North Carolina SPICE Statewide Program for Infection Control & Epidemiology

OUTBREAKS AND SAFE INJECTION PRACTICES

Infection Control in Long Term Care Facilities

April 1st, 2026

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- No Disclosures

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OBJECTIVES

1. Discuss the consequences of unsafe injection practices
2. Describe outbreaks
3. Discuss safe injection best practices
4. Describe One and Only Campaign

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UNSAFE INJECTION PRACTICES CONSEQUENCES

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HEALTHCARE-ASSOCIATED HEPATITIS B AND C OUTBREAKS (≥ 2 CASES) REPORTED TO CDC 2008-2019

- Total 66 outbreaks-94% occurred in non-hospital settings
- Hepatitis B (total ***25 outbreaks*** including two of both HBV and HCV, ***183 outbreak-associated cases***, ***13,246 persons notified for screening***):
  - Long-term care Facilities: 19 outbreaks
  - 133 outbreak cases of HBV and approximately 1,679 at risk persons notified for screening
  - **79% (15/19) associated with assisted monitoring of blood glucose (AMBG)**
- Hepatitis C (***43 outbreaks*** including two of both HBV and HCV , ***328 outbreak-associated cases, >112,406 at-risk persons notified for screening):***
  - 16 outbreaks in OP or LTC with 134 outbreak cases and >80,293 persons notified for screening

Health care-Associated Hepatitis B and C Outbreaks (≥ 2 cases) Reported to the CDC 2008-2019 | CDC Archive

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NC VIRAL HEPATITIS OUTBREAKS: REPORTED TO CDC (2008-2017)

	Year	State	Persons Notified	Persons Infected	Breach	Comments
Assisted Living Facility		NC	87	8	Use of fingerstick devices for >1 resident Use of blood glucose meter for >1 resident without cleaning and disinfection	6 died as a result of Hepatitis complications
SNF	2010	NC	116	6	Unclear	
SNF	2010	NC	109	6	Unclear; however 4/6 received ABGM	
Cardiology Clinic	2008	NC	>1200	5	Syringe reuse and contamination of MDV	An additional 2 new infections were identified in probable source patients

HIV/STD/Hepatitis Surveillance Unit
Division of Public Health North Carolina Department of Health and Human Services September 2025

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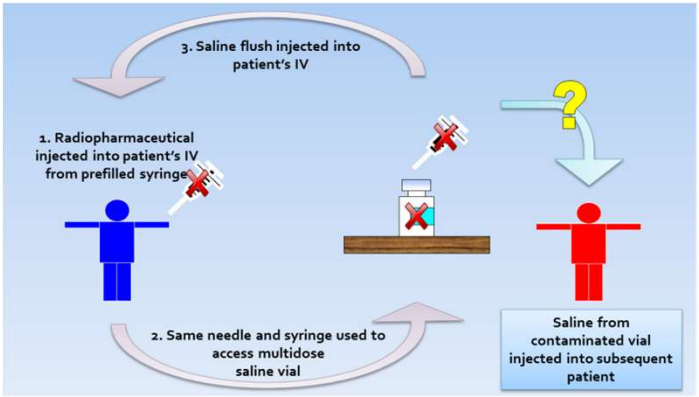
CLINICAL PICTURE: CARDIOLOGY CLINIC



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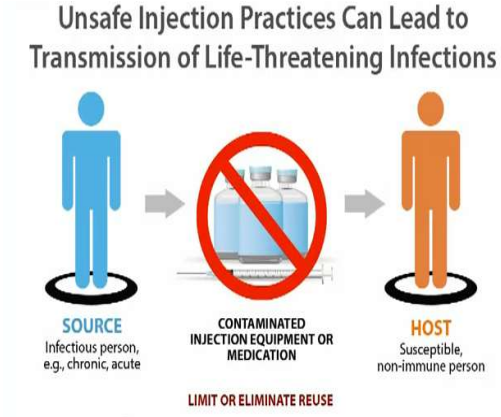
STANDARD PRECAUTIONS: SAFE INJECTIONS



The continued occurrence of outbreaks of hepatitis B and hepatitis C viruses in ambulatory settings indicated a need to re-iterate safe injection practice recommendations as part of Standard Precautions.

