

NEEDLESTICK CASE STUDIES
Video and Group Problem-Solving Exercise

After viewing the case studies of the nurses in the video, discuss the following questions with other course participants and your facilitator.

Karen Dailey, MPH, RN was working the evening shift, when a co-worker was having trouble getting blood from an elderly patient. She inserted a butterfly needle and was successful. She then removed the needle and while putting pressure on the patient's hand to stop any bleeding, reached behind her to place the used needle in the sharps box and was stuck in the hand by another needle in the box. Karen reasoned that because the needle had been exposed to air, there was a low risk of contracting any infectious virus. She deferred when offered the post-exposure prophylaxis (PEP) for HIV. At her follow-up check, she learned she had contracted both HCV and HIV.

What factors contributed to the exposure?

How could this exposure have been prevented?

Was the use of a sharp necessary?

Would a safer needle device have potentially prevented the injury? If yes, what type?

Would a change in work practices have prevented the injury?

Linda Arnold, BSN, RN had only been out of nursing school five months when she experienced her first needlestick injury. She was re-inserting an IV line and was following the OSHA guidelines to protect herself from BBP by wearing gloves. While inserting the needle her patient moved and she jammed the needle into her left palm. Linda followed protocol and washed her wound immediately and then reported to the ER because it was the evening shift and the employee health department was closed. No PEP was offered and AZT (recommended prophylaxis for HIV prevention) was not available in her facility. At her six months screening, she learned she was HIV positive.

What factors contributed to the exposure?

How could this exposure have been prevented?

Was the use of a sharp necessary?

Would a safer needle device have potentially prevented the injury? If yes, what type?

Would a change in work practices have prevented the injury?

Lisa Black was caring for a patient in the terminal stages of AIDS. During her night shift she noticed that his intravenous tube was backed up with blood and the line was occluded. To quickly irrigate the line, she filled a syringe with saline and inserted the pre-attached needle into a rubber port on the patient's IV line. While attempting to aspirate the coagulating blood and then flush the IV line, the patient became startled and jerked, causing the needle to dislodge from the rubber port of the his IV line. The needle punctured the palm of her left hand. Like many nurses who sustain sharps injuries, she was terrified.

She followed protocol and immediately scrubbed the wound, reported her injury and went to the emergency department. She was started on a regimen of antiviral medications and a protease inhibitor. She put up with the difficult side effects, thinking that if she could just get through the side effects and stay on the PEP protocol, she would not acquire HIV. Eight months later she began to feel ill and nine months and nine days after her injury she was diagnosed with HIV. Several months later she also learned she had hepatitis C.

What factors contributed to the exposure?

How could this exposure have been prevented?

Was the use of a sharp necessary?

Would a safer needle device have potentially prevented the injury? If yes, what type?

Would a change in work practices have prevented the injury?

Personal Needlestick Exposures Exercise

1. Have you ever experienced a needlestick?
2. What factors contributed to your injury?
3. Did you report it?
4. Have you ever found a sharp incorrectly disposed of? Did you report it?