Testimony of

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President

American Association of Nurse Anesthetists

Before the State of Nevada Legislative Committee on Health Care
Assemblywoman Sheila Leslie, Chair, and Senator Maurice Washington, Vice Chair

Grant Sawyer Office Building Rm. 4401, Las Vegas, Nevada
Monday, April 21, 2008, 9:00 am

Madam chair, members of the Committee, ladies and gentlemen:

My name is Wanda Wilson. I have been a Certified Registered Nurse Anesthetist and educator for 34 years. I am appearing today in my role as president of the 37,000-member American Association of Nurse Anesthetists. I ask that additional material I have submitted to you under separate cover be made part of the official record.

At the request of our Nevada association leadership, I am here today to discuss three things: What are the AANA's responses to past and present hepatitis outbreaks linked to healthcare facilities? What are our education and accreditation initiatives in infection control? And what recommendations does the AANA have for eliminating infections related to healthcare professionals' inappropriate use of equipment and drugs?

We start with the knowledge that this public health crisis has a face and a name. From the hearing you held March 24, we CRNAs know some of the faces and names of the patients who contacted Hepatitis C, and some of the 40,000 patients who have received public health notices.

But the face and name I know most well is that of the next patient I see in the morning, the one who wants to know whether his or her care will be safe. As a CRNA, I see myself as the defender of that patient when she is helpless to defend herself. Just as the surgeon is that patient's

defender against cancer or illness, and the nurse is the patient's defender within a complex healthcare system, the CRNA is the patient's defender in surgery or invasive procedures.

And so we express our deepest concern. While we cannot change the past, we are here to report we are working to change the future for the better, and to work with you.

Six years ago, AANA responded to a hepatitis outbreak in Oklahoma that was linked to syringe reuse. Then as now, our role and strategy to advance patient safety was to fix the problem, not affix blame.

The evidence available at *that* time, including a survey we conducted, indicated the prohibited, unsafe practice of syringe reuse was not unique to Oklahoma.

According to a 1995 study published in the journal *Anesthesia and Analgesia*, "20 percent of respondents reported frequently or always reusing syringes for more

than one patient, and 34.4 percent reported never or rarely disinfecting … multiuse vials before use."

Rosenberg reported in the *American Journal of Anesthesiology* in 1995 that 39 percent of respondents indicated they reused needles and syringes on multiple patients.

In a 2002 AANA-supported survey of critical care nurses, nurse anesthetists, oral surgeons, anesthesiologists and other physicians, 1-3 percent of the respondents indicated that they reused needles and/or syringes on multiple patients. Three percent and 1 percent sound like small numbers, but they represent a percentage of some 70,000 anesthesia professionals -- or 1,500 anesthesiologists and CRNAs -- putting over one million patients at risk of infectious disease.

So, AANA conducted a nationwide campaign to promote the *one-time* use of needles and syringes, and then throw them away. We mailed alerts and copies of the AANA

Infection Control Guide to 30,000 CRNAs, plus administrators of hospitals and ASCs, and asked them all to assess their practice for safety and compliance. We shared our information with the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Joint Commission, and numerous healthcare professional associations and organizations. The CDC issued publications and one-page guidelines on infection control and safe injection practices; otherwise, we are not aware of other organizations having taken further actions at that time.

Fast forward six years, to today. The Nevada hepatitis outbreak is not unique. It follows other hepatitis outbreaks that public health officials have linked to syringe reuse in Indiana and New York, since last October.

Again, the AANA has responded with a major campaign among our own members, sending emails and letters to CRNAs and to registered nurses in our accredited educational programs, some 40,000 in all. We alerted them

to the preliminary findings of Nevada public health officials, and reinforced adherence to AANA professional standards and guidelines.

In addition, we have reached out to the FDA and the CDC, joining forces in the interest of the public health to make black-and-white those gray areas of clinical practice where patient safety is at issue.

We have reviewed FDA-approved labeling for the anesthesia drug propofol. We have found that both the drug's labeling instructions, and FDA's standard definitions of key terms, are subject to multiple reasonable interpretations, leading to variations in practice. The labeling states the drug is for "single-use," and for "single-patient use only," using "strict aseptic technique." Yet it also states it "should be drawn into sterile syringes" – note the plural use of "*syringes*," which could be interpreted as "*multiple*" – "immediately after vials are opened." Neither FDA nor the manufacturers specifically define strict aseptic technique for propofol administration.

