Continuing Education Course Instructions

1. Welcome to the CCAOM’s CEU course, entitled “CNT and Blood Borne Pathogen Review Course”. Completion of this course will earn you 4 PDA points toward the NCCAOM safety CEU course requirement (NCCAOM Provider # ACHB 664-001). Completion of this course and worksheet should take approximately 4 hours.

2. Included with these instructions are the application form, course content, and worksheet. After you have read the course content and completed the worksheet, please do one of the following:
   - mail the completed application form (page 2 of this document), along with payment and the completed worksheet, to: CCAOM, 600 Wyndhurst Avenue, Suite 112, Baltimore, MD, 21210
   - or, fax the information to: 410-464-6042 (if you fax the information, please call the CCAOM national office at 410-464-6040 to confirm receipt, as faxes are not always successfully transmitted)
   - or, email the documents as attachments to: ccaaomcnt@comcast.net (if you email your documents, please call the office at 410-464-6040 to give us your credit card information, as it is not safe to send this information over the internet)

3. Fill out all sections of the application form and sign where indicated. INCOMPLETE OR ILLEGIBLE APPLICATIONS WILL BE RETURNED.

4. You must answer all questions on the worksheet to the best of your ability.

5. The cost of the CEU course is $35, payable in U.S. dollars to “CCAOM,” by personal or certified check, or by Mastercard or Visa. If you are using a credit card for payment, complete the applicable portion of the application form. If you are paying by check, please note that if your check is returned for insufficient funds, you will be charged an additional $20 fee.

6. Within ten days of receipt of your application, payment and worksheet, we will email you an assessment (a 10-question multiple choice exam), a course evaluation, and a request form for purposes of notifying the NCCAOM (this is optional). Please complete these documents and email them back to us at ccaaomcnt@comcast.net.

7. Within ten days of receipt of your completed assessment and course evaluation, we will send a certificate of completion to you in the mail. (NOTE: To pass the assessment, you must correctly answer at least 8 of the 10 questions. If you fail the assessment, you will be notified by email.)

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CCAOM CEU COURSE APPLICATION FORM

Send this completed application form, along with payment and completed worksheet to:

CCAOM CNT Course
600 Wyndhurst Ave., Suite 112
Baltimore, MD 21210

Or, fax the application and worksheet with credit card information to: 410-464-6042

(call the office at 410-464-6040 to confirm that your fax was received)

PLEASE TYPE OR PRINT ALL INFORMATION CLEARLY; INCOMPLETE OR ILLEGIBLE APPLICATIONS WILL BE RETURNED

CEU Course Title: ___________________________

Clean Needle Technique and Blood Borne Pathogen Review

Name, as it should appear on your certificate: ___________________________________________

Social Security Number: ____________________ or, Date of Birth: ____/____/____

(month) (day) (year)

Email Address: __________________________________________

(NOTE: You must provide us with an email address or your application will be considered incomplete.)

Mailing Address: ___________________________________________________________________

City: ____________________ State: _______ Country: _______ Zip Code: ____________

Phone: ____________________ Fax: ____________________

State in which you are licensed to practice acupuncture: _______________ License #: __________

How did you find out about this course? __________________________________________

Payment Information:

The cost of the CEU course is $35. Please include either a personal or certified check with this application form, or if paying by credit card, complete the following (we only accept Mastercard or Visa):

Card Number: ____________________ Exp. Date: _______ 3-digit Sec. Code: _______

Signature: ___________________________ Date: __________________

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CNT AND BLOODBORNE PATHOGEN REVIEW COURSE

Goals and Objectives

1. Review of the epidemiology of hepatitis B, hepatitis C and HIV
2. Review of blood borne pathogen safety as it relates to acupuncture practice
3. Review and update tuberculosis risks and prevention for acupuncturists
4. Review and update CNT guidelines
5. Review and update needlestick incident procedures for acupuncturists

Introduction

Safety remains the most important consideration for all clinicians, including acupuncturists. Any clinical efficacy is potentially endangered when a clinician is not cognizant of the potential risks of a clinical procedure to the patient, patient’s family, or the clinician and clinical staff. The field of acupuncture and Oriental medicine (AOM) has flourished in the United States in part because acupuncturists are perceived by members of the public, state regulators, and other providers to be well trained and the practice of acupuncture to be relatively safe. In this training we will review the basics of clean needle technique (CNT), as well as present new information on blood borne pathogens, tuberculosis, and emergency needlestick incident procedures.