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STANDARD PRECAUTIONS: INJECTION SAFETY PRACTICES

- All injections should be prepared and administered aseptically, in a dedicated clean area, avoiding touch or droplet contamination, away from potential sources of contamination (e.g., sinks)
- A syringe should only be used to administer medication to one patient
- Syringes should never be reused to access a medication container
- Medications that are labeled a single dose or for single-patient use should only be used for one patient

One & Only Campaign | National Prevention Information Network

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STANDARD PRECAUTIONS: INJECTION SAFETY PRACTICES

- Do not enter a vial with a used syringe or needle
- Bags or bottles of intravenous solution not be used as a common source of supply for more than one patient (e.g. flush)
- Cleanse the access diaphragm of medication vials before inserting a device into the vial
- Dedicate multi-dose vials to a single patient whenever possible
- Dispose of used sharps at the point of use in a sharps container that is closable, puncture-resistant and leak-proof
- Use facemasks when placing a catheter or injecting material into the epidural or subdural space (e.g., during myelogram, epidural or spinal anesthesia)

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INJECTION AND MEDICATION SAFETY

CDC, https://www.cdc.gov/injectionsafety/providers.html

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STANDARD PRECAUTIONS: INJECTION SAFETY/POINT OF CARE TESTING

- If blood glucose meters must be shared
  - Purchase glucose meters designed for healthcare use
  - The device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents
  - If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared
  - "The disinfection solvent you choose should be effective against HIV, Hepatitis C, and Hepatitis B virus. Outbreak episodes have been largely due to transmission of Hepatitis B and C viruses. However, of the two, Hepatitis B virus is the most difficult to kill. Please note that 70% ethanol solutions are not effective against viral bloodborne pathogens and the use of 10% bleach solutions may lead to physical degradation of your device. View a list of Environmental Protection Agency (EPA) registered disinfectants effective against Hepatitis B"
- Use single-use auto-disabling (retractable) fingerstick devices

http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html

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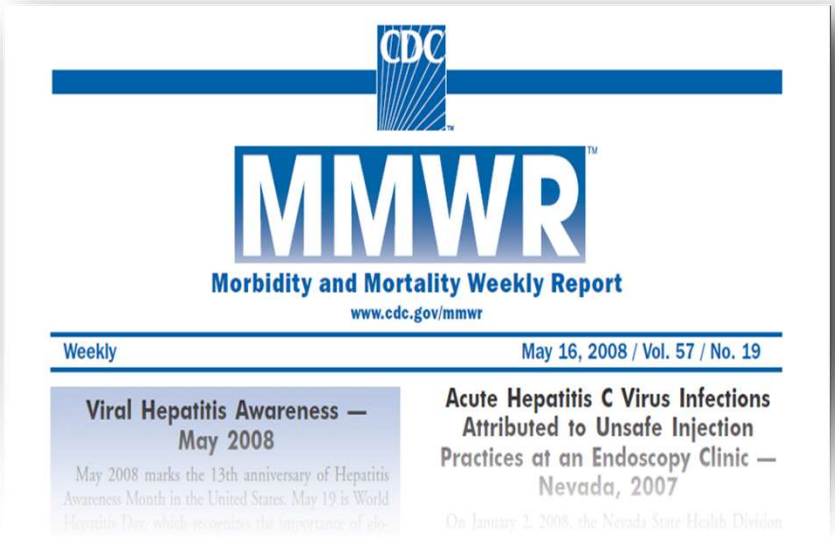
WHY DO OUTBREAKS HAPPEN


CDC

MMWR

Morbidity and Mortality Weekly Report

www.cdc.gov/mmwr

Weekly May 16, 2008 / Vol. 57 / No. 19

Viral Hepatitis Awareness — May 2008

May 2008 marks the 13th anniversary of Hepatitis Awareness Month in the United States. May 19 is World Hepatitis Day, which recognizes the importance of glo-

Acute Hepatitis C Virus Infections Attributed to Unsafe Injection Practices at an Endoscopy Clinic — Nevada, 2007

On January 2, 2008, the Nevada State Health Division

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THE BIG FIVE

1. Syringe re-use, directly or indirectly
2. Inappropriate use of single dose or single use vials
3. Failure to use aseptic technique (contamination of injection equipment)
4. Unsafe diabetes care/ assisted blood glucose monitoring (ABGM)
5. **Drug Diversion**

