Safe Injection Practices and Assisted Monitoring of Blood Glucose in Long-Term Care Facilities

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Disclosure

No conflict of interest in relation to this presentation
Objectives

● Describe and discuss outbreaks related to unsafe injection and infusion practices

● Describe and discuss outbreaks related to unsafe use of diabetes blood sugar monitoring equipment

● Identify infection prevention and control best practice recommendations for safe injection and assisted blood glucose monitoring

● Identify resources to aid in assuring safe injection practices and assisted monitoring of blood glucose
Safe Injection Practices

- Injection Safety, or safe injection practices, is a set of measures taken to perform injections in an optimally safe manner for patients, healthcare personnel, and others.

- **Standard Precautions** include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered:
  - Hand hygiene
  - PPE, depending on the anticipated exposure (gloves, gown, mask, eye protection, or face shield)
  - Safe injection practices
What are Unsafe Injection Practices?

- Unsafe injection practices that have resulted in disease transmission include:
  - Using the same syringe to administer medication to more than one patient (direct syringe reuse)
  - Accessing a medication vial or bag with a syringe that has already been used to administer medication to a patient, then using the remaining contents from that vial or bag for another patient (indirect syringe reuse)
  - Using medications packaged as single-dose or single-use for more than one patient
  - Failing to use aseptic technique when preparing and administering injections
Impact of Unsafe Injection Practices

● Globally, WHO estimated that in 2000, overuse and unsafe use of healthcare injections caused:
  ○ 30% of new infections with HBV (21 million)
  ○ 41% of new infections with HCV (2 million)
  ○ 9% of new infections with HIV (260,000, annually)

● In the US, more than 150,000 patients have been impacted by unsafe medical injections since 2001 according to CDC

● From 2008-2019, 66 outbreaks of healthcare-associated viral hepatitis in the US reported to CDC
  ○ Infection control breaches
  ○ Unsafe injection practices
  ○ Unsafe practices related to assisted blood glucose monitoring
"Never events": hepatitis B outbreaks and notifications resulting from unsafe practice in assisted monitoring of blood glucose, 2006

Nicola D Thompson, Melissa K Schaefer

Affiliations + expand
PMID: 22262657  PMCID: PMC3262706  DOI: 10.1177/193229681100500611
Free PMC article

Abstract

Hepatitis C Virus Infections Associated with Unsafe Injection Practices at a Pain Management Clinic, Michigan, 2014

Joseph R. Coyle, MPH, Emily Goerke, MSN, MPH, Kathryn & Ruby Rodgers, BSN, Patricia Raines, RN, Linda S. Vail, MPA, Sugandha Lowhim, MD  Author Notes

Pain Medicine, Volume 18, Issue 2, February 2017, Pages 322-3:
https://doi.org/10.1093/pm/pnw157
Published: 15 July 2016

PDF  Views  Cite  Permissions  Share

Background. In 2015, the Michigan Department of Health and Human Services (MDHHS) was notified of an acute case of hepatitis C virus (HCV). The patient had no traditional HCV risk factors.

Hepatitis B outbreak associated with a hematology-oncology office practice in New Jersey, 2009

Rebecca D Greeley, Shereen Semple, Nicola D Thompson, Patricia High, Ellen Rudowski, Elizabeth Handschur, Guo-Liang Xia, Lilia Ganova-Raeva, Jennifer Crawford, Corwin Robertson, Christina Tan, Barbara Montana

Affiliations + expand
PMID: 21658812  DOI: 10.1016/j.ajic.2010.11.011

Abstract

Background: Transmission of bloodborne pathogens due to breaches in infection control is becoming increasingly recognized as greater emphasis is placed on reducing health care-associated infections. Two women, aged 60 and 77 years, were diagnosed with acute hepatitis B virus (HBV) infection; both received chemotherapy at the same physician’s office. Due to suspicion of health care-associated HBV transmission, a multidisciplinary team initiated an investigation of the hematology-oncology office practice.
Acute Hepatitis C Cases Attributed to Unsafe Injection Practices - Endoscopy Clinic

- January 2008 - Nevada State Health Division (NSHD) contacted CDC regarding two persons diagnosed with acute hepatitis C. A total of six cases were identified during the initial investigation.
- Three patients with acute hepatitis C underwent procedures at the same endoscopy clinic within 35-90 days of illness onset.
- HCV transmission likely resulted from reuse of syringes on individual patients and use of single-use medication vials on multiple patients at the clinic.
- Approximately 40,000 patients of the clinic were notified.
FIGURE 2. Unsafe injection practices and circumstances that likely resulted in transmission of hepatitis C virus (HCV) at clinic A, Nevada, 2007

