VOLUME 4, ISSUE 3

JUNE 2010

In SafeHandS

Newsletter of the SafeHandS network

..Information, support and practical solutions to promote health care worker safety in the Asia Pacific

Inside this issue:

In SafeHandS is the official newsletter of the SafeHandS network to promote health care worker safety in the Asia Pacific. It is compiled and distributed by the Albion Street Centre.

SafeHandS is funded by AusAID.

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5 years of *In SafeHandS*!

The first SafeHandS newsletter was published in June 2005. Over the last five years we have continued to keep members and their colleagues informed about health care worker safety issues.

Thank you to all our contributors and readers - we hope you enjoy this 21st edition of *In SafeHandS.*

This issue focuses on:
Care of the deceased

The next issue will be published in September 2010
Deadline for contributions – 21 August 2010
Guidelines for contributors can be found on the SafeHandS website

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Care of the dead – safety issues

Are health workers at risk from handing deceased bodies?

There are no clear guidelines as when a deceased body should no longer be considered to be infectious for blood borne pathogens.

There have been relatively few studies of HIV infectivity after death. In one – HIV was cultured from tissue specimens at autopsy up to 6 days post mortem and from spleen specimens stored for 14 days.[1] In another – "viable HIV was isolated from blood obtained 16.5 days postmortem, from pleural liquid effusion obtained 13.8 days postmortem, and from pericardial liquid effusion obtained 15.5 days postmortem".[2] These were both studies on small numbers of cadavers (10 and 9 respectively) in the early 1990s. Although HIV was able to be cultured and was considered "viable", it is unknown whether the level of virus found would have been able to cause infection in an exposed health worker. The authors of the first study concluded "our findings in most cases suggest low concentrations of the virus and even though great individual variation was noted, HIV-infected patients should apparently be considered potentially infectious for at least one or two weeks after death". [1]

There has been one case of documented occupational transmission of HIV to a pathologist in the US who sustained injury with scalpel. [3] The US Centers for Disease Control Lists one documented and two possible cases of occupational HIV transmission in the category "embalmer/morgue technician".[4]

Higher hepatitis B virus (HBV) prevalence was recorded in embalmers than in the blood donor population in studies before vaccination was widely available[5] and there have been cases of deaths from occupationally acquired HBV[6]

Occupational transmission of Hepatitis C (HCV) from a deceased person has not been identified. Transmission of mycobacterium tuberculosis has been recorded to funeral home workers, particularly embalmers.[7,8] There are also many other infections which could pose a risk – such as Creutzfeld-Jakob disease, SARS, and others.

There is a commonly reported concern that dead bodies after a disaster are a risk for spread of disease, but this is largely untrue. [9,10] The risk from bodies is primarily from percutaneous injuries or mucous membrane exposures to people who are handling them. [9]

Skin cuts through gloves during autopsy are common – more so in inexperienced staff.[11] However, while there may be exposure to large amounts of blood and body fluids, most exposures to blood borne pathogens during autopsy are at the lower end of the risk scale because they are from scalpels or suture needles (solid sharps), rather than hollow needles used to withdraw blood (responsible for most cases of HIV and HCV in health care) and are usually through gloves.

However, there is also the possibility of exposure to pathogens spread by aerosolisation and airborne droplets such as mycobacterium tuberculosis.[12] Out of the scope of this paper, autopsy personnel may also be exposed to chemical agents and radiation. [6,12,13]

What precautions should be used?

As for many activities, although there are many infections which may pose a risk, it is only since people have become concerned about HIV that autopsy safety has been a major consideration. [13]

In general standard (universal) precautions are all that is needed for handling bodies or performing autopsies. Standard (universal) precautions should be used because, even if the deceased person is a hospital patient, infectious conditions may be undiagnosed, or undisclosed – and confidentiality still applies after death.

"The practice of basic hygienic measures, such as handwashing, the use of universal precautions as outlined in several documents and the use of personal protective equipment will greatly mitigate the risk of transmission of any potential pathogens from corpses. These practices include the use of gloves when handling corpses, avoidance of handling of personal items with contaminated gloves or hands, and the use of personal protective equipment (gowns, masks and eyewear) as appropriate if splashes are anticipated". [9]

Care should be taken with sharp objects and protocols should ensure minimal handling. Other recommendations are to wear two pairs of gloves,[14] change gloves frequently, protect the non-dominant hand with equipment such as cut resistant gloves (as that is where most cuts occur), and have well trained personnel. [11]

In some jurisdictions the use of body bags, not embalming the body and not suturing the body after autopsy are considered to be necessary for bodies with blood-borne infections; in others they are not.

Protection against aerosolisation such as N 95 respirators may also be required for protection against agents such as mycobacterium tuberculosis, rabies virus or Viral Haemorrhagic Fevers.[6] Autopsy of a patient with suspected Creutzfeld-Jakob disease requires more rigorous precautions. [14]

What policies are needed?

There are examples of policies and protocols following this article. They vary considerably in how they categorise different infections and the practices recommended. In developing policy, it is important to look at the scientific and anecdotal evidence for what is being recommended.

As with all aspects of health worker safety, the emphasis should be on:

- education of staff
- supervision of inexperienced staff
- hand washing
- use of standard (universal) precautions (whereby everyone is presumed to be infectious)
- availability and appropriate use of personal protective equipment
- safe work practices
- safer equipment - for example, using blunt instruments when possible
- safe sharps handling – including minimising the use of sharps
- HBV vaccination of staff
- avoiding fatigue – the US pathologist who acquired HIV at work started the autopsy 12 hours into his working day!
- management of exposure protocols – as for any occupational exposure

References

1. Nyberg M, Suni J, Haltia M. Isolation of human immunodeficiency virus (HIV) at autopsy one to six days postmortem. *American Journal of Clinical Pathology* 1990 Oct;94 (4):422-5
2. Douceron H, Deforges L, Gherardi R, Sobel A, Chariot P. Long-lasting postmortem viability of human immunodeficiency virus. *Forensic Science Int* 1993; 60(1-2): 61-6

3.Johnson M, Schaffner W, Atkinson J, Pierce M. Autopsy risk and acquisition of human immunodeficiency virus infection: a case report and reappraisal. *Archives of Pathology and Laboratory Medicine* 1997 Jan;121(1):64-6
4.Centers for Disease Control. *Surveillance of Occupationally Acquired HIV/AIDS in Healthcare Personnel, as of December 2006* http://www.cdc.gov/ncidod/dhqp/bp_hcp_w_hiv.html
5.Turner S, Kunches L, Gordon K, Travers P, Mueller N. Occupational exposure to human immunodeficiency virus (HIV) and hepatitis B virus (HBV) among embalmers: a pilot seroprevalence study. *American Journal of Public Health* 1989 Oct;79(10):1425-6
6.Nolte K, Taylor D, Richmond J. Biosafety considerations for autopsy. *The American Journal of Forensic Medicine and Pathology*2002, 23(2):107–122
7.Sterling T, Bishai W, Harrington S, Gershon RR, Chaisson R. Transmission of Mycobacterium tuberculosis from a cadaver to an embalmer. *New England Journal of Medicine* 2000; 342(4):246–8
8.Lauzardo M, Lee P, Duncan H, Hale Y. Transmission of Mycobacterium tuberculosis to a funeral director during routine embalming. *Chest* 2001, 119:640-2
9.Conly J, Johnston B. Natural disasters, corpses and the risk of infectious diseases. *Canadian Journal of Infectious Diseases and Medical Microbiology* 2005 Sep;16(5):269-70.
10.Morgan O. Infectious disease risks from dead bodies following natural disasters. *Rev Panam Salud Publica.* 2004;15(5):307–12
11.Gan´czak M, Boron´-Kaczmarska A, Dziuba I. Pathologist and HIV - Are safe autopsies possible? *Polish Journal of Pathology* 2003, 54, 2, 143-146
12.Sharma B, Reader M. Autopsy Room : A potential source of infection at work place in developing countries. *American Journal of Infectious Diseases* 2005, 1 (1): 25-33
13.Wetli C. Autopsy safety. *Laboratory medicine* 8(31) August 2001: 451-3
14.Nichols L. Universal precautions and high-risk autopsies. 2010 *WebMD, e-medicine. http://bit.ly/bW9vAg*

Policies and guidelines for care of the deceased

Infection control policy for the care of the cadaver.
Great Yarmouth and Waveney NHS Trust, United Kingdom. March 2009
http://tinyurl.com/24qqjad

This guideline sets out the procedures for staff to follow for the management of non infectious and infectious deceased clients.
Several of the United Kingdom NHS Trusts have similar policies available online. This is one example.

Post-mortem Care and Safe Autopsy Procedures for Novel H1N1 Influenza
Centers for Disease Control and Prevention (US). 2009
http://www.cdc.gov/h1n1flu/post_mortem.htm

The guidance in this document reflects what we currently know about the novel influenza A (H1N1) virus.
Objective: Safely handle human remains during autopsy procedures to prevent transmission of novel influenza A (H1N1) virus.

Management of dead bodies after disasters: a field manual for first responders.
Morgan O, Tidball-Binz M, Van Alphen D (eds). 2006. Pan American Health Organization. Washington, D.C, USA
http://tinyurl.com/273to4v

This manual has two broad aims: first, to promote the proper and dignified management of dead bodies, and second, to maximize their identification. Following disasters, implementing simple measures early on can significantly improve the opportunity for successful identification. However, after the majority of disasters the immediate management of human remains is done by local organizations and communities and not by specialist teams of national and international experts. Consequently this manual focuses on practical recommendations for non-specialists.