CNT is the set of practices employed by acupuncturists to ensure risk reduction in the acupuncture treatment environment. Since its inception CNT has become the national standard for safety in the acupuncture field. Consistency and accuracy in the implementation of CNT has been assured by a nationwide CNT training program. This update is part of that training program. Risk reduction in the acupuncture treatment environment is based on three premises:

- First is the understanding that there are hazards present in any clinical environment where sharps are used, including the acupuncture clinic. Sharps, which include any device designed to be or capable of piercing the skin, present a hazard to those in the clinical environment, including clinicians, staff, and patients.

- Second, the acupuncture clinic hazard stems from the potential for injury involving sharps, a risk that is greatly exacerbated by the potential of nosocomial infection when the sharp involved is contaminated by blood or body fluids which may contain an agent transmissible by such blood or fluids. Chief among these bloodborne pathogens/infectious agents are the human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV).

- Third, the appropriate use of standard precautions greatly reduces the risk of infection in the health care environment. In the context of AOM, the health care environment includes clinics, hospitals, and, where home visits are performed, the location of such home visits. In short, the health care environment in the context of acupuncture and Oriental medicine is any location where acupuncture is being performed.
The human immunodeficiency virus (HIV) is an RNA-containing virus that in humans leads to a constellation of problems extending from declining immune function that leads to an end-stage syndrome in untreated patients, called the acquired immune deficiency syndrome (AIDS). These medical problems may be exacerbated by co-infection with other disease-causing agents such as the herpes viruses. HIV continues to be a growing medical challenge worldwide. Mathers and Loncar indicate that over the 25 year period from 2006 to 2030, between 89 million and 117 million people will die of HIV/AIDS. (1)

The Centers for Disease Control and Prevention (CDC) report that in 2005, 45,669 cases of AIDS were diagnosed in the United States. (2) Currently the largest group of individuals who are HIV seropositive in the United States remains men who have had sex with men, at 45%. Injection drug users make up 24% of those who are infected, followed by 25% with high risk heterosexual contact, and 5% for men who have had sex with men and inject drugs. One percent of those who are infected with HIV are classified as “other,” and includes those infected by clotting factors associated with hemophilia, blood transfusion, perinatal exposure, and risk factors not reported or identified. Compared to HBV, HIV is relatively difficult to transmit, and transmission is limited to exposure to blood or blood products, sexual transmission, perinatal transmission, and through breast milk.

Of those healthcare personnel for whom case investigations were completed from 1981-2010, 57 had documented seroconversion to HIV following occupational exposures. In other words, as of 2010, there were 57 documented cases of occupationally-acquired HIV infection among United States health care workers. The most recent possible new case of occupationally acquired HIV reported to CDC occurred in 2009; no new documented cases have been reported since 1999, although several cases are currently in various stages of investigation. (3) The Centers for Disease Control and Prevention (CDC) indicated in a 2010 report that there were an additional 147 possible HIV exposures in health care workers. (3)

There remains a significant risk of infection in the healthcare workplace. In 1996, there were 786,885 percutaneous and mucocutaneous exposures to potentially infectious substances among health care workers (HCW) in the United States. (4) Retrospective studies and surveys have also shown high rates of blood contact among HCWs in different patient care settings. Most percutaneous exposures to blood are linked to surgery in general and most (73%) were related to suturing. Rates were highest (10%) during gynecologic surgeries. (5)

Prospective studies of HCWs have estimated that the average risk for HIV transmission after a percutaneous exposure to HIV-infected blood is approximately 0.3% (95% confidence interval = 0.2 to 0.5%) and that after a mucous membrane exposure it is 0.09% (95% confidence interval = 0.006 to 0.5%) (5, 6). Potentially infectious materials include blood, bloody body fluid, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid. Unfixed tissue samples may also pose a risk.

