NIOSH recommends that health care facilities use safer medical devices to protect workers from needlestick and other sharps injuries.
Since the passage of the Needlestick Safety and Prevention Act in 2000 and the subsequent revision of the OSHA Bloodborne Pathogen Standard, all health care facilities are required to use safer medical devices.

Safer Medical Device Implementation in Health Care Facilities

Sharing Lessons Learned

NIOSH has asked a small number of health care facilities to share their experiences on how they implemented safer medical devices in their settings. These facilities have agreed to describe how each step was accomplished, and also to discuss the barriers they encountered and how they were resolved, and most importantly, lessons learned.

DISCLAIMER: Provision of this report by NIOSH does not constitute endorsement of the views expressed or recommendation for the use of any commercial product, commodity or service mentioned. The opinions and conclusions expressed are those of the authors and not necessarily those of NIOSH. More reports on Safer Medical Device Implementation in Health Care Settings can be found at http://www.cdc.gov/niosh/topics/bbp/safer/

Background

The Department of Dentistry is a unit of a multi-site, public healthcare system. The system includes a 728 bed main campus teaching hospital and outpatient-based patient services. The system also includes 12 satellite outpatient locations. Dentistry sees patients at four sites: the main campus of the medical center, two satellite health centers and a skilled nursing center.

The healthcare system formed a Needlestick Committee several months ago. The committee was an ad hoc subcommittee of the Product Evaluation Committee. Dentistry is not represented on either committee. The subcommittee was scheduling its last meeting when I contacted them regarding becoming a participant in the committee. The committee provided me with the Systems Blood and Body Fluid Exposure Report for 2000 and 2001. This report details the reported Sharps injuries during the past 2 calendar years.

I decided that since the System-wide team was disbanding, and had already evaluated general medical use products and made recommendations, Dentistry should form its own Sharps Injury Prevention Team. Product Information and Evaluation Data from the larger committee will be used when appropriate in the Dentistry-specific process.

Dentistry had a few reported sharps injuries in 2001. The staff members injured by sharps were both dentists and assistant staff. I thought that it was important to involve the dental providers as well as the staff that assists the dentist, cleans the dental operatories, and cleans and sterilizes the instruments. In addition, since buy-in to any changes is required from faculty dentists and resident dentists, they were represented on the committee. A faculty member who worked with AIDS patients under a Ryan White Grant was included as well.

The dental team includes four members who provide direct patient care and two members who provide administrative and management support. The team members are:

Coordinator: Operations Director Dentistry

Member: Faculty Dentist with Ryan White Experience

Member: Faculty Dentist that Precepts Residents in Clinic

Member: Business Coordinator

Member: Expanded-Function Dental Assistant

Member: Chief, Resident

I am the coordinator of the project. My clinical training is in Audiology. I have a Masters of Arts in Audiology and Masters of Business Administration with a Specialization in Health Care Administration. I am the Director of Operations for both Dentistry and Oral Surgery. My past experience includes management and administrative positions in Surgery, Orthopedics, Otolaryngology, Ophthalmology, Endoscopy, and Physical Medicine and Rehabilitation. I have experience in evaluating clinical products in a

manner that ranges from a formal process (e.g., an evaluation for a capital expenditure) to more informal processes. My experience encompasses product comparisons based on clinical utility as well as price.

Expectations for the Team

I believe that the formation of a Dental sharps injury prevention team should be no different from Non-Dental teams. That is, the composition of the team should include a preponderance of clinical staff. That said the expectation of the clinical staff should be different than the expectations for the management and administrative staff. Clinical staff team members, who spend the majority of their time treating patients, will probably not assist with organizing the team, preferring rather to contribute to the actual content of the team's mission. The administrative and management staff should assume that they will be choosing the team, the meeting time, and setting the agenda for the early part of the team formation.

Questions the team members will ask before actually setting goals will primarily concern the universe of available safer sharps products. The coordinator of the dental team should research some of the available safer-sharps options during the team formation stage. This will allow the coordinator to begin thinking about the scope of the project and therefore provide the team with a sense of direction and mission form the start. In dentistry, sharps injuries occur during or after injecting a patient with anesthetic using a syringe. Injuries to support staff occur also during the pre-cleaning process prior to autoclaving instruments. Instruments involved in past sharps injuries include endodontic files, picks, scalers, etc. The team will need to decide on the whether they wish to focus on the syringes or broaden the scope to include environment controls to prevent non-syringe sharps injuries.

Lessons Learned

I did not encounter any unusual difficulties in forming the Dental Safer Sharps Team. The dentists, being a subset of the larger medical staff, were a much smaller group, which made communication relatively easy. I wanted to keep the group as small as possible, so that we could make decisions as quickly as possible. I also wanted to see that all the necessary team members were participating. I worked with the Medical Director in selecting the appropriate dentists to participate. When forming the team I looked for staff that could provide buy-in to some of the changes and also influence other clinical staff. Half of the dental clinical practice is a faculty/private practice model. The other half of the practice is a faculty-supervised/residency model of providing care. For this reason I choose to involve the staff that precept the resident's clinical activity as well as the chief resident. Inclusion of the expanded-function dental assistant was I think critical to our group. This person has historically been responsible for ordering all clinical supplies and is well versed on our current stock. She is also one of the support staff with many years of experience and is highly regarded by both dentists and assistant staff.

If I were doing form a similar team, I would allocate more time for this aspect of the process. The coordinator's pre-work and research is important during this phase. As the team recruiter, the coordinator must provide sufficient information to team members at the onset of the team formation. This, I think, would allow the team members to begin thinking about the direction of the team as well as become familiar with the issues and

possible solutions. I found it difficult to generate enthusiasm within/for this team at this point in the project. I did not encounter any direct resistance, just a bit of disinterest.

Staff Hours

Type of Staff	Hours Spent on Phase 1
Management	
Administrative	21
Front-line	0
Total	21

Other, non-labor items:

Item
1. Consult with Dental Supplier
2. Paper for Printing Internet Searches
3.