Precautions for Handling and Disposal of Dead Bodies: 8th Edition.
May 2010
Infection Control Branch, Centre for Health Protection, Department of Health, Hong Kong SAR, China
http://tinyurl.com/2f9z5c7
All dead bodies are potentially infectious and STANDARD PRECAUTIONS should be implemented for every case. Although most organisms in the dead body are unlikely to infect healthy persons, some infectious agents may be transmitted when workers are in close contact with blood, body fluids and tissues of dead body of person with infectious diseases.

To minimize the risks of transmission of known and also unsuspected infectious diseases, dead bodies should be handled in such a way that workers' exposure to blood, body fluids and tissues is reduced. A rational approach should include staff training and education, safe working environment, appropriate work practices, the use of recommended safety devices and vaccination against hepatitis B.

The following outline work practices are recommended when handling and disposing dead bodies. The objectives of drawing up this set of guidelines are: (i) to enable the deceased's family to obtain funeral services, and (ii) to protect the involved personnel, e.g. workers and relatives. Hospitals, public mortuaries, funeral parlours, undertakers of burials and staff on board conveyances are urged to adopt them in light of local circumstances and requirements. The adopted precautions should be widely disseminated to all staff involved.

Articles on health worker safety and care of the dead

Title	**Universal precautions and high-risk autopsies**
Author	Nichols L
Source	*WebMD, e-medicine.*2010 http://emedicine.medscape.com/article/1711526-overview
Country	USA
Extract	The term "high risk," as applied to autopsy, is generally used to refer to those autopsies in which there is a high risk of transmission of disease to those doing the autopsy. Universal precautions should be used in the performance of all autopsies, because any patient coming to autopsy may have an undiagnosed high-risk condition. Includes: General considerations; Specific types of high-risk autopsies; and Autopsy of a patient with suspected Creutzfeld-Jakob disease

Title	**Risk of infection and tracking of work-related infectious diseases in the funeral industry**
Author	Davidson S, Benjamin W Jr
Source	*American Journal of Infection Control* 2006 December 34(10): 655-660
Country	USA
Abstract	This review demonstrates that funeral service professionals (FSPs) have a risk of exposure to bacterial and viral pathogens as well as to prion-mediated diseases. It reveals a lack of published studies focusing on the implementation and effectiveness of infection control policies for this occupational group as well as the difficulty involved in determining actual infection rates related to workplace exposure events. Possible reasons for this lack of data include the categorization of these workers by the Bureau of Labor Statistics Standard Occupational Classification System as service providers rather than health care professionals.

Title	**Natural disasters, corpses and the risk of infectious diseases**
Author	Conly J, Johnston B
Source	*Canadian Journal of Infectious Diseases and Medical Microbiology* 2005 Sep;16(5):269-70. Full text http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2095048/?tool=pubmed
Country	Canada
Abstract	In summary, there is no compelling evidence to suggest that corpses themselves pose a risk for an acute epidemic of an infectious disease. It is more likely that the increased risk of infection occurs in the postevent period and that a higher risk of water-borne diseases is associated with flooding where there is contamination of drinking water facilities and a lack of proper sanitation.

Title	**Autopsy Room : A potential source of infection at work place in developing countries**
Author	Sharma B, Reader M
Source	*American Journal of Infectious Diseases* 2005, 1 (1): 25-33 Full text http://www.scipub.org/fulltext/ajid/ajid1125-33.pdf
Country	India
Abstract	Forensic pathologists/Autopsy surgeons and the forensic medicine personnel assisting to conduct an autopsy who come in direct contact with the body fluids, soft tissues of the dead and skeletal remains in different stages of decomposition, are at a continuous risk of acquiring various kinds of infections including blood-borne viral and other bacterial infections. However, limited data are available regarding these occupational risks to the persons who are usually exposed to dead bodies in the autopsy rooms. With the existing and growing HIV epidemic and high seroprevalence of hepatitis virus, safety becomes an issue not only relevant to the team performing the autopsy, but also has direct implications regarding the protection of the environment. Prevention strategies including immunization, exposure avoidance by the use of universal precautions and proper infrastructure in the autopsy rooms can go a long way in preventing the occupational hazards of the autopsy rooms.

Title	**Infectious disease risks from dead bodies following natural disasters**
Author	Morgan O
Source	*Rev Panam Salud Publica* 2004;15(5):307–12 Full text http://publications.paho.org/english/dead_bodies.pdf
Abstract	*Objective*. To review existing literature to assess the risks of infection from dead bodies after a natural disaster occurs, including who is most at risk, what precautions should be taken, and how to safely dispose of the bodies. [Edited] *Results*. Victims of natural disasters usually die from trauma and are unlikely to have acute or “epidemic-causing” infections. This indicates that the risk that dead bodies pose for the public is extremely small. However, persons who are involved in close contact with the dead—such as military personnel, rescue workers, volunteers, and others—may be exposed to chronic infectious hazards, including hepatitis B virus, hepatitis C virus, HIV, enteric pathogens, and Mycobacterium tuberculosis. Suitable precautions for these persons include training, use of body bags and disposable gloves, good hygiene practice, and vaccination for hepatitis B and tuberculosis. Disposal of bodies should respect local custom and practice where possible. [Edited] *Conclusions*. Concern that dead bodies are infectious can be considered a “natural” reaction by persons wanting to protect themselves from disease. However, clear information about the risks is needed so that responsible local authorities ensure that the bodies of disaster victims are handled appropriately and with due respect. This paper provides a source of information for those who are in the unfortunate position of managing those bodies.

Title **Theoretical risk for occupational blood-borne infections in forensic pathologists**

Author Nolte K, Yoon S

Source *Infection Control and Hospital Epidemiology* 2003 Oct;24(10):772-3

Country USA

Abstract Using a cumulative probability analysis and published data, we calculated the theoretical career risk of occupational HIV (2.4%) and HCV (39%; possible range, 13% to 94%) infections for forensic pathologists. Serologic studies of these physicians are needed to clarify occupational exposure and infection risks. Autopsy personnel should wear cut-resistant undergloves to decrease percutaneous injuries.

Title **Health and safety at necropsy**

Author Burton J

Source *Journal of Clinical Pathology* 2003; 56:254-260

Country United Kingdom

Abstract The postmortem room is a source of potential hazards and risks, not only to the pathologist and anatomical pathology technician, but also to visitors to the mortuary and those handling the body after necropsy. Postmortem staff have a legal responsibility to make themselves aware of, and to minimise, these dangers. This review focuses specifically on those hazards and risks associated with the necropsy of infected patients, with foreign objects present in the body, and with bodies that have been contaminated by chemicals or radioactive sources.

Title **Risk factors and prevention of infection in autopsy room - a review**

Author Vij K, Krishan K

Source *Indian Internet Journal of Forensic Medicine and Toxicology* 1(1) 2003 Full text http://www.icfmt.org/vol1no1/riskfactors.hhtm

Country India

Abstract Forensic medicine personnel who come in direct contact with the body fluids, soft tissues of the dead and skeletal material in various stages of decomposition are at continuous risk of acquiring various kinds of infections including blood-borne viral and other bacterial infections. However, limited data are available regarding these risks to persons who are usually exposed to large number of traumatized bodies in India, a country that has an existing and growing HIV epidemic and high hepatitis virus seroprevalence. In the pre-antibiotic and pre-vaccine eras, an occupational infection was a serious threat for a forensic medicine and general health care person, but many such fears were allayed with the advent of antibiotics, vaccines and infectious disease eradication and elimination programmes. Safety is an issue not only relevant to the team performing the autopsy, but also has direct implications regarding the protection of the environment. Prevention strategies include immunization, exposure avoidance by the use of universal precautions.

Title **Pathologist and HIV - Are safe autopsies possible?**

Author Gan´czak M, Boron´-Kaczmarska A, Dziuba I

Source *Polish Journal of Pathology* 2003, 54, 2, 143-146
Full text http://www.poljpathol.cm-uj.krakow.pl/03_2/GAN.pdf

Country Poland

Abstract Pathologists are at particularly high risk for blood contamination and skin injuries, so they are vulnerable to blood borne pathogens, like HIV. This article describes the first and the only one documented case of occupational HIV transmission in the world concerning American pathologist. The factors increasing the risk of contracting infection during the autopsy on the patient who has died of AIDS are considered. World-known recommendations to follow in such autopsy are described. The importance of compliance with universal precautions and the necessity of knowledge of the post-exposure prophylaxis are pointed as a way to avoid HIV infection.

Title **Infective agents in fixed human cadavers: a brief review and suggested guidelines**

Author Demiryürek D, Bayramoglu A, Ustaçelebi S

Source *The Anatomical Record* 2002;269:194–7

Country Turkey

Abstract Cadavers remain a principal teaching tool for anatomists and medical educators teaching gross anatomy. Infectious pathogens in cadavers that present particular risks include Mycobacterium tuberculosis, hepatitis B and C, the AIDS virus HIV, and prions that cause transmissible spongiform encephalopathies such as Creutzfeldt-Jakob disease (CJD) and Gerstmann-Straussler-Scheinker syndrome (GSS). It is often claimed that fixatives are effective in inactivation of these agents. Unfortunately cadavers, even though they are fixed, may still pose infection hazards to those who handle them. Specific safety precautions are necessary to avoid accidental disease transmission from cadavers before and during dissection and to decontaminate the local environment afterward. In this brief review, we describe the infectious pathogens that can be detected in cadavers and suggest safety guidelines for the protection of all who handle cadavers against infectious hazards.

