

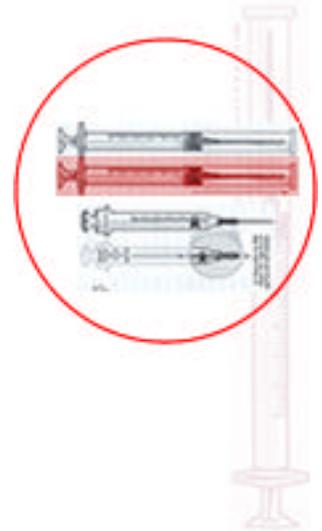
NIOSH recommends that health care facilities use safer medical devices to protect workers from needlestick and other sharps injuries. Since the passage of the Needlestick Safety and Prevention Act in 2000 and the subsequent revision of the OSHA Bloodborne Pathogen Standard, all health care facilities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



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Phase 5: Implement and Monitor the New Device

For the past seventy-five years, our faith-based health-care facility has played a critical role in contributing to the quality of life of the 600,000 culturally diversified residents in our community. We are dedicated to carrying out our mission of contributing to healthy communities and promoting quality healthcare to all with compassion. This is accomplished through a full spectrum of diagnostic, therapeutic, preventative, and rehabilitation services, which include Neighborhood Affiliate Physician Offices, Parish Nursing Program and a Health Connection Medical Call Center.

After a successful device evaluation or pilot test, health care facilities will purchase and use (i.e., implement) the selected safer medical device. NIOSH recommends that the new device be monitored after implementation. This might include determining the need for additional training, soliciting informal feedback on health care worker experience with the device, or identifying possible adverse effects of the device on patient care.

1. Were you able to obtain sufficient quantities of the new device for implementation?

Yes, we were able to obtain sufficient quantity of the product from the manufacturer. We worked with our Central Services department to ensure that there was sufficient quantity available on the patient care floors for use by phlebotomy personnel.

2. Did you determine whether or not the device was being used after implementation? If so, how? What problems, if any, did you have in getting employees to use the device? How did you resolve those problems?

Yes, we monitored the device for use after implementation. The Phlebotomy Technical Specialist would check floor stock and work with Central Services in any situation that did not have adequate supply. We conducted education and training on the device in conjunction with blood culture collection in-services which allowed employees to express any concerns about the device and its' use. Follow up of the implementation was also discussed at the Sharps Safety/Phlebotomy committee meetings.

3. Did you determine satisfaction with the new device among employees responsible for direct patient care? If so, what methods and criteria did you use?

The device was reviewed with resource phlebotomy staff and at the Sharps Safety/Phlebotomy committee meetings. The discussion is documented in the meeting minutes. We did not use a formal evaluation form to determine employee satisfaction of this device.

4. Did this process yield sufficient information to allow you to determine the level of satisfaction among these employees?

Yes, we feel that the discussion of the product at the committee and comments garnered from resource phlebotomy personnel gave us sufficient information to determine that the device was satisfactory.

5. Did you determine patient satisfaction with the new device? If so, how? Did this process provide you with the data necessary to determine the level of patient satisfaction?

Honestly we did not consider patient satisfaction with this new device. The device implemented does not interfere or come in contact with the patient so this aspect of the process was not considered.

6. Did you determine management's satisfaction with the new device? If so, how? Did this process provide you with the data necessary to determine the level of satisfaction among management?

Nursing leadership personnel were present during discussions at the Sharps Safety/Phlebotomy subcommittee meetings. They expressed satisfaction in our ability to provide a safety device for the collection of blood cultures where no safety device had been available. There was a reduction in needle-stick injuries directly related to the use of the new device. This gained the endorsement of management and administration.

7. Did you evaluate the effectiveness of the device? If so, how?

The committee in conjunction with Infection Control and Employee Health continued to monitor the number and type of needle-stick injuries. The laboratory continued to monitor the blood culture contamination rate.

8. What lessons were learned about implementing safer medical devices in your facility? Describe the difficulties encountered and the way problems were resolved.

When implementing a new device it is important to trial the device in an area that will have actual volume. Garnering the opinion of the trial personnel is essential in moving forward to implementation of the device. Using their comments you are able to design an introductory program that addresses any concerns raised during the trial and points out any benefits identified as well.

As with any new product the difficulty is getting employees to remember to use it in the appropriate situation. Education and training are key to the success of implementation. Also, with this particular device we discovered that there was a design flaw in that it could not be disposed of in the regular sharps containers. We worked with the manufacturer as they made both the containers and the device to modify the device to meet the organizational needs.

9. What would you do differently if you were to begin this process again?

One item that would be important to emphasize would be tracking of implementation, device use, and satisfaction as pointed out with this phase of the process. While we documented this process informally through meeting minutes and discussion a more formal process may have been designed that would “tell the tale” in a concise format.

10. What advice would you offer a similar facility that is just starting this process?

Ensure that the scope of the activity is well defined prior to taking any actions or choosing any devices. Inclusion of actual product users in selection, trial and implementation is the key to successful implementation of the product.

11. Please provide any other information you wish to share about the process used or problems encountered in evaluating safer medical devices.

Communication and openness to critical analysis have aided in the process. The input regarding alternative products, or improvement in the delivery system of the device to all areas, must all be welcomed and considered. Employees are more apt to readily adopt a product that they have evaluated and had the opportunity to conduct a personal comparison.

Materials

Materials distributed at the meeting included a) previous meeting minutes for approval, b) an agenda of items to be discussed - both old and new business, c) copies of Employee Health Service sharps injury statistics, d) product evaluation summaries, and e) inventory listing of current sharps supplies stocked in Central Service.

Staff Hours

Type of Staff	Hours Spent on Phase 4
Management	28
Administrative	5
Front-line	38
Total	71

Other, non-labor items

Item
1) Tablet for recording minutes
2) Copy Paper
3) Evaluation Forms
4) Sample product from vendor to conduct trial