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GAO Releases Report on VA Hospitals and Use of Safer Needle Devices

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A GAO report to Congress, released late in 1994, indicated that Department of Veterans Affairs (VA) medical centers individually are responsible for acquiring medical devices, including safer needle and sharps devices. However, insufficient data are available in these medical centers to demonstrate the extent to which safer devices are needed and whether the devices will reduce the number of percutaneous injuries.

Further, the report noted there was a 19% decrease in reported needle injuries from 1992 to 1993. However, VA officials did not know to what extent this decrease could be attributed to better use of universal precautions, safer devices, or underreporting of needle injuries. Infection control personnel at VA medical centers and clinical staff at the private hospitals told the GAO researchers that percutaneous injuries frequently go unreported and could be understated by as much as 75% because of underreporting. However, a current surveillance study conducted by three private hospitals and a VA medical center in San Francisco indicated that the reporting of percutaneous injuries can be improved substantially if immediate, confidential counseling and follow-up are available to the injured workers.

The report also noted that VA healthcare workers are at risk of life-threatening diseases from a percutaneous injury involving HIV or hepatitis-infected blood. However, as of September 1994, there were no documented cases of VA healthcare workers being infected with HIV as a result of such an injury. The VA did not have any data on the number of healthcare workers that may have developed hepatitis from a percutaneous exposure, because this type of data is not maintained.

Acquisition of safer devices to prevent percutaneous injuries was found to vary by medical center, and the information needed to make informed procurement decisions was not always available. In 1993, 90 VA acute and nonacute medical centers spent about $1.1 million to purchase 33 types of new and safer devices that FDA approved. However, several of the medical centers that did not purchase safer devices are in areas of high HIV prevalence.

Recommendations were for the Secretary of Veterans Affairs to require the Under Secretary of Health to 1) test ways to improve the reporting of percutaneous injuries and to develop a systemwide strategy to implement successful approaches; 2) fund pilot projects in which acute care medical centers acquire and test safer needle and sharps devices, and to determine their impact on incidence of injuries over a period of time; and 3) establish a communication network to disseminate information on the results of tests and studies involving safer devices to all medical centers and to others when requested.

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