Title **Biosafety considerations for autopsy**

Author Nolte K, Taylor D, Richmond J

Source *The American Journal of Forensic Medicine and Pathology*2002, 23 (2):107–122
Full text http://www.buffalofilter.com/PDF/AutopsyHazards.pdf

Country USA

Abstract An autopsy may subject prosectors and others to a wide variety of infectious agents, including bloodborne and aerosolized pathogens such as human immunodeficiency virus, hepatitis B and C viruses, and *Mycobacterium tuberculosis*. Other hazards include toxic chemicals (e.g., formalin, cyanide, and organophosphates) and radiation from radionuclides used for patient therapy and diagnosis. These risks can be substantially mitigated through proper assessment, personal protective equipment, appropriate autopsy procedures, and facility design.

Title	**Autopsy safety**
Author	Wetli C
Source	*Laboratory medicine* 8(31) August 2001: 451-3 http://labmed.ascpjournals.org/content/32/8/451.full.pdf
Country	USA
Abstract	Autopsy safety was not much of a consideration until the 1980s when HIV infection appeared. At first, the emphasis was placed on the prevention of infection by establishing “universal precautions” and the development of Occupational Safety and Health Administration (OSHA) regulations. Along with this came procedures and regulations to minimize the possibility of cuts and needle sticks. Other hazards were eventually identified, and appropriate precautions were implemented to varying degrees. Although OSHA regulations were first met with reluctance and resistance, they did have the effect of creating an awareness of autopsy safety. This is highly significant since it has been shown that the vast majority of occupational accidents are due to human error and that safety awareness in the workplace is more effective in preventing accidents than bureaucratic regulations. There are 6 main categories of potential injury to pathologists and their assistants during the performance of an autopsy: mechanical injury, sharp force injury, electrical shock, chemical exposure, radiation exposure, and infection. Each category will be considered separately with recommendations on avoiding or minimizing the potential for injury.

Title	**Code of practice for funeral workers: managing infection risk and body bagging**
Author	Bakhshi S
Source	*Communicable Disease and Public Health* 2001, 4: 283-7 http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1200660055420
Country	United Kingdom
Sum-mary	There is substantial variation in the advice given to funeral workers on handling bodies with infection risk. Inconsistent advice results in inappropriate practice. A model code of practice is presented that uses risk assessment in response to statutory and executive responsibilities to provide health and safety advice to funeral workers. The code of practice should increase compliance with safety requirements, avoid unnecessary bagging and allow bereaved families freer access to the deceased

Title	**Transmission of Mycobacterium tuberculosis to a funeral director during routine embalming**
Author	Lauzardo M, Lee P, Duncan H, Hale Y
Source	*Chest* 2001, 119:640-2
Country	USA
Abstract	Several studies have shown that funeral directors have an increased risk of tuberculosis (TB). Although there is indirect evidence of transmission of TB from cadavers to mortuary workers, there is only one recently documented case in the literature. We report here another case of occupationally acquired TB in a funeral director, which was confirmed by conventional epidemiology and genotyping. This case illustrates the risk of TB transmission to mortuary workers from routine embalming of deceased TB patients with active disease.

Title	**Transmission of Mycobacterium tuberculosis from a cadaver to an embalmer. Brief report**
Author	Sterling T, Bishai W, Harrington S, Gershon RR, Chaisson R
Source	*New England Journal of Medicine* 2000; 342(4):246–8. Full text http://content.nejm.org/cgi/content/full/342/4/246
Country	USA

Title	**The infection hazards of human cadavers**
Author	Healing T, Hoffman P, Young S
Source	*Communicable Disease Report CDR Rev.* 1995 Apr 28;5(5): R61-8 http://tinyurl.com/298d7p4
Country	United Kingdom
Abstract	Cadavers may pose infection hazards to people who handle them. None of the organisms that caused mass death in the past--for example, plague, cholera, typhoid, tuberculosis, anthrax, smallpox--is likely to survive long in buried human remains. Items such as mould spores or lead dust are much greater risks to those involved in exhumations. Infectious conditions and pathogens in the recently deceased that present particular risks include tuberculosis, group A streptococcal infection, gastrointestinal organisms, the agents that cause transmissible spongiform encephalopathies (such as Creutzfeldt-Jakob disease), hepatitis B and C viruses, HIV, and possibly meningitis and septicaemia (especially meningococcal). The use of appropriate protective clothing and the observance of Control of Substances Hazardous to Health regulations, will protect all who handle cadavers against infectious hazards.

Title	**Long-lasting postmortem viability of human immunodeficiency virus: a potential risk in forensic medicine practice**
Author	Douceron H, Deforges L, Gherardi R, Sobel A, Chariot P
Source	*Forensic Science International* 1993 Jun;60(1-2):61-6
Country	France
Abstract	To determine the time from death when an autopsy could be carried out without any risk of contamination by human immunodeficiency virus (HIV), we cultured HIV from serial samples of blood and liquid effusion, collected as long as possible alter death from refrigerated dead bodies of HIV-infected patients. Samples were cocultivated with stimulated normal human lymphocytes and viral replication was assessed by p24 HIV1 antigen ELISA determination and by reverse transcriptase HIV1 and HIV2 activity microassay. Viable HIV was isolated from blood obtained 16.5 days postmortem, from pleural liquid effusion obtained 13.8 days postmortem, and from pericardial liquid effusion obtained 15.5 days postmortem. Viral replication was in evidence in at least one sample from all nine patients of the study. The present study did not allow us to determine a time from death when an autopsy could be carried out without any risk of contamination by HIV. We conclude that postponement of autopsies does not eliminate occupational risk of contamination by HIV.

Free online course

The Albion Street Centre has recently developed an online course *Managing occupational exposures to blood-borne pathogens.* The first course is currently running with twenty participants from Australia. The course is being adapted to be relevant to health workers in the Asia-Pacific region and twenty free places will be offered to SafeHandS members. The course will start in late July. The course will be facilitated and allow opportunities to interact with and learn from fellow participants.

The course gives an overview of the management of needlestick and other exposures to blood and body substances that could potentially contain blood borne pathogens, such as hepatitis B, hepatitis C, or HIV.

Topics covered include: reasons for exposure management; risk assessment; post-exposure management steps; post exposure prophylaxis; testing and counselling the exposed person; follow up and policy development.

A **free** place on the course will be offered to the first twenty applicants who meet the following criteria:

- Member of SafeHandS
- Able to read and write English
- Access to a computer with email and internet connection. (Browser needs to be Internet Explorer 6 or higher)
- Able to commit about 3 hours per week for six weeks to participate in the course. (There is no set time during which you need to be online – the coursework can be completed when convenient to you.)

To apply or for further information, please email:
safehands@sesiahs.health.nsw.gov.au

SAVE LIVES: Clean Your Hands - update

The WHO second SAVE LIVES: Clean Your Hands global annual initiative received 11 500 registrations from health-care facilities by 5 May 2010, exceeding the target of 10 000 set a year earlier.

Examples of activities undertaken, a hand hygiene self-assessment tool, the WHO hand hygiene guidelines and other resources are available on the website. http://www.who.int/gpsc/5may/en/

New webinars associated with the program and slides and audio of previous webinars are available from:
http://www.who.int/gpsc/5may/news/webinars/en/index.html

Member Profile

We provide a profile of one of our SafeHandS members

Member Profile: Onne Myrna D Berliantin

Title: Infection Control Manager

Contact Details: Siloam Hospital Lippo Village –Tangerang, Indonesia;Tel. +62215460055, ext. 9950

Describe your current job

1. As an Infection Control Coordinator across the Siloam Hospitals Group (4 hospitals)
2. Plays a lead role in the development of educational programmes for the prevention and management of Infection, participating as a educator within multi-disciplinary forums
3. Develops and updates best practice infection control policies and procedures
4. Internal audit across the hospital
5. Accountable for development and evaluation of policy relevant to Infection Control
5. Develops, implements and evaluates safe work practice in relation to infection control in collaboration with occupational health and safety
6. Liaises between all hospital departments and clinical microbiology laboratories
7. Ensures the effective management of patients in isolation
8. Performs other appropriates duties as determined by Hospital CEO and Quality & Risk Manager

What was your career path that brought you to your current job?

1. 1979 – 1985 as OR nurse
2. 1985 – 1987 Scrub nurse training for Neuromicrosurgery /cardiac surgery/ orthopaedic-trauma surgery in West Berlin , Germany
3. 1987 – 1995 OR – Deputy
4. 1990 – 1992 Post graduate for OR nurse (RN) in Free university –Klinikum Steglitz West Berlin, Germany
4. 1995 – 2003 HN/Clinical Nurse educator in OR
5. 1996 – 2003 member of IC committee at Siloam hospital Lippo Village - Tangerang
5. 2003 – Infection Control Course at Fremantle Hospital, Western Australia
6. 2003 – 2005 as full time Infection Control Nurse at Siloam Hospital
7. 2005 – 2010 Infection Control manager/Coordinator across Siloam Hospital Group

What do you like most about your job?

1.Teaching 2. Audit

What do you like least about your job?

To remind everyone to work safely and implement the procedure consistently

What does health care worker safety mean to you?

Very important and they should be aware all the time !

What are you reading at the moment?

Infection Control issues from internet

What are you currently listening to?
Music and World News from TV

What is your favourite saying?
Hallo good morning and Thank You

Nurses and health workers at risk

Australian Nursing Federation Media release, 4 May 2010

The Australian Nursing Federation is gravely concerned about the serious risk to nurses from needlestick injury, with more than 18,000 pricked by syringes and sharps each year.

Ged Kearney, ANF Federal Secretary, said nurses were sustaining injuries from contaminated syringes putting them at great risk of contracting hepatitis B or C, or HIV/AIDS.