1. Clean needle and syringe are used to draw medication.
2. When used on an HCV-infected patient, backflow from the injection or removal of the needle contaminates the syringe.
3. When again used to draw medication, a contaminated syringe contaminates the medication vial.
4. If a contaminated vial is subsequently used for other patients, they can become infected with HCV.

https://www.cdc.gov/mmwr/PDF/wk/mm5719.pdf
Outbreak of Tsukamurella Species Bloodstream Infection Among Patients - Oncology Clinic

- Between 2011 - 2012, fifteen cases of Tsukamurella (Tsukamurella pulmonis or Tsukamurella tyrosinosolvens) were identified
- Tsukamurella species are gram-positive bacilli that have been isolated in the environment from soil and sludge
- A bloodstream infection
- All cases were in patients with underlying malignancy and indwelling central lines
- Clinic had been preparing saline flush from a common-source bag of saline
# Viral Hepatitis Outbreaks - Unsafe Injection Practices

<table>
<thead>
<tr>
<th>State</th>
<th>Year</th>
<th>Setting</th>
<th>Type</th>
<th>Mode of Transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>2019</td>
<td>LTCF</td>
<td>HCV</td>
<td>IC lapses in injection safety practices and inadequate environmental disinfection in the shared dialysis treatment area.</td>
</tr>
<tr>
<td>WA</td>
<td>2018</td>
<td>Outpatient Clinic</td>
<td>HCV</td>
<td>IC breach with receipt of IV therapy</td>
</tr>
<tr>
<td>PA</td>
<td>2016</td>
<td>Vascular Clinic</td>
<td>HCV</td>
<td>Reuse of syringes to access multi-dose vials of ketamine that were possibly used for &gt;1 patient; MDVs accessed in the immediate patient treatment area; lack of disinfection of medication vials and medication preparation area</td>
</tr>
<tr>
<td>TX</td>
<td>2015</td>
<td>Hospital</td>
<td>HCV</td>
<td>Reuse of saline flush syringes for multiple patients</td>
</tr>
<tr>
<td>WV</td>
<td>2015</td>
<td>Cardiology Clinic</td>
<td>HCV, HBV</td>
<td>Reuse of syringes to access saline vials for an individual patient; Suspected use of these single-dose vials for &gt;1 patient</td>
</tr>
</tbody>
</table>
Injection Safety Principles

- Use a new sterile syringe and needle for each patient.
  - Even if the needle is changed or you are injecting through an intervening length of IV tubing
- Always use aseptic technique when preparing and administering injections
- Always use a new sterile needle and new sterile syringe to enter a vial (SDV or MDV), bottle or IV bag
- Never use medications packaged as single-dose or single-use for more than one patient
- Ensure appropriate sharps disposal immediately after an injection
Injection Safety - Aseptic Technique

- Use aseptic technique when preparing and administering IV medications, flush/locking solutions, and other parenteral solutions

- Aseptic technique includes:
  - Hand hygiene prior to and after preparation and administration of the medication/solution
  - Disinfect medication access diaphragm on vial or the neck of an ampule prior to accessing medication/solution
    - 70% alcohol; allow adequate dry time before entry
  - Disinfect IV access port, needleless connector, or other vascular access device (VAD)
  - Use personal protective equipment (PPE) if contact and exposure to blood or bodily fluids are possible
Injection Safety - Hand Hygiene

- Practice proper hand hygiene:
  - Before preparing and giving an injection (2)
  - After injection administration (3)

- When hand hygiene is performed at the right moment, it keeps the patient, other HCWs, and yourself safe

https://www.who.int/campaigns/world-hand-hygiene-day
Injection Safety - Medication Preparation

- Never store needles and syringes unwrapped. Remove the needle/cannula, syringe from its sterile packaging immediately before use.
- Draw up medication into a syringe as close to administration time as possible.
- Disinfect the rubber septum of medication vials and the neck of glass ampules with 70% alcohol, allowing adequate time to dry before entry.
Injection Safety- Vial Caps

- The “pop-off” vial caps from manufacturers are considered “dust covers” and are not intended to maintain sterility of the vial diaphragm or access point.

