PSNet
PATIENT SAFETY NETWORK

Patient notification for bloodborne pathogen testing due to unsafe injection practices in the US health care settings, 2001–2011.

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Guh AY, Thompson ND, Schaefer MK, et al. Patient notification for bloodborne pathogen testing due to unsafe injection practices in the US health care settings, 2001-2011. Med Care. 2012;50(9):785-91. doi:10.1097/MLR.0b013e31825517d4.
https://psnet.ahrq.gov/issue/patient-notification-bloodborne-pathogen-testing-due-unsafe-injection-practices-us-health

This review documents 35 cases of unsafe injection practices in the United States over the past decade, leading to more than 100,000 patients being exposed to communicable diseases. In most cases, clinicians reused syringes or medication vials intended for single-dose usage. Although the authors ascribe these violations to failure to follow basic infection control practices, subsequent analysis of one widely publicized case also revealed that safety culture played a role, as nurses did not feel empowered to report improper injection practices due to fear of retaliation. The article also discusses the challenges of notifying patients about potential harm, and a recent Australian article describes the notification process used after a similar large-scale safety problem was identified.