“Police wear bullet proof vests, fire fighters are given fire-adverse clothing so why shouldn’t nurses be protected from the risks associated with their work? Just like police and firefighters nurses are dedicated to saving lives but this should not be at high risk to themselves,” she said.

“Currently only about half of needlestick and sharp injuries are reported. This means there could be as many as 30,000 incidents each year.”
“We are calling on federal and state governments to introduce consistent rules to prevent needlestick injuries in Australia and fund the introduction of needle-less access devices,” Ms Kearney said.

Estimated costs for public hospitals to provide education and equipment is just $50 million over three years, Ms Kearney said.

A coalition of interested groups has united to call for the mandatory use of safety engineered devices, education of healthcare workers and mandatory reporting of injuries.

“Nurses must be able to work in a safe environment where measures are taken to protect them from risk, especially with something as preventable and yet potentially deadly as needlestick injury.”

The ANF, with 175,000 members, is the professional and industrial voice for nurses and midwives in Australia.

http://www.anf.org.au/html/media/news_media_100504.html

Small grants scheme – reminder

SafeHandS Health Care Worker Safety Demonstration Projects

Call for applications for 2010-2011

Just a reminder that applications for the small grants for 2010 – 2011 close on 30th June 2010. The previous edition of In-SafeHandS (March 2010) had more details about the grants.
http://www.uow.edu.au/health/safehands/newsletters/index.html

SafeHandS will support a small number of demonstration projects each year in which selected health facilities will be assisted to implement innovative health care worker safety initiatives. The sites will be chosen by response to a circulated call for applications. Currently expressions of interest are invited for projects to begin in July 2010. Sites chosen to host demonstration projects will receive a small grant of A$5,000 to run the project.

It is intended that the demonstration projects will be evaluated for effectiveness in terms of outputs, cost effectiveness and resource efficiency and so be able to provide practical examples of what can be achieved in developing countries. This lived experience is expected to be more 'believable' for other developing country settings than resource intensive strategies proposed by countries such as Australia or the United States of America.

Objectives

1. To develop the capacity of regional HCW and their organisations to scale up and manage HIV and infectious disease services by facilitating a network to improve health worker safety in the workplace in the Asia-Pacific region
   - To encourage 'ownership' of the existing network by HCW in the region
   - To develop a regional body of knowledge about improving health care worker safety
   - To promote the culture of HCW safety by disseminating knowledge, research findings and lessons learnt throughout the region
2. To develop and maintain a local evidence base on health care worker safety
   - To implement and evaluate health care worker safety strategies at selected sites in the Asia-Pacific region to demonstrate their effectiveness in a resource constrained setting
   - To refine the *SafeHandS Health Care Worker Surveillance Tool* as an instrument to assist institutions to improve health worker safety from infectious disease
3. To establish and maintain sustainable capacity building partnerships with health worker organisations across the region to improve health care sector response to HIV care and support
   - To identify and liaise with country and regional professional organisations to promote and disseminate information about health worker safety

Eligibility

Proposed projects must:

- be based in the Asia-Pacific region
- be from developing countries, countries with economies in transition, or middle income countries which have resource constraints for providing health care
- address protecting health care workers (rather than patients or the community) from blood borne or respiratory infectious diseases
- be able to be achieved within the budget and timeframe
- be sustainable

For more information or for an application form, contact Maggy Tomkins safehands@sesiahs.health.nsw.gov.au

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New WHO resources

WHO guidelines on drawing blood: best practices in phlebotomy
World Health Organization, Geneva 2010
http://whqlibdoc.who.int/publications/2010/9789241599221_eng.pdf

These guidelines were produced to improve the quality of blood specimens and the safety of phlebotomy for health workers and patients, by promoting best practices in phlebotomy. In April 2008, the WHO Injection Safety programme – part of the Department of Essential Health Technologies (EHT) at WHO Headquarters in Geneva – convened a consultation on best practices for phlebotomy and blood collection. The consultation included special categories, such as arterial blood sampling, capillary blood sampling and paediatric blood collection. A working group of international experts and colleagues from WHO departments identified the need for phlebotomy guidelines, and this document was produced in response.
This document provides guidance on the steps recommended for safe phlebotomy, and reiterates the accepted principles for drawing and collecting blood. The guidelines are based on a literature review that focused on identifying systematic literature reviews and evidence relating specifically to phlebotomy practices in developing countries. Draft guidelines and evidence were reviewed by an expert panel, who reached consensus on the recommendations.

Protecting health workers (From the Executive Summary p xiv)
Best practices in phlebotomy protect health workers as well as patients. One way to reduce accidental injury and blood exposure among health workers is to use safety (i.e. engineered) devices such as retractable lancets, syringes with needle covers or retractable needles and, when appropriate, plastic laboratory tubes. Another approach is to eliminate two-handed needle recapping and manual device disassembly, and instead dispose of the sharps into a puncture resistant sharps container (i.e. a safety container) immediately after use. The best practice is to discard the needle and syringe, or needle and tube holder, as a single unit, into a sharps container that is clearly visible and within arm's reach. The size of the container should permit disposal of the entire device rather than just the needle.
Institutions should conduct surveillance on sharps injuries and accidental exposure to blood, so that preventable factors can be identified. Support services should also be available for health workers accidentally exposed to blood. These should include immunization with hepatitis B before assuming duties that include potential exposure to blood and body fluids, and postexposure prophylaxis for HIV and hepatitis B. All health-care facilities should display clear instructions for procedures to follow in case of accidental exposure to blood and body fluids.
These guidelines also outline the responsibilities of managerial staff, including provision of:

- gloves in multiple sizes, single-use disposable needles, and syringes or lancing devices in sufficient numbers to ensure that each patient has a sterile needle and collection device or equivalent for each blood sampling;
- sufficient laboratory sample tubes to prevent reuse and manual washing.

WHO best practices for injections and related procedures toolkit
World Health Organization and Safe Injection Global Network, Geneva 2010
http://whqlibdoc.who.int/publications/2010/9789241599252_eng.pdf (1.7Mb)

From the Preface
A safe injection is one that does not harm the recipient, does not expose the provider to any avoidable risks and does not result in waste that is dangerous for the community. Unsafe injection practices can lead to transmission of bloodborne pathogens, with their associated burden of disease. To ensure rational and safe use of injections globally, better injection safety practices are needed. The responsibility for ensuring injection safety rests with national governments, prescribers, administrators, receivers of injections and the wider community. The World Health Organization (WHO) acknowledges this responsibility of its member states and the challenges they face.

Through the WHO Injection Safety programme and the Safe Injection Global Network (SIGN – whose secretariat is hosted by WHO), the organization demonstrates its commitment to preventing injection-related disease transmission for patients, health workers and the community at large, through the rational and safe use of injections. WHO and SIGN recognize the importance of infection prevention and control in injection safety.

The WHO strategy for the safe and appropriate use of injections worldwide has four objectives:

- formulating national policies and plans for the safe and appropriate use of injections;
- ensuring quality and safety of injection equipment;
- facilitating equitable access to safe injection practices and equipment;
- achieving appropriate, rational and cost-effective use of injections.

In keeping with these objectives, SIGN has developed this toolkit for injection safety and related procedures. The toolkit covers elements of standard precautions relevant to the transmission of bloodborne pathogens through unsafe injection practices in health-care settings. The document will help to increase health workers' awareness of the importance of standard precautions relevant to injection safety. Its main target is health workers actively engaged in the administration of the various types of injections in all health and related care services, particularly at the peripheral level. However, other people administering injections may find the toolkit useful.

The main areas covered by the toolkit are:

- bloodborne pathogens transmitted through unsafe injection practices;
- relevant elements of standard precautions and associated barrier protection;
- best injection and related infection prevention and control practices;
- occupational risk factors and their management.

The toolkit is illustrated with practical designs that make it an easy source of reference for the user, and can be used to produce posters, flash cards and spreadsheets.

Current Resources

Recent articles and resources relevant to health care worker safety in the Asia-Pacific Region. The content of resources is not necessarily endorsed by SafeHandS

Title	**National Strategies for blood borne viruses and sexually transmissible infections**
Author	Australian Department of Health and Ageing
Source	http://tinyurl.com/2ah**maep**
Country	Australia

The Australian Health Ministers' Conference has endorsed five new national strategies for blood borne viruses (BBVs) and sexually transmissible infections (STIs). For the next three years, these documents will guide policies in relation to the prevention, testing, treatment and more in relation to BBVs and STIs. The documents were developed in a spirit of cooperation with significant contributions from community stakeholders, research organisations, medical professionals and state and territory health departments. The five strategies are:

The Sixth National HIV Strategy; (PDF 110 KB)
The First National Hepatitis B Strategy; (PDF 81 KB)
The Second National Sexually Transmissible Infections Strategy; (PDF 97 KB)
The Third National Hepatitis C Virus (HCV) Strategy; (PDF 105) and
The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy. (PDF 133 KB)

Title **Evaluation of biologic occupational risk control practices: Quality indicators development and validation**

Author Takahashi R, Luíza A, Gryschek F, Nichiata L, Lacerda R, Ciosak S, Gir E, Padoveze M

Source *American Journal of Infection Control* 2010 May 38(4): 16-e20

Country Brazil

Abstract *Background:* There is growing demand for the adoption of qualification systems for health care practices. This study is aimed at describing the development and validation of indicators for evaluation of biologic occupational risk control programs.
Methods: The study involved 3 stages: (1) setting up a research team, (2) development of indicators, and (3) validation of the indicators by a team of specialists recruited to validate each attribute of the developed indicators. The content validation method was used for the validation, and a psychometric scale was developed for the specialists' assessment. A consensus technique was used, and every attribute that obtained a Content Validity Index of at least 0.75 was approved.
Results: Eight indicators were developed for the evaluation of the biologic occupational risk prevention program, with emphasis on accidents caused by sharp instruments and occupational tuberculosis prevention. The indicators included evaluation of the structure, process, and results at the prevention and biologic risk control levels. The majority of indicators achieved a favorable consensus regarding all validated attributes.
Conclusion: The developed indicators were considered validated, and the method used for construction and validation proved to be effective.