We are asking that FDA direct the labeling instructions for propofol and other medications to be changed, to conform to safe practice standards consistent across agencies, professions and manufacturers.

Having also met with senior CDC officials earlier in April, and heard from one of them at a recent AANA national meeting, we are convinced that national healthcare professional organizations, federal agencies and standard-setting bodies must work together to develop a common standard approach to strict aseptic technique, and to handling anesthesia and other parenteral drugs.

Establishing such a common standard approach, which could be used immediately but which then must be implemented by a date certain, removes a critical barrier to patient safety by assigning *all* clinicians the responsibility of conducting and monitoring the same safe practice, without assigning blame or posing a threat to any one person or group.

At one stroke, starting on a specific *Day One*, a commonly observed standard makes *every* clinician the patient's defender. Because everyone would be responsible for knowing and adhering to the same common standard, this *Day One* strategy reduces the likelihood that any one clinician would be put in the difficult position of resisting the pressures of expressly unsafe practice such as syringe reuse.

The driving force behind such a change: a summit of clinicians, agencies and other healthcare professionals to develop educational, clinical, procedural, and technological solutions for eliminating infections related to healthcare professionals' inappropriate use of equipment and drugs. While awaiting final findings of the Nevada Health Bureau and the results of the planned national summit, AANA is developing an *interim definitive process* for the appropriate use of needles and syringes, as well as single-dose and multi-dose vials.

These are the things healthcare organizations can do to advance safe injection practices. Where there are gray areas, we should work together to make them black and white where ever we can,

But restoring trust in healthcare ultimately begins with each clinician working with each patient.

It begins with clinicians observing the rule that for every patient they should use *one* needle, *one* syringe, *one* vial, *one* time only… followed by immediate and proper disposal. It begins with clinicians who are willing to be their patients' defender.

I spoke with one nurse anesthetist from rural Nevada who has heard his patients' fears, and who reports he is rebuilding trust one patient at a time. He opens anesthesia supplies and medications right in front of the patient, out in the open, saying, "This is brand new, and this is what I'll be using to take care of you. I am staying with you during

your entire procedure, and taking care of you as if you're my own family." He puts the patient at ease, so that they will safely and willingly undergo the procedure that will help save and extend life.

I know that opening the anesthesia supplies in the open in front of the patient helps build trust, because that's how I have done it myself for my patients in Ohio.

Thank you, and I would be happy to take your questions.

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Attachments:

1. Summary of the AANA Scope and Standards for Anesthesia Practice, with selected passages identified (PDF)
2. Scope and Standards for Nurse Anesthesia Practice (PDF)
3. Standards for Office Based Anesthesia (PDF)
4. Council on Accreditation of Nurse Anesthesia Educational Programs C20 Standard (PDF)
5. National Board on Certification & Recertification of Nurse Anesthetists Candidate handbook (PDF)
6. Oklahoma Hepatitis outbreak survey documents, AANA 2002 (PDF)
7. CDC MMWR article regarding hepatitis outbreaks in Oklahoma, New York and Nebraska, 2002 (PDF)
8. Rosenberg article (PDF)
9. Tait and Tuttle article (PDF)
10. AANA Infection Control Guide (PDF)

11. Initial AANA recommendation of healthcare professional organizations and agencies to participate in a summit on safe injection practices (PDF)
12. AANA recommendations and actions document.

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President
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Wanda Wilson, CRNA, PhD, MSN is the 2007-2008 president of the American Association of Nurse Anesthetists, a national association representing more than 37,000 CRNAs nationwide. She is also the Program Director at the University of Cincinnati's College of Nursing, Nurse Anesthesia Major, which has been ranked one of the top nurse anesthesia educational programs nationally by *U.S. News and World Report,* and has a primary clinical site at the University Hospital in Cincinnati.

A resident of Cincinnati, Ohio, Wilson earned her doctorate in nursing science and physiology, a master's degree in nursing, a bachelor's degree in nursing and a bachelor's degree in science from the University of Cincinnati. She also received her nurse anesthesia diploma from Cincinnati General Hospital, and her nursing diploma from Holzer Medical Center in Gallipolis, Ohio. A longtime member of the AANA, she has served in many committee and leadership positions for both her national association and the Ohio State Association of Nurse Anesthetists.