- Always disinfect the diaphragm after removing new vial cap
Injection Safety - Medication Preparation

- Check manufacturer’s label and expiration date
- Draw medications in designated clean medication preparation area
  - Not adjacent to potential sources of contamination; > 3 feet from the sink or other water sources
- Regularly clean and disinfect medication preparation area
- Ensure access to necessary supplies
- Practice aseptic technique
- Never store needles/canulas/syringes unwrapped. Remove from sterile packaging immediately before use
- Draw medication into a syringe as close to administration time as possible

https://depts.washington.edu/edgt/app_jpc/web/injection_safety.html
THE PROVIDER
DO YOU MULTI-DOSE?

A SINGLE-DOSE VIAL (SDV) is approved for use on a SINGLE patient for a SINGLE procedure or injection.

SDVs typically lack an antimicrobial preservative. Do not save leftover medication from these vials. Harmful bacteria can grow and infect a patient.

DISCARD after every use!

SIZE DOES NOT MATTER!

SDVs and MDVs can come in any shape and size. Do not assume that a vial is an SDV or MDV based on size or volume of medication. ALWAYS check the label!

A MULTIPLE-DOSE VIAL (MDV) is recognized by its FDA-approved label.

Although MDVs can be used for more than one patient when aseptic technique is followed, ideally even MDVs are used for only one patient.

MDVs typically contain an antimicrobial preservative to help limit the growth of bacteria. Preservatives have no effect on bloodborne viruses (i.e. hepatitis B, hepatitis C, HIV).

Discard MDVs when the beyond-use date has been reached, when doses are drawn in a patient treatment area, or any time the sterility of the vial is in question!

www.cdc.gov/injectionsafety/1anonly.html
Injection Safety

- One time only use of needles and syringes

- The One & Only Campaign is a public health campaign to raise awareness among patients and health care providers about safe injection practices

- Injection Safety is every provider’s responsibility!

https://www.cdc.gov/injectionsafety/one-and-only.html
Assisted Monitoring of Blood Glucose
Assisted Monitoring of Blood Glucose

- Since 2008, 19 HBV outbreaks in long-term care facilities
  - 79% associated with infection control breaks during assisted monitoring of blood glucose (AMBG)
  - **34.2 million people** with diabetes in the US (1 in every 10)
- **Self-monitoring of blood glucose and insulin administration**
  - Individual performs all steps of the testing and insulin administration themselves
- **Assisted monitoring of blood glucose and insulin administration**
  - Another person assists with or performs testing and insulin administration for an individual
  - Often occurs in: hospitals, clinics, long-term care facilities, senior centers, health fairs, correctional facilities, and schools/camps
Assisted Monitoring of Blood Glucose

- Activities associated with BBP transmission to residents, patients, and HCPs
  - Using penlet-style spring-loaded fingerstick devices on multiple persons
  - Sharing blood glucose testing meters without proper cleaning and disinfection
  - Using insulin pens for more than one person
  - Failure to change gloves and perform hand hygiene between fingerstick procedures
Assisted Monitoring of Blood Glucose: Fingerstick Devices

- **Reusable Devices**
  - Looks like a pen
  - Allows removal and replacement of lancet after each use
  - Single person use only
  - Intended to be used by individual persons for self-monitoring of blood glucose

- **Single-use, auto-disabling fingerstick devices**
  - Disposable devices
  - Prevent reuse through an auto-disabling feature
  - Single use; used in settings where assisted monitoring of blood glucose is performed.

Source: MyFreestyle.com

Source: CDC
Assisted Monitoring of Blood Glucose: Fingerstick Devices

Transmission Risks

- Reusable fingerstick devices contaminated with blood on inner/outer device surfaces
  - Wiping device does not successfully remove blood
- Do NOT use a fingerstick device for multiple residents even if the lancet and disposable components are changed and the device is cleaned and disinfected after use

Locking end cap; from adwdiabetes.com

pre-loaded lancets in a drum from AACC.org
Assisted Monitoring of Blood Glucose: Fingerstick Devices

- It is NOT OK to use fingerstick devices that are equipped with cartridges of multiple preloaded lancets for multiple patients.
  - These devices are not approved nor safe for use on multiple patients. Even if the device is advanced and a new lancet is used for each fingerstick procedure, unused lancets could become contaminated through contact with blood remaining on the end cap or the device barrel.