Title **The impact of requiring completion of an online infection control course on health professionals' intentions to comply with infection control guidelines: A comparative study**

Author Yassi A, Bryce EA, Maultsaid D, Lauscher HN, Zhao K

Source *Canadian Journal of Infectious Diseases and Medical Microbiology* 2009 Spring;20(1):15-9

Country Canada

Abstract *Background*: [Edited] An online infection control module was developed to provide ready access to training. Controversy exists about whether successfully completing such a course should be mandatory or strongly encouraged for all health care professionals. The objective of the present study was to compare the perception of safety culture and intention to comply with infection control guidelines in professionals who were required by their supervisors to take the course, and those who did so voluntarily.
Methods: Survey responses on learning environment, safety climate and intention to comply with infection control guidelines in health care professionals who were required to take the course (supervisor-required group [n=143]) and those who took the same course voluntarily (voluntary group [n=105]) were compared. Because randomization was thought to be too difficult to implement in the policy context in which the study was conducted, significant differences between the two groups were taken into account in the analysis.
Results: Those required to take the course had a significantly better perception of the institutional safety climate (P<0.001), and had a higher reported intention to comply with infection control guidelines (P=0.040) than those who took the course voluntarily.
Discussion: Requiring that staff complete a 30 min interactive online infection control module increased their intention to comply with infection control guidelines compared with those who voluntarily accessed this material based on promotional material. Consideration should be given to making the successful completion of an online infection control module a requirement for all health care professionals.

Title	**Educational intervention for preventing bloodborne infection among medical students in China**
Author	Zhang Z, T. Yamamoto T, Wu X, Moji K, Cai G, Kuroiwa C
Source	*Journal of Hospital Infection* 2010, 75: 47–51
Country	China
Abstract	Although medical students are known to be at risk for bloodborne infections, there have been no systematic studies, effective intervention programmes, or guidelines for them in China. We developed prevention guidelines, implemented an intervention, and evaluated the effectiveness of knowledge among medical students. This study was designed as a cluster randomized controlled trial. All those who completed a consent form were randomly assigned either to an intervention or to a control group. The intervention group underwent an educational intervention programme consisting of a series of lectures and videos following a baseline survey. The control group completed the same intervention programme after the study was completed. A questionnaire of 25 items was sent to participants three months and nine months after the initial intervention programme. Outcomes measured before and after intervention included knowledge of transmission route, first-aid care, and post-exposure prophylaxis. Pearson's c2-test was used, and the efficacy of students was analysed to control for bias. Intervention in the form of a one-time bloodborne pathogen educational prevention programme for Chinese medical students had little effect on knowledge.

Title	Risk of sharps exposure among health science students in northeast China.
Author	Zhang Z, Moji K, Cai G, Ikemoto J, Kuroiwa C
Source	*Bioscience Trends* 2008 Jun 2 (3):105-11
Country	China
Abstract	Previous studies have demonstrated that sharps-related infectious disease is a global concern. Several papers have also reported that students are at a higher risk than healthcare workers. The prevalence of sharps exposure in China, however, is unknown. This study explored the incidence of sharps exposure and its related risk factors among students in all academic years and majors at a medical university in China. This cross sectional study was conducted at a Chinese medical university in May 2005. Stratified random sampling was used. Students in all five academic years (Y1-Y5) who were majoring in clinical medicine, nursing, dentistry, medical technology, pharmacology, acupuncture/massage, and public affairs management were provided questionnaires. Nine hundred seventy of 1,070 (90.7%) students completed the questionnaire. One hundred twenty-two of 968 (12.6%) students reported a total of 131 sharps exposures during the previous 12 months. Of these exposures, 24.7% occurred in academic year five (Y5) students, followed by 23.4% in academic year four (Y4) students. Dental students had the highest incidence rate at 20.6%, followed by medical students (16.0%), nursing students (12.2%), and acupuncture/massage students (5.0%). Only 45 (34.4%) of sharps exposures were reported to a supervisor, and the students displayed a general lack of knowledge of occupational exposure standards (OES). In conclusion, sharps exposures most frequently occurred among students from 3 majors: dentistry, nursing, and clinical medicine. Sharps exposures were underreported to supervisors. Effective OES educational programs need to be developed and should be implemented early in health science students' education.

Title **Needlestick injury rates according to different types of safety-engineered devices: Results of a French multicenter study.**

Author Tosini W, Ciotti C, Goyer F, Lolom I, L'hériteau F, Abiteboul D, Pellissier G, Bouvet E.

Source *Infect Control and Hospital Epidemiology* 2010 Apr 31(4): 402-7

Country France

Abstract *Objectives.* To evaluate the incidence of needlestick injuries (NSIs) among different models of safety-engineered devices (SEDs) (automatic, semiautomatic, and manually activated safety) in healthcare settings. *Design.* This multicenter survey, conducted from January 2005 through December 2006, examined all prospectively documented SED-related NSIs reported by healthcare workers to their occupational medicine departments. Participating hospitals were asked retrospectively to report the types, brands, and number of SEDs purchased, in order to estimate SED-specific rates of NSI. *Setting*. Sixty-one hospitals in France.

Results. More than 22 million SEDs were purchased during the study period, and a total of 453 SED-related NSIs were documented. The mean overall frequency of NSIs was 2.05 injuries per 100,000 SEDs purchased. Device-specific NSI rates were compared using Poisson approximation. The 95% confidence interval was used to define statistical significance. Passive (fully automatic) devices were associated with the lowest NSI incidence rate. Among active devices, those with a semiautomatic safety feature were significantly more effective than those with a manually activated toppling shield, which in turn were significantly more effective than those with a manually activated sliding shield ([Formula: see text], chi(2) test). The same gradient of SED efficacy was observed when the type of healthcare procedure was taken into account.

Conclusions. Passive SEDs are most effective for NSI prevention. Further studies are needed to determine whether their higher cost may be offset by savings related to fewer NSIs and to a reduced need for user training.

Title **Comparison of 4 different types of surgical gloves used for preventing blood contact**

Author Wittmann A, Kralj N, Ko¨ver J, Gasthaus K, Lerch H, Hofmann F

Source *Infection Control and Hospital Epidemiology* May 2010, 31(5):498-502

Country Germany

Abstract *Background*. Needlestick injuries are always associated with a risk of infection, because these types of punctures may expose healthcare-workers to a patient's blood and/or body fluids.

Objective. To compare the efficacy of 4 different types of surgical gloves for preventing exposure to blood as a result of needlestick injury.

Methods. For simulation of needlestick injury, a circular sample of pork skin was tightened onto a bracket, and a single finger from a medical glove was stretched over the sample. [Edited]

Results. For the powder-free surgical glove with a gel coating, a mean volume of 0.048 mL of blood (standard error of the mean [SEM], 0.077 mL) was transferred in punctures with an automated lancet at a depth of 2.4 mm through 1 layer of latex. For the glove with an integrated disinfectant on the inside, the mean volume of blood transferred was 0.030 mL (SEM, 0.0056 mL) with a single glove and was 0.024 mL (SEM, 0.003 mL) with 2 gloves. For the glove with the patented puncture indication system, a mean volume of 0.024 mL (SEM, 0.003 mL) of blood was transferred.

Conclusions. Double gloving or the use of a glove with disinfectant can result in a decrease in the volume of blood transferred. Therefore, the use of either of these gloving systems could help to minimize the risk of bloodborne infections for medical staff.

Title **Needle stick injuries among health care workers in a tertiary care hospital of India.**

Author Muralidhar S, Singh PK, Jain RK, Malhotra M, Bala M

Source *Indian Journal of Medical Research* 2010 March 131: 405-10

Country India

Abstract *Background*: Percutaneous injuries caused by needlesticks, pose a significant risk of occupational transmission of bloodborne pathogens. Their incidence is considerably higher than current estimates, and hence a low injury rate should not be interpreted as a non existent problem. The present study was carried out to determine the occurrence of NSI among various categories of health care workers (HCWs), and the causal factors, the circumstances under which these occur and to, explore the possibilities of measures to prevent these through improvements in knowledge, attitude and practice.
Methods: The study group consisted of 428 HCWs of various categories of a
tertiary care hospital in New Delhi, and was carried out with the help of an anonymous, self-reporting questionnaire structured specifically to identify predictive factors associated with NSIs.
Results: The commonest clinical activity to cause the NSI was blood withdrawal (55%), followed by suturing (20.3%) and vaccination (11.7%). The practice of recapping needles after use was still prevalent among HCWs (66.3%). Some HCWs also revealed that they bent the needles before discarding (11.4%). It was alarming to note that only 40 per cent of the HCWs knew about the availability of PEP services in the hospital and 75 per cent of exposed nursing students did not seek PEP.
Conclusion: The present study showed a high occurrence of NSI in HCWs with a high rate of ignorance and apathy. These issues need to be addressed, through appropriate education and other interventional strategies by the hospital infection control committee.

