

## HEP-C case in Denver has hospitals examining preventive strategies

BY GERI ASTON

In June the unthinkable happened at Rose Medical Center in Denver. The state notified the hospital that two newly identified hepatitis C cases were possibly linked to surgeries at the facility. Hospital officials then made the connection that an infected surgical scrub technician fired for drug diversion was the likely cause.

"I was overwhelmed, panic stricken, angry. I felt betrayed," says Kenneth H. Feiler, president and CEO. Instead of dwelling on those emotions, he gathered his crisis team and got to work.

Hospital officials met with representatives from the Colorado Department of Public Health and Environment and the Centers for Disease Control and Prevention and came up with a plan. They agreed that everyone who had surgery at the medical center or its Wolf Building between Oct. 21, 2008, and April 13, 2009 – the period of the technician's employment – should be tested. The hospital notified those 4,700 patients via return receipt letters and offered free testing.

As of July 29, about 3,500 people had been tested, Feiler says. On July 24, the health department reported that 13 cases had been epidemiologically associated with exposure to the former employee, Kristin Parker, who was indicted in July and is being held without bail. The department has identified another associated case at Audubon Surgery Center, Colorado Springs, where Parker went to work after leaving Rose.

The case has left hospital and public health officials pondering what can be done to prevent future outbreaks.

**Drug diversion policies.** Rose Medical

Center already had strong drug diversion policies in place. Job candidates undergo background and criminal record checks. New employees are given a witnessed drug test, Feiler notes. Narcotics in the operating room (OR) are dispensed by AcuDose-Rx™ machines located in each room. They require the anesthesiologist to input a password, the patient's name and the drug to be used before they will dispense medication.

Parker, who wasn't in a position where she was to handle drugs, was identified as having hepatitis C before she began work. An employee health nurse notified Parker of her disease status and advised her to get medical attention, Feiler says. At orientation, Parker was trained in universal precautions to prevent the spread of blood-borne illnesses.

The CDC has no recommendations to restrict health care workers who are infected with hepatitis C. It recommends that all health care personnel follow strict aseptic technique and standard precautions, such as appropriate hand hygiene, use of protective barriers and safe injection practices.

"Many people who have hepatitis C and have been in health care a long time are valuable workers," Feiler says.

In the incident's aftermath, the hospital is increasing use of tamper-proof syringes in the OR. It is buying and putting at OR bedsides more advanced drug-dispensing machines, which require not only a password but a biometric fingerprint. All key



Rose Medical Center had strong drug diversion policies in place before the hepatitis C case occurred in June.

personnel will get additional training on drug diversion, and the message that anesthesiologists should not dispense narcotics until the patient is in the room will be reinforced, Feiler says.

To guard against incidents at their facilities, Feiler says hospital CEOs should review their hiring practices, drug testing procedures and staff awareness. They should make sure staff members feel comfortable reporting suspicious behavior and ensure that doctors understand the standards for preventing diversion.

Nurses and another surgical technician are the reason Parker was caught. They found her in a room she wasn't authorized to be in with a syringe she shouldn't have had, and they reported her. She underwent a drug test, and fentanyl was found in her system.

**Culture of cooperation.** Promoting a culture of cooperation among staff is essential, says Evelyn McKnight, founder and president of HONORreform, a Nebraska non-profit foundation that advocates for policies to prevent hepatitis infection. "If one person sees something they don't

agree with, have an open dialogue. Don't be bashful in that regard."

The foundation recommends use of safety engineered, one-use syringes, and before year's end is launching a campaign, called "One and Only," promoting their use.

John Burke, president of the National Association of Drug Diversion Investigators, advises hospitals to report diversion to law enforcement, which Rose officials did. "You need to address it as a crime," he says. He also recommends that OR narcotic wastage be sent back to the hospital pharmacy for spot checks to make sure the excess material is what it is supposed to be.

However, Feiler points out, this approach raises some questions, including who should transport the wastage to the pharmacy and how should they be monitored, and who will handle it at the pharmacy and how are they monitored?

**CHA task force.** The outbreak has

sparked reflection beyond Rose Medical Center. The Colorado Hospital Association (CHA) is convening a special task force to study diversion. It plans to have a final report by November before its annual meeting. The end product could be suggestions for voluntary hospital guidelines and recommendations to the state for legislative or regulatory changes, says Stephen Summer, CHA president and CEO.

Among the issues the panel will examine are hospital hiring practices and the "Americans With Disabilities Act's" impact on them, and the idea of licensing surgical technicians. Because the outbreak is so rare in its circumstances, care should be used not to "build a huge system" in reaction, Summer says.

A hepatitis C outbreak caused by an infected drug diverter is unprecedented in Colorado, and apparently nationwide, says Ned Calonge, MD, chief medical officer for the Colorado health department. "We're kind of writing the approach as we go."

The department is looking at whether changes are needed. Hospitals must notify the department of a drug diversion, but employee names aren't part of the report. Diversion reports are sent to one division, but disease outbreak investigations are handled by another. A possible change would be to include diverters' names on hospital reports so they can be checked against the state's disease registry, Calonge says. Another option is to strictly regulate hospital drug-diversion prevention policies, he says. "My nervousness is I don't know that the same process would work for every facility."

Diversion prevention experts and health officials agree that hospitals can't completely guard against the problem. "If a person really wants to get it, they're going to get it. We put things in place to make it harder, but it's never hard enough," Calonge says.

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