- Even if a reusable fingerstick device is dedicated for single-patient use, it is NOT OK to use it when HCPs are providing assistance with BGM.
  - In settings where assisted BGM is performed, CDC recommends single-use, auto-disabling fingerstick devices to prevent inadvertent reuse for more than one person. If residents in LTC are able to perform their own self-BGM and prefer to use the reusable fingerstick device that is acceptable.
Assisted Monitoring of Blood Glucose: Fingerstick Devices

Recommended Practices:

- Fingerstick devices should never be used for more than one person
- Reusable lancing devices are not recommended for healthcare settings
  - Reusable fingerstick devices for persons performing self-monitoring of blood glucose
- Auto-disabling, single-use fingerstick lancets used for assisted monitoring of blood glucose
- Do not reuse lancets
- Dispose of used lancets immediately at the point of use in an approved sharps container
- Change gloves and perform proper hand hygiene between fingerstick procedures
Assisted Monitoring of Blood Glucose: Glucometers

Blood Glucose Meter (BGM) or Glucometer

- Portable, medical device for measuring concentration of glucose in blood
- Small amount of blood collected from fingertip
Assisted Monitoring of Blood Glucose: Glucometers

Transmission Risks

- Use of blood glucose meter for >1 resident with improper cleaning and disinfection
- Cross-contamination of clean supplies with contaminated blood glucose monitoring equipment
- Not removing gloves and performing hand hygiene after performing AMGB - risk of patient exposure via transfer of virus from the HCP’s hands or gloves
- Disinfecting a BGM but not following the MIFU for product, dwell time, etc.
- Even if a shared BGM never touches the patient, the device MUST BE cleaned and disinfected per manufacturer’s instructions
Assisted Monitoring of Blood Glucose: Glucometers

Recommended Practices:

- Assign BGM to an individual person (label & store appropriately)
- Shared BGM or when HCP provide AMBG:
  - Clean and disinfect device after every use, per manufacturer’s instructions
    - Do not share device if the manufacturer does not specify how to clean & disinfect
    - Disinfectant should be effective against viral BBP
      - 70% ethanol solutions are not effective against viral BBP
      - Use of 10% bleach solutions may lead to physical degradation of device
      - EPA-Registered Disinfectants
- Wear gloves during BGM and change (perform hand hygiene) between patient contacts, when potentially contaminated, and before touching other medical supplies intended for use on other residents.
Assisted Monitoring of Blood Glucose: Insulin Pens

- Pen shaped injector device that contains a reservoir for insulin or an insulin cartridge with multiple doses;
- Provides an alternative to a vial and syringe for injecting diabetes medicines
- Designed to be used multiple times for a single person, using a new needle for each injection.
- Self-injection; single-person use (One pen, one person)
Assisted Monitoring of Blood Glucose: Insulin Pens

Transmission Risks
- Reusing/sharing insulin pens
- Changing the needle and reusing the cartridge of an insulin pen
  - Regurgitation of blood into the insulin cartridge after injection
  - Changing the cartridge does not protect against contamination and does not make these devices safe for multi-person use (same as syringe reuse)
- Accidental use of insulin pen on unintended resident
- Failure to clearly label and properly store insulin pens

Factors Contributing to Multi-person Use of Insulin Pens
- Inconsistencies in or insufficient training on proper use of device
- Confusion on the difference between MDV and multi-dose insulin pens
- Time constraints
- Missing medications
- Lack of appropriate warning labels
Recommended Practices

- Each pen designed for **one patient to use multiple times** with a new, fresh needle for each injection
- Label insulin pens and store in a clean location; preferably patient’s room
- Wear gloves during BGM, insulin administration and during other procedures with exposure risks
- Perform proper hand hygiene immediately after removal of gloves
- Review policies and procedures and educate staff regarding safe use
- Report medication errors or adverse events involving diabetes drugs
Injection Safety and Assisted Monitoring of Blood Glucose

Other Infection Control Considerations

- Use a “clean field” or clean area on med cart to contain equipment (do not put supplies on the bedside table, or soft bedding); keep separate from used supplies
- Do not carry supplies/medications in pockets
- Unused supplies taken to a patient or resident’s bedside during fingerstick monitoring or fingerstick administration should not be used for another patient
- Infection Control Considerations from Guiding Agencies:
  - CDC
    - One and Only Campaign
    - CDC Clinical Reminder - Fingerstick devices
    - CDC Clinical Reminder - Insulin Pens
    - Blood Glucose Meters
  - CMS
    - Concerns over transmission risks for each device - injection, fingerstick, glucometer, and insulin pen
Injection Safety and Assisted Monitoring of Blood Glucose