Title **Hepatitis B in health care workers: Indian scenario**

Author Singhal V, Bora D, Singh S

Source *Journal of Laboratory Physicians* 2009, 1(2): 41-8
Full text http://tinyurl.com/2anjpwl

Country India

Abstract Healthcare workers have a high risk of occupational exposure to many blood-borne diseases including HIV, Hepatitis B, and Hepatitis C viral infections. Of these Hepatitis B is not only the most transmissible infection, but also the only one that is preventable by vaccination. In developing countries, Hepatitis B vaccination coverage among healthcare workers is very low for various reasons, including awareness, risk assessment, and low priority given by the health managements of both government and private hospitals. Most of the hospitals lack post-exposure management strategies including the coordination among various departments for reporting, testing, and vaccination. This review, therefore, focuses on the current situation of Hepatitis B vaccine status in the healthcare workers of India, and provides updated guidelines to manage the accidental exposure to hepatitis B virus-infected biological materials in healthcare workers. The review also emphasizes on what options are available to a healthcare worker, in case of exposure and how they can respond to the standard vaccination schedules, besides the need to educate the healthcare workers about Hepatitis B infection, available vaccines, post-vaccine immune status, and post-exposure prophylaxis.

Title **Study of prevalence and response to** needle **stick injuries among health care workers in a tertiary care hospital in Delhi, India**

Author Sharma R, Rasania SK, Verma A, Singh S

Source *Indian Journal of Community Medicine* 2010, 35 (1):74-7 Full text http://www.ijcm.org.in/text.asp?2010/35/1/74/62565

Country India

Abstract *Background:* Because of the environment in which they work, many health care workers are at an increased risk of accidental needle stick injuries (NSI).
Objective: To study prevalence and response to needle stick injuries among health care workers.
Materials and Methods: Study Design: Cross-sectional study. Setting: A tertiary care hospital in Delhi. Participants: 322 resident doctors, interns, nursing staff, nursing students, and technicians. Statistical Analysis: Proportions and Chi-square test.
Results: A large percentage (79.5%) of HCWs reported having had one or more NSIs in their career. The average number of NSIs ever was found to be 3.85 per HCW (range 0-20). 72 (22.4%) reported having received a NSI within the last month. More than half (50.4%) ascribed fatigue as a cause in their injury. Most of the injuries (34.0%) occurred during recapping. In response to their most recent NSI, 60.9% washed the site of injury with water and soap while 38 (14.8%) did nothing. Only 20 (7.8%) of the HCWs took post-exposure prophylaxis (PEP) against HIV/AIDS after their injury.
Conclusions: The occurrence of NSI was found to be quite common. Avoidable practices like recapping of needles were contributing to the injuries. Prevention of NSI is an integral part of prevention programs in the work place, and training of HCWs regarding safety practices indispensably needs to be an ongoing activity at a hospital.

Title **Incidence and patterns of needlestick injuries during intermaxillary fixation**

Author Bali R, Sharma P, Garg A

Source *British Journal of Oral and Maxillofacial Surgery* 2010 May 18 [Epub ahead of print]

Country India

Abstract Intermaxillary fixation (IMF) carries an appreciable risk of occupational exposure to bloodborne viruses. Our aim was to establish the incidence and patterns of needlestick injuries during IMF at DAV Dental College. We surveyed 12 residents working in the Department of Maxillofacial Surgery for 1 year (December 2008 to December 2009) to find out how many injuries occurred during IMF. A total of 40 needlestick injuries were recorded during 172 IMF procedures (23%). Most injuries occurred in the maxillary left quadrant (n=16, 40%). Procedures done during the night had a much higher incidence (13/29, 45%) compared with 27/153 (18%) done during the day. Of the 40 injuries, 31 (78%) were recorded as superficial, the rest being deep. All injuries affected the non-working hand, and 39 (98%) were caused by a wire. Surgeons are at high risk of occupational exposure to bloodborne viruses from needlestick injuries during IMF. Detailed attention to the pattern of these injuries could help to develop improved strategies to minimise the incidence.

Title **Rural Indonesian health care workers' constructs of infection prevention and control knowledge**

Author Marjadi B, McLaws ML

Source *American Journal of Infection Control* 2010 Mar 13 [Epub ahead of print]

Country Indonesia

Abstract *Background*: Understanding the constructs of knowledge behind clinical practices in low-resource rural health care settings with limited laboratory facilities and surveillance programs may help in designing resource-appropriate infection prevention and control education.
Methods: Multiple qualitative methods of direct observations, individual and group focus discussions, and document analysis were used to examine health care workers' knowledge of infection prevention and control practices in intravenous therapy, antibiotic therapy, instrument reprocessing, and hand hygiene in 10 rural Indonesian health care facilities.
Results: Awareness of health care-associated infections was low. Protocols were in the main based on verbal instructions handed down through the ranks of health care workers. The evidence-based knowledge gained across professional training was overridden by empiricism, nonscientific modifications, and organizational and societal cultures when resources were restricted or patients demanded inappropriate therapies. This phenomenon remained undetected by accreditation systems and clinical educators.
Conclusion: Rural Indonesian health care workers would benefit from a formal introduction to evidence-based practice that would deconstruct individual protocols that include nonscientific knowledge. To achieve levels of acceptable patient safety, protocols would have to be both evidence-based and resource-appropriate.

Title **Using an intravenous catheter system to prevent needlestick injury**

Author Sossai D, Puro V, Chiappatoli L, Dagnino G, Odone B, Polimeri A, Ruzza L, Palombo P, Fuscoe MS, Scognamiglio P.

Source *Nursing Standard* 2010 Mar 24-30; 24(29): 42-6

Country Italy

Abstract *Aim*: To identify the effect of a sharps awareness campaign and the introduction of a safety catheter device on the annual incidence of needlestick injuries between 2003 and 2007.
Method: In 2003, a sharps awareness campaign began in San Martino Hospital in Genoa, Italy. In 2005, a safety catheter was introduced and healthcare workers were trained in its use. Data for all occupational accidents from 2003 to 2007 were collected and analysed.
Results: After introduction of the sharps awareness campaign and use of safety catheters, reported incidents of sharps injuries involving catheters fell from 19 in 2004 to two in 2007 and in neither of those two cases were needlestick prevention devices used. Overall, the rate of needlestick injuries was 24.1 per 100,000 cases when conventional catheters were used and 0.4 per 100,000 cases with safety catheters.
Conclusion: The sharps awareness campaign and newly adopted needlestick prevention device may have contributed to the prevention of percutaneous injuries caused by catheters. Until the onset of the campaign, the reported annual incidence of needlestick injuries was six. This increased to a peak of 19 reported injuries in 2004, which could be attributed to improved reporting effected by the campaign.

Title	**Hospital safety climate, psychosocial risk factors and needlestick injuries in Japan**
Author	Smith D, Muto T, Sairenchi T, Ishikawa Y, Sayama S, Yoshida A, Townley-Jones M
Source	*Industrial Health* 2010; 48(1): 85-95
Country	Japan
Abstract	To investigate the interactions between safety climate, psychosocial issues and Needlestick and Sharps Injuries (NSI), a cross-sectional study was undertaken among nurses at a university teaching hospital in Japan (89% response rate). NSI were correlated with various aspects of hospital safety climate including supporting one another at work, the protection of staff against blood-borne diseases being a high management priority, managers doing their part to protect staff from blood-borne disease, having unsafe work practices corrected by supervisors, having the opportunity to use safety equipment to protect against blood-borne disease exposures, having an uncluttered work area, and having minimal conflict within their department. In conclusion, this study has demonstrated the importance of hospital safety climate in Japanese health care practice, particularly its relationship with NSI. Although the provision of safer devices remains critical in preventing injuries, ensuring a positive safety climate will also be essential in meeting these important challenges for nurses' occupational health.

Title	**Knowledge, attitudes and practices of medical students regarding needle stick injuries**
Author	Saleem T, Khalid U, Ishaque S, Zafar A
Source	*Journal of Pakistan Medical Association* 2010 February 60 (2):151-6
Country	Pakistan.
Abstract	*Objective*: To ascertain knowledge, attitude and practices of medical students regarding needle stick injuries. *Methods*: A cross sectional survey was conducted among the consenting medical students of 3rd, 4th and 5th years at a teaching hospital of Karachi, Pakistan. Convenience sampling was used. Pre-tested questionnaires were administered to approximately 70% of each class. Data was analyzed using SPSS version 16.0. Associations were assessed using chi-square test and Fisher's exact test. A p-value of <0.05 was considered as significant. *Results*: The response rate of the survey was 85.7%. Sixty one students (33.9%) were from 3rd and 4th year each while 58 students (32.2%) were from 5th year. More than 85% students from each class were aware of the possibility of acquisition of Hepatitis B, Hepatitis C and HIV from needle stick injuries. Only 16.4% 3rd year students, 29.5% 4th year students and 36.2% final year students knew the full details of needle stick injury prevention protocols. Curriculum was cited as an important source of information regarding needle stick injuries. Forty seven (26.1%) students had received a needle stick injury in the past; however, only 14 students (29.7%) had reported the incident either to their consultant or the Infection Control Office. *Conclusion*: Overall knowledge of medical students regarding various aspects of needle stick injuries improved with seniority in medical college. However, the domains of attitude and practices need to be improved as the frequency of needle stick injuries was also observed to increase with the increasing year of medical education.