While it is clear that there are risks from incidents leading to occupational exposure to blood or other materials infected with HIV, it remains unclear what the risk is due to an accidental needle stick accident involving a contaminated acupuncture needle. To date there are no confirmed cases of occupational HIV transmission following an accidental needle stick involving an acupuncture needle in the United States. There was a case report from 2003 of a patient in Thailand indicating that acupuncture was the only known risk for the seroconversion of a previously HIV seronegative 60 year-old female.(7) Whether or not acupuncture was the cause of the observed HIV infection remains unclear; however, the potential for occupational exposure through an acupuncture needle must remain a concern.

The Centers for Disease Control and Prevention published revised guidelines for the management of
occupational exposures to HIV. (See http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm September 30, 2005)

These responses include talking to the source of the infected material if known, immediate evaluation of the incident, and emergency treatment with antiretroviral medication if warranted by that review. (8)

In the event of occupational exposure through a needle stick accident, the following steps should be taken:

1. The affected area should be washed with soap and water. Where an iodophor is available, the area should be disinfected. There is no evidence that expressing blood from the puncture site reduces the likelihood of seroconversion.

2. The individual involved in the needle stick accident should get to a hospital emergency room or occupational medicine center/walk-in clinic as soon as possible. Take any pertinent information such as the serostatus of the source of the contaminated sharp if known. After an investigation, the physician will determine if emergency treatment is warranted. Emergency treatment will consist of a course of antiretroviral medications. The CDC has published a rationale for antiretroviral post-exposure prophylaxis. (8) The victim should be treated with an antiretroviral cocktail, ideally within hours of exposure.

3. The affected individual should be tested for exposure to HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV).

4. Counseling should be made available from someone trained in counseling post-exposure victims.

5. Follow-up testing at three and six months should follow.

6. The patient who constituted the potential source of infection should be contacted and requested to get blood tests at the institution’s expense. It is important to note that the patient may not be compelled to undergo testing, and that results from such testing should not constitute a justification for not testing the victim of the needle stick accident.

It is imperative that the victim of the needle stick accident be provided support during such an incident. There is a great deal of anxiety that may result from such an accident. This sense of anxiety may impact not only the victim, but the victim’s family. Potential exposure to HIV and infection can be transmitted to a partner through sexual contact. Helping the victim of the possible exposure must include counseling about such issues.
HEPATITIS:

Disease Burden from Viral Hepatitis A, B, and C in the United States (8)

<table>
<thead>
<tr>
<th></th>
<th>Hepatitis A</th>
<th></th>
<th>Hepatitis B</th>
<th></th>
<th>Hepatitis C</th>
</tr>
</thead>
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<tr>
<td>No. of Acute Clinical Cases Reported a</td>
<td>1,670</td>
<td>1,987</td>
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<td>2,979</td>
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<td>Estimated No. of Acute Clinical Cases b</td>
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<td>13,000</td>
<td>15,000</td>
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<tr>
<td>Estimated No. of New Infectionsb (current)</td>
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<td>21,000</td>
<td>22,000</td>
<td>25,000</td>
<td>32,000</td>
</tr>
<tr>
<td>Percent Ever Infected c</td>
<td>29.1% - 33.5%</td>
<td>4.3% - 5.6%</td>
<td>1.3% - 1.9%</td>
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<tr>
<td>Number of Persons Living with Chronic Infection d</td>
<td>No chronic infection</td>
<td>800,000 - 1.4 million persons</td>
<td>2.7-3.9 million persons</td>
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<tr>
<td>Annual Number of Chronic Liver Disease Deaths associated with Viral Hepatitis e</td>
<td>No chronic infection</td>
<td>3,000</td>
<td>12,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Notes on sources and methodology:

a. **Number of Acute Clinical Cases Reported:**
For Hepatitis A, Hepatitis B, and Hepatitis C/non-A, non-B hepatitis, the number of cases reported to the National Notifiable Disease Surveillance System (NNDSS).

