

## **Nevada Association of Nurse Anesthetists Response to Hepatitis C Outbreak**

The Nevada Association of Nurse Anesthetists (NVANA) stands behind the American Association of Nurse Anesthetists in expressing our deepest concern for the six patients who contracted Hepatitis C allegedly during a procedure at the Endoscopy Center of Southern Nevada and for all the patients who also underwent procedures at the center who must now be tested.

According to the investigation report from the State of Nevada Health Division, the following is what is believed to have occurred at the center:

- A syringe that was used to give medication to a patient was reused on the same patient to draw up additional medication from the same opened vial of medication.
- Even though a different needle was used, the process of redrawing medication using the same syringe could have contaminated the vial with the blood of the patient.
- This vial of medicine, which was not labeled for use on multiple patients, was then used for a second patient.
- Even though a clean needle and syringe were used for the second patient, if the vial was contaminated with the blood of the first patient, any subsequent patients given medication from that vial could have been exposed to hepatitis C or other bloodborne pathogens.

It is vital for CRNAs and all healthcare providers to practice strict aseptic technique which is known to prevent cross contamination or infection of patients as stated in the American Association of Nurse Anesthetists Infection Control Guide, ([\*AANA Infection Control Guide\*](#)).

As a member of NVANA and the American Association of Nurse Anesthetists, our mission is advancing patient safety and excellence in anesthesia. I am asking all of us to remember this mission statement as we continually strive to administer the safest anesthetic to our patients.