Title	**Needle stick injuries among health care workers of public sector tertiary care hospitals of Karachi**
Author	Aslam M, Taj T, Ali A, Mirza W, Ali H, Dar M
Source	*Journal of the College of Physicians and Surgeons Pakistan* 2010 March 20(3):150-3
Country	Pakistan
Abstract	*Objective*: To estimate the frequency of needle stick injuries (NSI) among health care workers (nurses, student nurses and paramedical staff) in public hospitals of Karachi. *Study Design:* Cross sectional, observational. *Place and Duration of Study:* This study was conducted in three public tertiary care hospitals of Karachi, from November 2007 to January 2008. Methodology: Data was collected by structured interview-based questionnaires in Urdu and English language. Questionnaire was designed to obtain information regarding demography, work experience, hepatitis vaccination status, and occurrence of needle stick injuries with associated factors. Needle stick injury that occurred in the previous month was the defined outcome. Data was entered in Epi Data and analyzed in SPSS version 15. *Results:* A total of 417 health care workers participated in the study. Mean age of the participants was 24±11 years. Estimated proportion of participants with history of at least one time NSI was found in 66%. Around 13% (n=54) had one or more NSI in the previous one month at work and half of them were affected by non-sterile needle. None of them sought medical care. Almost 90% of them were not wearing gloves or taking any other protective measures at the time of injury. *Conclusion:* There can be serious consequences of needle stick injuries in public hospitals as large proportion of injuries involve non-sterile used needles and health care workers do not take appropriate measures of protection.

Title	**Occupational exposure of health care personnel to hepatitis B and hepatitis C: prevention and surveillance strategies**
Author	MacCannell T, Laramie A, Gomaa A, Perz J
Source	*Clinical Liver Disease* 2010 February 14(1): 23-36, vii
Country	USA
Abstract	Ensuring the safety of personnel working in health care environments can be challenging and requires a multifaceted approach to target reductions in occupational exposures to blood-borne pathogens, such as hepatitis B or hepatitis C. This article reviews the epidemiology of occupational exposures to hepatitis B and hepatitis C in health care personnel in hospital settings. The nature and likelihood of risk to health care personnel are evaluated along with estimates of seroconversion risk. The review focuses on prevention programs and available surveillance programs to aid in monitoring and reducing occupational exposures to blood-borne pathogens.

Title	**Why don't workers use PPE?**
Author	DeJoy D
Source	http://www.shea-online.org/Assets/files/policy/PPE.pdf (2.5Mb)
Country	USA
Abstract	Powerpoint presentation from the National Institute for Occupational Safety and Health (NIOSH) Personal Protective Technology Program Stakeholder Meeting

Title **Increase in sharps injuries in surgical settings versus nonsurgical settings after passage of national needlestick legislation**

Author Jagger J, Berguer R, Phillips E, Parker G, Gomaa A

Source *Journal of American Collage of Surgery* 2010 April 210(4): 496-502.

Country USA

Abstract *Background*: The operating room is a high-risk setting for occupational sharps injuries and bloodborne pathogen exposure. The requirement to provide safety-engineered devices, mandated by the Needlestick Safety and Prevention Act of 2000, has received scant attention in surgical settings.
Study Design: We analyzed percutaneous injury surveillance data from 87 hospitals in the United States from 1993 through 2006, comparing injury rates in surgical and nonsurgical settings before and after passage of the law. We identified devices and circumstances associated with injuries among surgical team members.
Results: Of 31,324 total sharps injuries, 7,186 were to surgical personnel. After the legislation, injury rates in nonsurgical settings dropped 31.6%, but increased 6.5% in surgical settings. Most injuries were caused by suture needles (43.4%), scalpel blades (17%), and syringes (12%). Three-quarters of injuries occurred during use or passing of devices. Surgeons and residents were most often original users of the injury-causing devices; nurses and surgical technicians were typically injured by devices originally used by others.
Conclusions: Despite legislation and advances in sharps safety technology, surgical injuries continued to increase during the period that nonsurgical injuries decreased significantly. Hospitals should comply with requirements for the adoption of safer surgical technologies, and promote policies and practices shown to substantially reduce blood exposures to surgeons, their coworkers, and patients. Although decisions affecting the safety of the surgical team lie primarily in the surgeon's hands, there are also roles for administrators, educators, and policy makers.

Title **APIC position paper: Safe injection, infusion, and medication vial practices in health care**

Author Dolan S, Felizardo G, Barnes S, Cox T, Patrick M, Ward K, Arias K

Source *American Journal of Infection Control* 2010 April 38(3): 167-172

Country USA

Abstract Outbreaks involving the transmission of bloodborne pathogens or other microbial pathogens to patients in various types of health care settings due to unsafe injection, infusion, and medication vial practices are unacceptable. Each of the outbreaks could have been prevented by the use of proper aseptic technique in conjunction with basic infection prevention practices for handling parenteral medications, administration of injections, and procurement and sampling of blood. This document provides practice guidance for health care facilities on essential safe injection, infusion, and vial practices that should be consistently implemented in such settings.

Title	**Occupational exposure of health care personnel to hepatitis B and hepatitis C: prevention and surveillance strategies**
Author	MacCannell T, Laramie A, Gomaa A, Perz J
Source	*Clinics in Liver Disease* 2010 Feb 14(1):23-36, vii
Country	USA
Abstract	Ensuring the safety of personnel working in health care environments can be challenging and requires a multifaceted approach to target reductions in occupational exposures to blood-borne pathogens, such as hepatitis B or hepatitis C. This article reviews the epidemiology of occupational exposures to hepatitis B and hepatitis C in health care personnel in hospital settings. The nature and likelihood of risk to health care personnel are evaluated along with estimates of seroconversion risk. The review focuses on prevention programs and available surveillance programs to aid in monitoring and reducing occupational exposures to blood-borne pathogens.

Title	**The effect of work hours on adverse events and errors in health care**
Author	Olds D, Clarke S
Source	*Journal of Safety Research* 2010 April 41(2):153-162
Country	USA
Abstract	*Introduction:* We studied the relationship between registered nurses' extended work duration with adverse events and errors, including needlestick injuries, work-related injuries, patient falls with injury, nosocomial infections, and medication errors. *Method*: Using bivariate and multivariate logistic regression, this secondary analysis of 11,516 registered nurses examined nurse characteristics, work hours, and adverse events and errors. *Results*: All of the adverse event and error variables were significantly related to working more than 40hours in the average week. Medication errors and needlestick injuries had the strongest and most consistent relationships with the work hour and voluntary overtime variables. *Discussion:* This study confirms prior findings that increased work hours raise the likelihood of adverse events and errors in healthcare, and further found the same relationship with voluntary overtime. *Impact on industry:* Legislation has focused on mandatory overtime; however, this study demonstrated that voluntary overtime could also negatively impact nurse and patient safety.

Title	**Changing the culture of hand hygiene compliance using a bundle that includes a violation letter**
Author	Chou T, Kerridge J, Kulkarni M, Wickman K, Malow J
Source	*American Journal of Infection Control* 2010 Apr 22 [Epub ahead of print]
Country	USA
Abstract	Hand hygiene is the best method of preventing transmission of infections in health care, but compliance is usually suboptimal. In one hospital, compliance with hand hygiene was improved and sustained using a multifaceted bundle approach. A unique aspect of the bundle was the creation of a violation letter that was sent to and enforced by managers of noncompliant personnel. The letter appeared to be the major factor in raising the hand hygiene compliance rate from 34% to >90% in a 2-year period.

Title **Factors associated with increased healthcare worker influenza vaccination rates: Results from a national survey of university hospitals and medical centers**

Author Talbot T, Dellit T, Hebden J, Sama D, Cuny J

Source *Infection Control and Hospital Epidemiology* 2010; 31:456–462

Country USA

Abstract *Objective:* To ascertain which components of healthcare worker (HCW) influenza vaccination programs are associated with higher vaccination rates.
Design: Survey. *Setting:* University-affiliated hospitals.
Methods: Participating hospitals were surveyed with regard to their institutional HCW influenza vaccination program for the 2007–2008 influenza season. Topics assessed included vaccination adherence and availability, use of declination statements, education methods, accountability, and data reporting. Factors associated with higher vaccination rates were ascertained.
Results: Fifty hospitals representing 368,696 HCWs participated in the project. The median vaccination rate was 55.0% (range, 25.6%–80.6%); however, the types of HCWs targeted by vaccination programs varied. Programs with the following components had significantly higher vaccination rates: weekend provision of vaccine (58.8% in those with this feature vs 43.9% in those without); train-the-trainer programs (59.5% vs 46.5%); report of vaccination rates to administrators (57.2% vs 48.1%); or to the board of trustees (63.9% vs 53.4%), a letter sent to employees emphasizing the importance of vaccination (59.3% vs 47%; and any form of visible leadership support (57.9% vs 36.9%). Vaccination rates were not significantly different between facilities that did and those that did not require a signed declination form for HCWs who refused vaccination (56.9% vs 55.1%), although the precise content of such statements varied.
Conclusions: Vaccination programs that emphasized accountability to the highest levels of the organization, provided weekend access to vaccination, and used train-the-trainer programs had higher vaccination coverage. Of concern, the types of HCWs targeted by vaccination programs differed, and uniform definitions will be essential in the event of public reporting of vaccination rates.

Title **Infection control guidelines for prevention of health care-associated transmission of hepatitis B and C viruses**

Author Michelin A, Henderson D

Source *Clinics in Liver Disease* 2010 Feb 14(1):119-36; ix-x

Country USA

Abstract Viral hepatitis was first identified as an occupational hazard for health care workers more than 60 years ago. For the past few decades, hepatitis B has been one of the most significant occupational infectious risks for health care providers. With the increasing prevalence of hepatitis C infections around the world, occupational transmission of this flavivirus from infected patients to their providers has also become a significant concern. Several factors influence the risk for occupational blood-borne hepatitis infection among health care providers, among them: the prevalence of infection among the population served, the infection status of the patients to whom workers are exposed (ie, the source patient's circulating viral burden), the types and frequencies of parenteral and mucosal exposures to blood and blood-containing body fluids, and whether the patient or provider has been immunized with the hepatitis B vaccine. This article reviews patient-to-provider, patient-to-patient, and provider-to-patient transmission of hepatitis B and C in the health care setting. Current prevention strategies, precautions, and guidelines are discussed.