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1: SYRINGE RE-USE

Most common cause of outbreaks in the outpatient setting is inappropriate use of syringes

- Direct reuse:
  - Using the same syringe to administer medication to more than one patient, even if the needle is changed or the injection was administered through an intervening length of tubing

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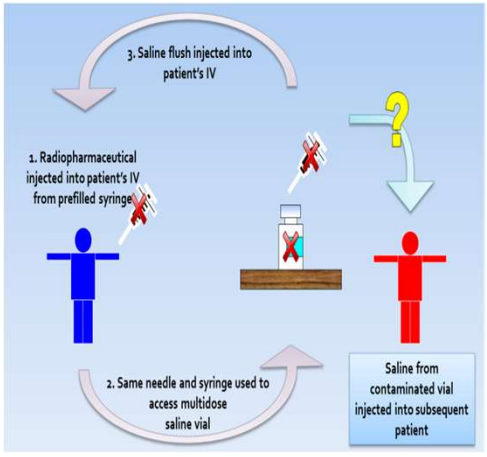
SYRINGE RE-USE

- Indirect reuse or "double dipping":
  - Accessing a medication vial or bag with a syringe that has already been used to administer medication to a patient, then reusing the contents from the vial or bag for another patient



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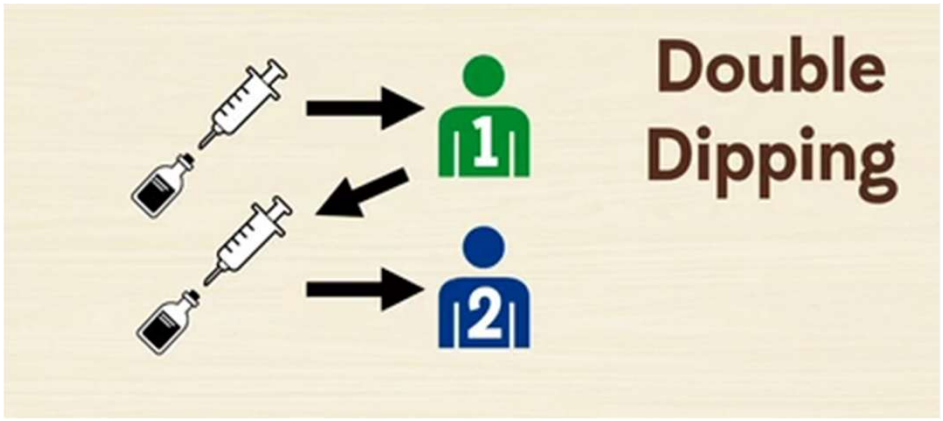
UNSAFE PRACTICE: DOUBLE DIPPING



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ENDOSCOPY CENTER, NEVADA (2008)

- 9 clinic-associated hepatitis C virus cases
- 106 possible clinic-associated cases
- 63,000 potential exposures
- $16–21 million total cost

CDC

MMWR

Morbidity and Mortality Weekly Report

www.cdc.gov/mmwr

Weekly May 16, 2008 / Vol. 57 / No. 19

Viral Hepatitis Awareness — May 2008

May 2008 marks the 13th anniversary of Hepatitis Awareness Month in the United States. May 19 is World Hepatitis Day, which recognizes the importance of global commitments to prevent liver disease and cancer

Acute Hepatitis C Virus Infections Attributed to Unsafe Injection Practices at an Endoscopy Clinic — Nevada, 2007

On January 2, 2008, the Nevada State Health Division (NSHD) contacted CDC concerning surveillance reports

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DANGEROUS MISPERCEPTIONS

1. Changing the needle makes a syringe safe for reuse.
2. Syringes can be reused as long as an injection is administered through an intervening length of IV tubing.
3. If you don't see blood in the IV tubing or syringe, it means that those supplies are safe for reuse.

Once they are used, both the needle and syringe are contaminated and must be discarded!