b. **Estimated Number of Acute Clinical Cases and New Infections:**
Incidence estimates for Hepatitis A and Hepatitis B are derived from catalytic modeling of seroprevalence data from the Third National Health and Nutrition Examination Survey (NHANES III) applied to cases reported to the Nationally Notifiable Disease Surveillance System (NNDSS). Incidence estimates for Hepatitis C are derived by adjusting rates from the Sentinel Counties Study of Viral Hepatitis (1982–2006) and Emerging Infection Program (2007) for underreporting and asymptomatic infection.

c. **Percent Ever Infected:**

da. **Number of Persons Living with Chronic Infection:**

e. **Annual Number of Chronic Liver Disease Deaths associated with Viral Hepatitis:**
Hepatitis B (HBV)

Hepatitis B is caused by the hepatitis B virus (HBV), a double-stranded DNA-containing virus. Between 1990 and 2005 the incidence of acute hepatitis B declined 79%. Among persons aged 6 years or older, 0.27% had chronic HBV infection (corresponding to approximately 704,000 persons nationwide). (9)

In adults, ongoing HBV transmission occurs primarily among unvaccinated persons with behavioral risks for HBV transmission (e.g., heterosexuals with multiple sex partners, injection-drug users [IDUs], and men who have sex with men [MSM]) and among household contacts and sex partners of persons with chronic HBV infection. (9)

An estimated 800,000–1.4 million persons in the United States have chronic HBV infection. (10) A total of 10,515 chronic hepatitis B cases were reported by eight sites in 2010.

- New York City reported the greatest number of cases (n=7,286; 69.3%) compared with other sites.

- San Francisco reported the highest rate of chronic HBV infection, with 110 cases per 100,000 population.

With respect to ethnicity, among cases for whom race/ethnicity was known, Asian/Pacific Islanders accounted for the highest proportion of chronic HBV cases reported from all sites. (11)


A comprehensive program to eliminate HBV in the United States began in 1991. This program has four parts:

1. Universal vaccination of infants at birth.

2. Prevention of perinatal HBV infection through routine screening of all pregnant women for HBV infection and providing immunoprophylaxis to infants born to infected women or women of unknown serostatus.

3. Routine vaccination of previously unvaccinated children and adolescents.

4. Vaccination of adults at increased risk of infection, including health care workers, dialysis patients, household contacts and sex partners of persons with chronic HBV infection, recipients of certain blood products, persons with a recent history of multiple sex partners or a sexually-transmitted disease, men who have had sex with men, and injection drug users. (12)

While HBV can be treated, the risk of chronic hepatitis is significant, and prevention remains the most important way to reduce the potential for a negative outcome. In the workplace, the risk of contracting hepatitis B is associated with contact with infected body fluids such as blood. The risk of a health care worker developing hepatitis following exposure to HBV is 22%–31%. The risk of developing serologic evidence of infection is 37%–62%. This risk is significantly higher than the approximately 0.3% cited for HIV above. (5)

In the event of exposure, hepatitis B immune globulin and hepatitis B vaccine have been shown to be effective responses. For the health care worker, multiple doses of hepatitis B immune globulin or hepatitis B vaccine alone is 70%–75% effective. Combining these two treatments increases efficacy. The HBV vaccine is safe and effective.
Hepatitis C (HCV)

HCV is a virus containing a single strand of RNA that is most effectively transmitted by percutaneous contact through injection drug use or exposure to infected blood or blood products. Today, most people become infected with the Hepatitis C virus by sharing needles or other equipment to inject drugs. Before 1992, when widespread screening of the blood supply began in the United States, Hepatitis C was also commonly spread through blood transfusions and organ transplants. (12)

While HCV may be transmitted through sexual contact, contracting a HCV infection through this route is considerably less efficient. The risk of transmission from sexual contact is believed to be very low. The risk increases for those who have multiple sex partners, have a sexually transmitted disease, engage in “rough sex”, or are infected with HIV. (12)

