Q&A: Playing It Safe With Sharps

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***Surgical Products* talked with Bryan Webb, Clinical Nurse Consultant, Molnlycke Healthcare, about sharps injuries, their consequences, and what can be done to limit incidents and improve staff and patient safety.**

***SP:* Generally speaking, how prevalent are sharps injuries in the OR today? Is this an issue you believe is on the rise or on the decline?**

Webb: First of all, it happens a lot. Available information is being gathered, but when we talk about reporting needle sticks and sharps injuries, many aren't reported. It’s happening on a daily basis in every facility, in a lot of different departments, and the OR is being impacted a lot more because we’re around so many sharp pieces of equipment and patients.

It’s jumping up a lot. You have to realize as the population gets larger and more people need surgery, the more opportunity there is for exposure. But on a daily basis, it is happening all the time.

Before I was double-gloving, oftentimes I’d take my gloves off and see blood on my hands. I would not know if I stuck myself and didn’t feel it or there was a micro-hole in my glove. However, I’d see blood on my hands after a surgical case. So I know it’s

happening from personal experience, and certainly it's increasing.

SP: **What are some of the misconceptions out there that are putting hospital personnel at risk?**

Webb: There are a lot of things that can contribute to it. Single-gloving versus double-gloving is one of the most important factors. Even for me, I wasn't strongly aware about double-gloving until truly a few years ago. I think there are so many people that are so resistant to doing that and making that change, that they are missing out on the vital piece of safety equipment. There are also other factors that come into play, especially with the cost of staff and having to use employees for more than eight hours. Fatigue has to be considered The less attentive you are to minute details, the more you get tired. When you start talking about handling needles and knife blades when you are tired, the chances do increase.

SP: **What are some of the obvious and not-so-obvious consequences of these injuries?**

Webb: There's a lot of talk about HIV and hepatitis because that's a serious issue with a lot of patients. I think people presume if they have a hepatitis B vaccination they've been vaccinated for it. Well, the problem with that is it doesn't always take in some people, and there is a definite need for occasional boosters. So people think they have immunity, but they don't.

Also, people make assumptions about patients just by looking at them. They think nothing is wrong just because it looks like nothing is wrong. That person could potentially have something.

As healthcare workers, we rely on the data we receive about a patient. However, that doesn't necessarily mean it is true. Unfortunately, some people aren't honest and they don't tell us they are infected, or they don't know they are infected. They look healthy, act healthy, and don't think anything's going wrong. We presume they are fine, but something is underlying and we just don't know.

SP: **You mentioned double-gloving as one way to prevent or limit the chances of these types of injuries. What are some other good measures to keep in mind?**

Webb: What I've found to be very helpful is to create a neutral zone. A hospital I used to work at provided us disposable towels that were white instead of blue. Anything that was loaded and sharp, they had to stay on the white portion. so there was always constant awareness of exactly where the sharps were. That way we didn't make those types of mistakes.

I've also seen places that use a small emesis basin, and the knife or suture is set in there. It's then handed over to the surgeon, who reaches in and takes it out himself or herself.

There are great ideas out there, and regardless of whatever ones you are choosing,

doing something to make people be more aware of what they are doing, is extremely helpful.

SP: **What's holding some facilities and staff back from embracing more effective methods?**

Webb: I think a lot of different things can come into play here. There's staff education, and there's also enforcement.

I think one of the most impactful ways to get the staff is to tell or show them how easy it is to contract something if you are exposed, and why it's so important to take measures to avoid it. Education is huge, as is having staff members onboard and willing to enforce the rules. That can be difficult.

When we talk about double-gloving, that's an AORN recommendation. Unfortunately, we don't see a lot of facilities enforce that as a rule in the operating room. Part of this is the old adage, "This is the way I've always done it." But when we talk to people who have been around for awhile who are used to wearing one pair of gloves, they don't want to make a change. They may not like the way it feels, or it's too thick, or they suddenly can't sense anything with their fingertips. They come up with reasons why it isn't effective for them, even if those reasons can be disproven.

It's just about resistance. And I think people resist because they don't want it to affect what they do.

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