN), Jacksonville, FL.

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Background

Each year, ***nearly 400,000 needlestick and sharps-related injuries*** are reported by healthcare workers throughout the United States. This occupational related exposure brings the risk of transmission of deadly bloodborne diseases.

Healthcare organizations are mandated by the United States Occupational Safety and Health Administration to investigate every needlestick and sharps-related injury.

Identified Need

A ***sharps safety task force*** was established to standardize the existing electronic post-exposure investigation process to better identify behavioral actions and/or system failures that may have contributed to an exposure.

Purpose

- **Identify** the behaviors and/or systems that contributed to an exposure.
- **Assist** unit-based managers in addressing the identified behaviors and/or system failures.
- **Imbed *guided actions*** (aka educative resources) into the electronic post-exposure investigation process to assist the unit-based manager in resolving behaviors and/or system errors to reduce injury recurrence.

Process Revision Steps

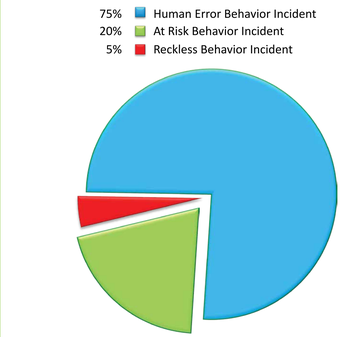
Revision of the existing electronic post-exposure investigation process to better identify behaviors and/or systems that contributed to the exposure.

Standardization of the electronic post-exposure investigation selections to ensure objective sharps safety practices are advised and system errors are addressed.

Incorporation of fair and just ***guided actions*** into the electronic post-exposure investigation design to create a systematic approach in identifying, addressing, and promoting best sharps safety practices.

Integration of educational resources into the electronic post-exposure investigation design to foster clinician self-awareness and reflection.

Sharps Injury Categories



Reflects 99 post-exposure investigations from July 2015 to December 2015

Injury Category Examples

Human Error Behavior Category Examples

Clinician places finger too close to needle insertion site during blood draw/intravenous insertion and inadvertently injuries self.

Clinician does not account for potential patient response and patient flails arms/moves after an injection while clinician is utilizing the sharps device and sustains an injury.

Clinician does not account for potential patient response and patient moved while clinician was suturing which results in an injury.

At Risk Behavior Category Examples

Clinician uses non-dominant hand to engage the safety engineered device and sustains an injury.

Clinician injured while unnecessarily manipulating contaminated sharps (recapping, and/or manipulating sharps already secured in needle pad).

Clinician injured while passing sharps device and/or surgical instrument from one clinician to another instead of using a safe hands-free instrument/sharps pass zone.

Reckless Behavior Category Examples

Clinician discards sharps in an unapproved container (trash can/bag, recycle container, biohazard container, or linen bag).

Clinician deliberately removes/alters safety engineered device prior to use.

Clinician utilized sharps device in an unintended manner (i.e., uses a blunt tip needle to transfer blood or body fluid instead of using approved safety engineered transfer device).

Guided Actions

Console employee. Be supportive and offer available employee assistance counseling as needed.

Determine why the employee made the choice that was made.

Review the system involved and why it allowed the error to occur.

Review sharps safety policy and procedures to prevent future events.

Determine educational needs of the employee and provide accordingly.

Coach employee by having a supportive discussion on the need to engage in safe behavioral choices.

Determine the reasons why the behavior exists and attempt to frame the solution around why the behavior occurred.

Instruct the employee to review resources available to address the event, i.e. review of sharps safety policy and procedures and/or assignment of sharps safety e-learning module.

Direct the employee to complete a reflective educational assignment that promotes sharps safety practices.

Determine if the employee took a substantial and unjustifiable risk when handling needles/sharps devices.

Determine if the employee consciously disregarded what he/she knew to be a substantial and unjustifiable risk when handling needles/sharps devices.

Ensure employee is counseled as part of a disciplinary process.

Critical Points

- Conducted survey to gain managerial feedback on revised investigation survey process.
- Launched investigation revision to coordinate with a network-wide launch of an enhanced culture of safety process.
- Created managerial educational resources. Resources include a reference tool and an e-learning video on how to perform an objective and meaningful post-exposure investigation.
- Completed survey investigations are audited for integrity by the task force.
- Identified system errors are reviewed by the Sharps Safety Committee.

Summary

The majority of needlestick and sharps related injuries occur inadvertently. The standardization of the post-exposure investigation process and the incorporation of guided actions facilitates managers and employees to promote best sharps safety practices and resolve system errors.

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