- Infection Control Considerations from Guiding Agencies:
  - FDA
    - FDA alert issued to HCPs reminding that “single-patient insulin pens and insulin cartridges should not be used to administer medication to multiple patients”. (3-22-2009)
    - FDA requires label warning to prohibit sharing of multi-dose diabetes pen devices among patients: “For single patient use only.” (2-25-2015)
  - Joint Commission
      - Documentation that staff are trained on use and maintenance of glucometer.
      - Staff need to be able to speak to how to properly use a lancet, lancet holding device, and insulin pen, and when to discard
Injection Safety and Assisted Monitoring of Blood Glucose

- Infection Control Considerations from Guiding Agencies:
  - VDH
    - VDH Educational Flyer: Diabetes and Viral Hepatitis: Important Information on Safe Diabetes Care
    - Infection Control Breaches: Protocol for Follow-Up of Infection Prevention Breaches Related to Blood Glucose Monitoring and Insulin Administration in Assisted Living Facilities
  - OCCUPATIONAL HEALTH TOOLS AND RESOURCES
    - Safe Blood Glucose Monitoring (BGM)
    - Practice Safe Blood Glucose Monitoring poster
    - Single-Use Devices vs Penlets poster
    - Monitoring Tool for Assessing Compliance with BGM practices
    - Talking Points: Preventing Outbreaks Associated with Unsafe Injection Practices and Assisted Blood Glucose Monitoring Practices
Injection Safety and Assisted Monitoring of Blood Glucose

Training and Education

- Provide Hepatitis B vaccination to previously unvaccinated at risk staff
- Establish infection prevention & control (IPC) oversight
  - Provide IPC training to staff on standard precautions and PPE, safe injection practices, aseptic technique, and reporting IC breaches
  - Staff demonstrate knowledge competency on safe injection practices before performing injections
  - Conduct training and assess competency at the time of hire, annually, and with changes to equipment/devices.
  - Reinforce and monitor safe injection practices through routine audits by periodically observing staff who perform or assist with these procedures
Injection Safety and Assisted Monitoring of Blood Glucose

Training and Education

- Consider diagnosis of acute viral hepatitis infection in patients/residents with illness that includes hepatic dysfunction or elevated liver transaminases (ALT, AST)

- Promptly report any suspected instances of newly acquired bloodborne infection, such as Hepatitis B, in a facility resident, or staff member to the public health authorities

- Check with state authorities for specific state and federal regulations regarding laboratory testing of the source and exposed persons
Safe Injection Practices & Assisted Monitoring of Blood Glucose

Important Take Home Messages

● Use one needle, and one syringe, only one time

● Identify locations for designated clean medication preparation where needed

● Perform proper hand hygiene and use aseptic technique during all steps of medication preparation and administration

● Fingerstick devices should never be used for more than one person
  ○ Select single-use devices that permanently retract upon puncture

● Dedicate blood glucose meters to a single patient/resident, if possible
  ○ If shared, clean and disinfect the device after every per manufacturer’s instructions

● Insulin pens and other medication cartridges and syringes are single-use only

● Use available resources from guiding agencies to educate staff on blood glucose monitoring and safe injection practices
Resources - Quick Observation Tools

### Injection Safety: Observation of Centralized Medication

**Instructions:** Observe medication preparation area. For each category, record the observation. Observe each practice. Sum all yes and no responses. Divide by sum of "yes" + "no". Disregard not applicable categories.

#### Medication preparation room: Observation Categories

1. If multi-dose injectable medications are present, is the medication container maintained in a dedicated medication preparation space?
2. Is the medication preparation area free of opened single-dose vials or opened single-use containers?
3. If open multi-dose vials are present, are they dated and within the Beyond Use Date (BUD) and the manufacturer’s expiration period?
4. Medications are prepared in a clean area free from contamination or contact with blood, body fluids, or contaminated equipment.
5. Are splash guards installed at sinks that are located close to medication prep areas?
6. Are sinks readily accessible to healthcare providers?