Title	**Influence of double-gloving on manual dexterity and tactile sensation of surgeons**
Author	Fry D, Harris W, Kohnke E, Twomey C
Source	*Journal of the American College of Surgeons* 2010 Mar 210(3): 325-30
Country	USA
Abstract	*Background*: Double-gloving in the performance of surgical procedures has been demonstrated to reduce the frequency of blood contact with the hands of members of the surgical team. Concerns persist that double-gloving can compromise the dexterity and tactile sensitivity of the surgeon. *Study Design*: Fifty-three surgeons and surgeons-in-training volunteered at the Clinical Congress of the American College of Surgeons and were studied using the Purdue Pegboard test and a standard 2-point discrimination test to compare no gloves, a single pair of gloves, and double-gloving on manual dexterity and tactile sensitivity. Categorical and continuous variables were identified, general linear prediction models were computed, and the influence of glove status was analyzed as an independent variable. Monte Carlo simulation was employed to validate conclusions. *Results*: Gender, specialty, and handedness did not affect prediction models. Glove status did not affect dexterity performance scores ($p = 0.57$) after accounting for the influence of age on score variation ($p < 0.001$). Comparing ulnar and radial surfaces of the index finger for 2-point discrimination, no difference was detected between trials ($p < 0.66$), nor was an interaction effect detected with glove status ($p = 0.40$). Monte Carlo simulations validated the apparent absence of differences. *Conclusions*: Double-gloving does not have a substantial impact on manual dexterity or tactile sensitivity when compared with no gloves or single-gloving in this study.

Coming Events

International Conference on Emerging Infectious Diseases (ICEID)
11– 14 July 2010, Atlanta, Georgia,(USA
The International Conference on Emerging Infectious Diseases was first convened in 1998; 2010 marks its seventh occurrence. The conference brings together public health professionals to encourage the exchange of scientific and public health information on global emerging infectious disease issues. The program will include plenary and panel sessions with invited speakers as well as oral and poster presentations on emerging infections. Major topics to be included are current work on surveillance, epidemiology, research, communication and training, bioterrorism, and preventions and control of emerging infectious diseases, both in the United States and abroad.
For more information visit the website: http://www.iceid.org/

Association for Professionals in Infection Control and Epidemiology, Inc (US) (APIC) Annual Conference
11 – 15 July 2010, New Orleans, LA (USA)
The theme of conference is 'Spreading knowledge, preventing infection.'
Attend APIC 2010:

- To learn about the latest science from leading experts and get answers to some of your most challenging infection prevention and control issues.
- To invest in your professional and clinical development to add more value to your institutions infection prevention program.
- For latest information about evolving regulations, emerging concerns with legal issues, accreditation requirements, and clinical best practices.

Abstract submission closed 15 January 2010
For more information visit the website: http://www.apic.org

XVIII International AIDS Conference
18 – 23 July 2010, Vienna, Austria
The International AIDS Conference is the premier gathering for those working in the field of HIV, as well as policy makers, persons living with HIV and other individuals committed to ending the pandemic. It is a chance to assess where we are, evaluate recent scientific developments and lessons learnt, and collectively chart a course forward.
The selection of the AIDS 2010 host city is a reflection of the central role Vienna has played in bridging Eastern and Western Europe, and will allow for an examination of the epidemic's impact in Eastern Europe.
The AIDS 2010 programme will present new scientific knowledge and offer many opportunities for structured dialogue on the major issues facing the global response to HIV. A variety of session types – from abstract-driven presentations to symposia, bridging sessions and plenaries – will meet the needs of various participants. Other related activities, including the Global Village, satellite meetings, exhibitions and affiliated events, will contribute to an exceptional opportunity for professional development and networking. Following the success of the pilot programme at AIDS 2008, the XVIII International AIDS Conference will provide or facilitate hubs (centres) where selected sessions of the conference will be screened, to increase the access to the conference programme.
Abstract submission closed on 10 February 2010
For more information visit the website: http://www.aids2010.org/

Hong Kong Infection Control Nurses' Association, 4th International Infection Control Conference
27 – 29 August 2010, Hong Kong SAR, China
The expanding horizons of infection control. "We have invited renowned speakers both locally and from overseas to give an account on the latest evidence and cutting edge information on infection control."
Abstract submission deadline is 16 June 2010
For more information visit the website: http://www.mvdmc.com/hkicna/

Joint Infection Prevention and Control Africa Network (IPCAN) – International Federation of Infection Control (IFIC) Conference
28 August – 1 September 2010, Cape Town, South Africa
For more information visit the website: http://www.theific.org/conferences.asp

7th International Conference of the Hospital Infection Society
20 – 22 October 2010, Liverpool, United Kingdom
The conference takes place every four years and is the major international conference focusing on infection control. It is internationally recognised as the most important infection prevention and control conference in Europe and attracts leading world experts in healthcare associated infections as speakers and delegates. It provides a unique opportunity for everyone involved to learn the latest developments in this rapidly expanding and changing field. As well as an excellent scientific programme covering topics such as infection prevention and control, epidemiology and surveillance, decontamination and new technologies, to name a few there will also be an opportunity for delegates to speak with companies with a particular interest in nosocomial or hospital acquired / healthcare associated infections.
Abstract submission closed on 10 May 2010
For more information visit the website: http://www.his2010.com

Australasian Society of HIV Medicine, 22nd Annual Conference
20 – 22 October 2010, Sydney, Australia
The Australasian HIV/AIDS Conference 2010 will be held back-to-back with the 2010 Australasian Sexual Health Conference. The Australasian HIV/AIDS Conference brings together the range of disciplines involved in HIV Management including Basic Science, Clinical Medicine, Community Programs, Education, Epidemiology, Nursing and Allied Health, Policy, Prevention, Primary Care, Public Health and Social Research. The conference will include sessions on HIV and co-infection with Sexual Health, Hepatitis and other related diseases.
For more information visit the website: http://www.hivaidsconference.com.au

Indian Society of Hospital Waste Management (ISHWM) Annual Conference
30 – 31 October 2010, New Delhi, India
"In spite of a decade having elapsed proper management of healthcare waste remains deficient and improper; and a lot needs to be done in this regard. ISHWM has been at the forefront to propagate best practices in healthcare waste management. We find that effective waste management with system development for infection control and workers as well as patients safety is a grossly neglected area in most of the hospitals and other healthcare facilities, and remains deficient. Therefore the theme of the conference selected is 'Safe and Effective Biomedical Waste Management'"
For more information visit the website: http://www.medwasteind.org

Society for Healthcare Epidemiology of America, 2011 Annual Scientific Meeting
1 – 4 April 2011, Dallas, Texas, USA
For more information visit the website:
http://www.shea-online.org/about/annual_meeting_overview.cfm

Asia Pacific Society of Infection Control, 5th International Congress
8 – 11 November 2011, Melbourne, Australia
The International Congress of APSIC is held every two years and attendance at the past few Congresses has increased substantially. It is being hosted by the Victorian Infection Control Professionals Association. The Congress is valued as an integral part of ongoing professional development and provides a carefully assembled program including state of the art keynote presentations, research papers, education presentations of scientific quality in all areas of infection prevention and control.
Infection Control is a rapidly increasing area within the Health Care sector of the Asia Pacific Region. Health Care professionals involved in this field will be well represented at the Congress.
For more information visit the website: http://www.apsic2011.com/

Contribute to the newsletter

We would welcome member contributions to the newsletter.

We would love to receive:

- ideas for future topics
- photos
- articles
- case studies
- teaching materials
- policies or protocols
- hints and tips
- letters
- member profiles

To contribute, send an email to:
safehands@sesiahs.health.nsw.gov.au

What is SafeHandS?

SafeHandS is a 'virtual' network designed to link and support health care workers across the Asia-Pacific region who are caring for people with HIV and other communicable diseases.

We know that health care workers are essential in responding to HIV and other communicable diseases. Without health care workers, there is no health system. We want this network to provide information, support and practical solutions to help health care workers in resource limited settings to feel safe and encouraged to provide optimal care.

SafeHandS is a forum where health care workers can share issues and ideas. We can encourage and learn from each other to find practical solutions to improve health care worker safety in resource limited settings.

SafeHandS is being funded by the Australian Agency for International Development (AusAID) and coordinated by the Albion Street Centre (ASC). ASC is a public health care facility based in Australia for the treatment, care and support of people living with or affected by HIV. The team includes infection control specialists with international experience in health care worker safety.

Become a member

Benefits of membership include:

- Receiving a newsletter (In SafeHandS) every 3 months
- Participating in a moderated group email discussion e-list for posting questions, comments and issues
- Access to a clearinghouse of new resources and publications produced by different organizations about health care worker safety (links are posted on the website.
- Access to resources developed by SafeHandS
- Joining a database of expertise.

Membership is free. To join, you can either:

- Go to our website: http://www.uow.edu.au/health/safehands/index.html

- Send an email to: safehands@sesiahs.health.nsw.gov.au

You can elect to receive a hard copy of the newsletter by post. However, this will be a shorter version than the electronic version.

Update on SafeHandS membership

We are pleased to report that at the end of May 2010, we had over 230 members of SafeHandS working in 38 countries.