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2: INAPPROPRIATE USE OF SINGLE-DOSE/SINGLE-USE VIALS

- Vials labeled as single use:
  - NO PRESERVATIVE
  - Can be accessed one time only and for one patient only and remaining contents must be discarded
- CDC is aware of at least 19 outbreaks involving single dose vial use
  - All occurred in outpatient setting with almost half in pain remediation clinics

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SINGLE DOSE VIALS: CDC POSITION STATEMENT, 2012

- Vials labeled by the manufacturer as “single dose” or “single use” should only be used for a single patient.
- Ongoing outbreaks provide ample evidence that inappropriate use of single-dose/single-use vials causes patient harm.
- Leftover parenteral medications should never be pooled for later administration
  - In times of critical need, contents from unopened single dose vials can be repackaged for multiple patients in accordance with standards in United States Pharmacopeia General Chapter ‹797›

www.cdc.gov/injectionsafety/CDCposition-SingleUseVial.html

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3: FAILURE TO USE ASEPTIC TECHNIQUE

- Two women diagnosed with HBV infection, receiving chemotherapy at the same physician practice
- Multidisciplinary team investigation
- Office closed; physician license suspended
- 2,700 patients notified
- 29 outbreak-associated cases of HBV

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NEW JERSEY – ONCOLOGY OFFICE

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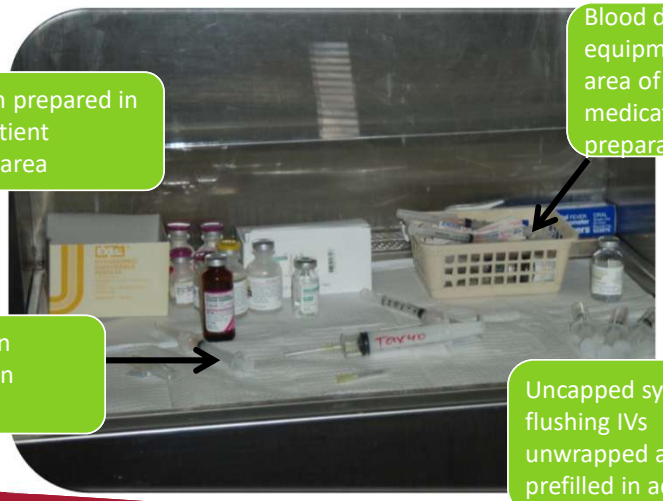
NEW JERSEY – ONCOLOGY OFFICE



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NEW JERSEY – ONCOLOGY OFFICE

Reused Vacutainer holders in contact with gauze

Blood contamination

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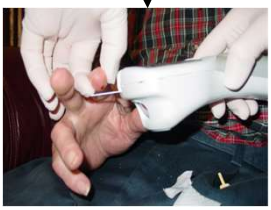
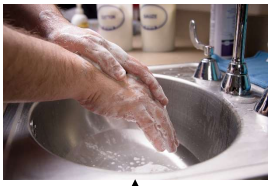
4: UNSAFE DIABETES CARE

Sharing of blood glucose meters without cleaning and disinfection between uses

Use of fingerstick devices or insulin pens on multiple persons





Failure to perform hand hygiene or change gloves between procedures

Patel et al. ICHE 2009; 30:209-14, Thompson et al. JAGS 2010, MMWR 2005; 54:220-3

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Fingerstick Devices

- Fingerstick devices, also called lancing devices, are devices that are used to prick the skin and obtain drops of blood for testing.
- There are two main types of fingerstick devices: those that are designed for reuse on a single person and those that are disposable and for single-use.

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FINGERSTICK DEVICES

- **Reusable Devices:**
  - These devices often resemble a pen and have the means to remove and replace the lancet after each use, allowing the device to be used more than once. Some of these devices have been previously approved and marketed for multi-patient use and require the lancet and disposable components (platforms or endcaps) to be changed between each patient. However, due to failures to change the disposable components, difficulties with cleaning and disinfection after use, and their link to multiple HBV infection outbreaks, **CDC recommends that these devices never be used for more than one person. If these devices are used, it should only be by individual persons using these devices for self-monitoring of blood glucose.**
- **Single-use, auto-disabling fingerstick devices:**
  - These are devices that are disposable and prevent reuse through an auto-disabling feature. In settings where assisted monitoring of blood glucose is performed, single-use, auto-disabling fingerstick devices should be used.

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Blood Glucose Meters

- Whenever possible, blood glucose meters should be assigned to an individual person and not be shared.
- If blood glucose meters must be shared;
  - The device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents.
  - If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared.