### Injection Safety: Point of Care Testing

**Instructions:** Observe the ambulatory care point of care testing area. For each category, record the observation. Sum all yes and no responses. Divide by sum of "yes" + "no".

#### Patient Care Area: Observation Categories

1. Are sharps containers properly secured and not full?
2. Are sharps containers available at the point of use?
3. Are cleaning and disinfection supplies for examination tables and test surfaces readily available?
4. Is a new single-use auto-disabling lancet device used for each patient?
5. Are all point of care testing devices being disinfected after each use with an EPA-registered product that is consistent with manufacturer instructions for use?
6. Is the required personal protective equipment for disinfectant use readily available?

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### Monitoring tool to ensure safe practices when assisting with blood glucose monitoring

<table>
<thead>
<tr>
<th>Date</th>
<th>Observation</th>
<th>Finger-stick device**</th>
<th>Glucometer</th>
<th>Insulin administration**</th>
<th>Hand hygiene [H11]</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/DD/YY</td>
<td>Location of Observation</td>
<td>Role of observer</td>
<td>Single-use/contaminating device used</td>
<td>Medicated-needle-side-out device</td>
<td>Hand contam. after use</td>
<td>Other contam. after use</td>
</tr>
<tr>
<td>Y/N</td>
<td>Y/N</td>
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</tbody>
</table>

*Includes role of observer if other details listed related to recommendations, etc.*
More Resources

- **Check Your Injection Safety Knowledge**
- **Injection Safety Handout**

Please visit the HAI/AR Education & Training website for more information and supplemental resources

Additional Resources:

- Health care-Associated Hepatitis B and C Outbreaks (≥ 2 cases) Reported to the CDC 2008-2019: https://www.cdc.gov/hepatitis/outbreaks/healthcarehepoutbreaktable.htm
- CDC Injection Safety: https://www.cdc.gov/injectionsafety/index.html
- CDC One and Only Campaign: https://www.cdc.gov/injectionsafety/one-and-only.html
- Virginia Department of Health Infection Prevention: https://www.vdh.virginia.gov/haiar/infection-prevention/
- CDC Insulin Pen: https://www.cdc.gov/injectionsafety/PDF/Insulin-Pen-Safety-Handout-P.pdf
- CDC Infection Prevention during Blood Glucose Monitoring and Insulin Administration: https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html#anchor_1556215586
References


Centers for Disease Control and Prevention. Health care-Associated Hepatitis B and C Outbreaks (≥ 2 cases) Reported to the CDC 2008-2019. Available at: https://www.cdc.gov/hepatitis/outbreaks/healthcarehepoutbreaktable.htm


References


University of Washington. Injection Safety Overview. Available at: https://depts.washington.edu/edgh/app-ipc/web/injection_safety.html
Thank you for your time!

We hope this webinar on Safe Injection Practices and Assisted Monitoring of Blood Glucose has been helpful.

Virginia Department of Health
Healthcare-Associated Infections and Antimicrobial Resistance (HAI/AR) Team
Additional Slide:

These are questions one could ask regarding AMBG. What would your answers be?

- Is hand hygiene performed before and after performing a fingerstick procedure to obtain a sample of blood and when using the glucometer (or other POC device)?
- Are gloves worn by HCP when performing a fingerstick procedure to obtain a sample of blood, and are they removed after the procedure, followed by hand hygiene? (To prevent transfer of blood to another person’s fingerstick wound or piece of patient care equipment)
- Is a new single-use auto-disabling lancing device used for each patient? Are they used for only one person, and discarded immediately after use? (never for more than one resident/patient)
- If used for more than one resident/patient, is the BGM properly cleaned and disinfected with appropriate disinfectant and dwell time after each use following manufacturer’s instructions? (If the manufacturer does not provide instructions for cleaning and disinfection, then the device should not be used for >1 resident.)
- Are insulin pens dedicated for single-resident use only? (they should never be used for more than one person, even when the needle is changed, remember one pen-one person only)
- Is the resident insulin pen clearly labeled with their name and other identifiers to verify that the correct pen is used on the correct resident? (This is very important to help prevent the inadvertent use of the pen on someone other than the intended person creating a need for investigation, notifications, and resident testing for BBPs of the exposee and the exposer)
- Do employees providing AMBG receive training with regard to proper use of lancets, lancet holding devices, insulin pens, and blood glucose monitors? (These staff should receive training on hire, annually, and anytime a new device is employed)