



DIVISION OF PUBLIC HEALTH

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Department of Health Services

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Dear Health Care Providers:

Health care acquired infections associated with unsafe injection practices are causing growing concern among public health officials about the prevalence of these unsafe practices. According to the Centers for Disease Control and Prevention (CDC), infectious disease outbreaks related to unsafe injection practices have increased in recent years and are occurring in various health care settings, including ambulatory, dialysis, home health, and long term care settings.

The most recent outbreak of disease transmission associated with unsafe injection practices occurred in 2007 at a licensed Las Vegas, Nevada endoscopy clinic, in which eight confirmed and 77 possible cases of acute hepatitis C virus (HCV) infections were likely caused by the re-use of syringes (not needles) and the use of single dose vials of anesthesia medication on multiple patients. At least 40,000 potentially exposed patients were contacted and advised to undergo testing for HCV, HIV, and hepatitis B virus infections. The estimated cost of the outbreak exceeds ten million dollars, not including pending lawsuits against the clinic and individual clinicians. Owners of the two Nevada clinics associated with the HCV outbreak lost their business licenses, paid \$500,000 in fines, and do not plan to re-open the clinics.

Infections caused by re-use of syringes or needles or from contaminated multi-dose vials or commonly used IV bags are serious, costly, and preventable medical errors. These practices can lead to disastrous outcomes not only for patients but also for clinicians and health care organizations. Health care professionals should establish and maintain appropriate infection control programs that include oversight and monitoring of safe practices, regular staff education, and procedures for reporting and investigating breaches in safe practices.

Wisconsin Division of Public Health and Division of Quality Assurance staff members have collaborated in developing educational materials to assist health care professionals in assuring strict adherence to safe injection practices and standard infection control measures at all times, on all patients, and by all personnel. Please read the enclosed materials carefully, rigorously assess the current practices in your facility, and implement changes immediately if necessary. We strongly recommend that a designated staff person in your facility be given oversight of these and other infection control processes to ensure patient safety and quality care.

Please contact Gwen Borlaug in the Bureau of Communicable Diseases at 608-267-7711 or Lydia Reitman in the Bureau of Technology, Licensing, and Education at 608-266-7881 if you have questions or if we can assist in any way.

Thank you for your attention to this very critical issue.

Sincerely,

Jeffrey P. Davis, MD
Chief Medical Officer and State Epidemiologist
for Communicable Diseases
Wisconsin Division of Public Health

Otis Woods
Administrator
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