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INSULIN PENS

- Insulin Pens containing multiple doses of insulin are meant for single-resident use only, and must never be used for more than one person, even when the needle is changed
- Insulin pens must be clearly labeled with the resident's name or other identifiers to verify that the correct pen is used on the correct resident
- Facilities should review their policies and procedures and educate their staff regarding safe use of insulin pens

State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities

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SURVEY OF PHYSICIAN AND NURSE PRACTICES AROUND INJECTION SAFETY

- 370 Physicians
- 320 Nurses
- Eight States Included
  - NC, NY, NJ, Nevada, Colorado, Tennessee, Wisconsin, Montana
- Types of healthcare settings:
  - Acute care, long term care, outpatient settings

https://www.sciencedirect.com/science/article/pii/S0196655317306806?via%3Dihub

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SURVEY FINDINGS

Topic Is Acceptable Practice	Physician Response	Nurse Response
Reuse of syringe for > one patient	12.4%	3.4%
Reentering a vial with a used needle/syringe	12.7%	6.7%
Using SDVs for multiple patients	34%	16.9%
Using source bags as diluent for multiple patients	28.9%	13.1%

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SUMMARY: BEST PRACTICES

Syringe reuse (direct and indirect)

- Never administer medications from the same syringe to multiple patients
- Do not reuse a syringe to enter a medication vial or solution
- Limit the use of multi-dose vials and dedicate them to a single patient whenever possible

Misuse of single-dose/single-use vials

- Do not administer medications from a single dose vial or IV solution bag to more than one patient, more than one time

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SUMMARY: BEST PRACTICES

Failure to use aseptic technique

- Use aseptic technique when preparing or administering medications

Unsafe diabetes care

- Use insulin pens and lancing devices for only one patient
- Dedicate glucometers to a single patient. If they MUST be shared, clean and disinfect after each use

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5: DRUG DIVERSION

- When prescription medicines are obtained or used illegally

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DRUG DIVERSION FACTS

- Drug diversion costs / year (2007):
  - $120 ***billion*** in lost productivity
  - $72.5 ***billion*** in medical insurer costs
  - $61 ***billion*** in criminal justice costs
  - $11 ***billion*** in health care costs
- HCPs with a drug/alcohol dependency
  - 15% of pharmacists
  - 10% of nurses
  - 8% of physicians

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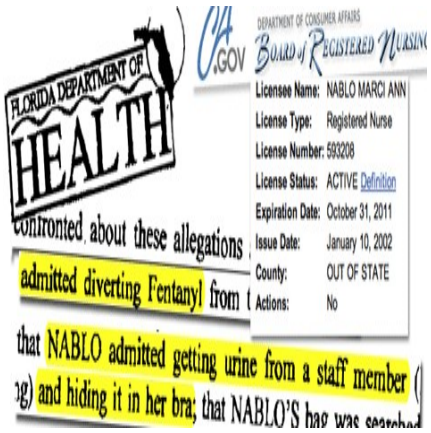
DRUG DIVERSION: THREE TYPES OF HARM

- Substandard care delivered by an impaired provider
- Denial of essential pain medication or therapy
- Risks of infection
  - Bloodborne Pathogen
  - Bacterial contaminants.



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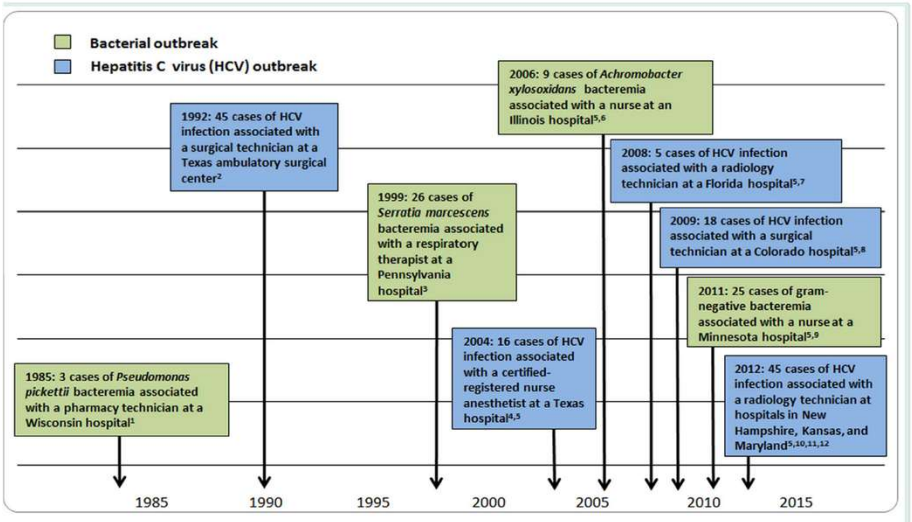
U.S. Outbreaks Associated with Drug Diversion, 1983–2013



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U.S. OUTBREAKS ASSOCIATED WITH DRUG DIVERSION BY HEALTHCARE PROVIDERS, 2014-2018

Year	Cases	Outbreak
2018	12	HCV infections associated with an emergency department nurse at a hospital in Washington [2]
2018	6	*Sphingomonas paucimobilis* bacteremia associated with a nurse at a cancer center in New York [3]
2015	7	HCV infections associated with a nurse at a Utah hospital [4]
2014	5	*Serratia marcescens* bacteremia associated with a nurse in a post-anesthesia care unit at a hospital in Wisconsin [5]

Clinician Brief: Drug Diversion | Injection Safety | CDC

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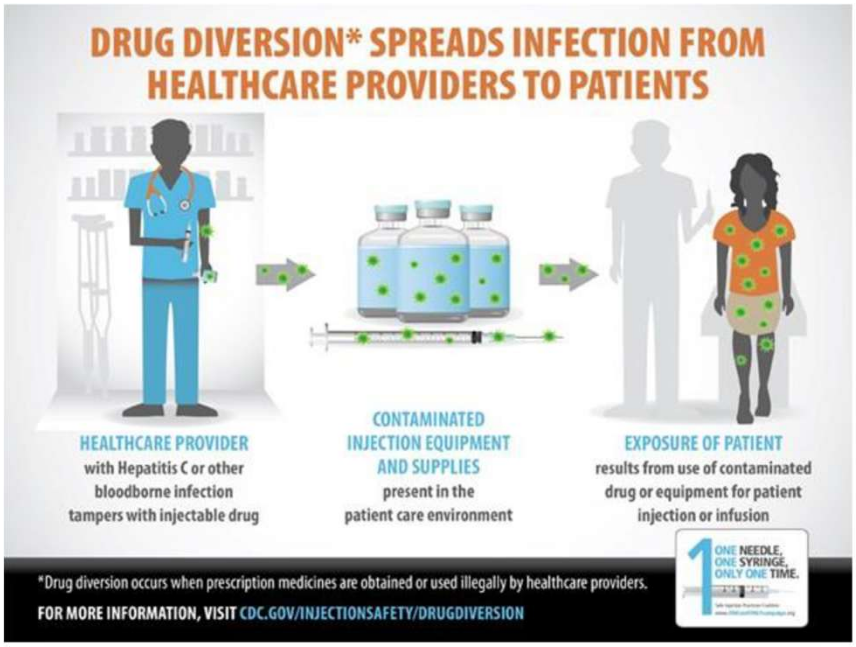

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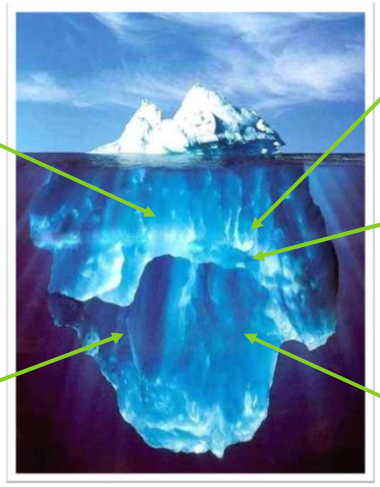
MOST OUTBREAKS ARE NEVER DETECTED



- Asymptomatic infection
- Under-reporting of cases
- Under-recognition of healthcare as risk
- Long incubation period; difficult to identify single healthcare exposure
- Barriers to investigation, resource constraints

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BEST PRACTICE

- Designate someone to provide ongoing oversight
- Develop written infection control p
- Provide training
- Conduct quality assurance assessments

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ONE AND ONLY CAMPAIGN

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CAMPAIGN RESOURCES

- Print Materials
- Audio & Visual
- Social Media
- Toolkits

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QUESTIONS?

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