In 2010, there were an estimated 17,000 new Hepatitis C virus infections in the United States. However, the official number of reported Hepatitis C cases is much lower. Many people who are infected never have symptoms and therefore never come to the attention of medical or public health officials. (13)

Peak rates of HCV occurred in the 1980s, and have declined due to a reduction in infections resulting from injection drug use. While new infections are declining, approximately 3.9 million individuals in the United States are chronically infected with HCV as of 2010. (8)

The risk of seroconversion after percutaneous occupational exposure is approximately 1.8% if the source blood is seropositive for HCV. This is considerably higher than the risk of percutaneous occupational exposure due to HIV seropositive blood and lower than the risk of seroconversion after percutaneous occupational exposure to HBV seropositive fluids. (5)

While the risk of occupational exposure leading to HCV seroconversion may be limited to needles with a lumen, it is important to state at this point that as with HIV, exposure following a needle stick involving an acupuncture needle must be treated as a possible source of infection.

No protective antibody response is observed after infection. Anti-HCV immunoglobins are non-protective. There is no effective vaccine for HCV. Interferon/ribaviron therapy may be effective as a treatment but only in established infections, not as a preventative. As with HIV and HBV, it is critical to avoid infection by safe practice methods.
Tuberculosis

Tuberculosis (TB) is caused by the bacterium Mycobacterium tuberculosis. This organism is an acid-fast bacterium with a waxy coat, is transmitted through the air, and has a long incubation period of up to 12 weeks. (14, 15, 16)

A total of 11,182 TB cases (a rate of 3.6 cases per 100,000 persons) were reported in the United States in 2010. Both the number of TB cases reported and the case rate decreased; this represents a 3.1% and 3.8% decline, respectively, compared to 2009. The number of reported TB cases in 2010 was the lowest recorded since national reporting began in 1953. (17)

While TB infection rates are in decline in the United States, it remains a significant source of risk in the health care environment. Jensen et al (14) list the following populations who are especially at risk for TB:

- Foreign-born persons, including children, especially those who have arrived in the United States within 5 years after moving from geographic areas with a high incidence of TB disease (e.g., Africa, Asia, Eastern Europe, Latin America, and Russia) or who frequently travel to countries with a high prevalence of TB disease.

- Residents and employees of congregate settings that are high risk (e.g., correctional facilities, long-term-care facilities [LTCFs], and homeless shelters).

- Health care workers (HCWs) who serve patients who are at high risk.

- HCWs with unprotected exposure to a patient with TB disease before the identification of TB and institution of correct airborne precautions for this patient.

- Certain populations who are medically underserved and who have low income, as defined locally.

- Populations at high risk who are defined locally as having an increased incidence of TB disease.

- Infants, children, and adolescents exposed to adults in high-risk categories.

Persons who are infected are more likely to progress to active disease if they were infected within the previous two years, are HIV seropositive or in some other way immunocompromised, an infant or child less than four years of age, have one of several disorders such as silicosis or diabetes mellitus, or have a history of improperly treated TB.

The presence of HIV contributes to the TB infection rate, possibly by reducing immunity and therefore resistance to TB infection. Another factor that increases the potential for harm from TB is the presence of strains of TB that are resistant to multiple antitubercular antibiotics. Since 1993, when the TB surveillance system was expanded to include drug-susceptibility results, reported multidrug-resistant (MDR) TB cases have decreased in the United States. Among TB cases in the United States with initial drug-susceptibility testing results who did not have prior treatment, the percentage of primary MDR TB cases changed slightly from 1.1% (94 cases) in 2009 to 1.2% (88 cases) in 2010. (17)

While most strains of M. tuberculosis can be treated by antitubercular antibiotics, the treatment takes nine months to complete, and in the event the strain of M. tuberculosis involved is drug resistant, treatment may be difficult and take longer. As with the virally mediated diseases discussed previously, TB is most effectively managed by preventing infection. Preventing the transmission of TB is done by the following:
1. You should have an annual skin test for TB. This test should be repeated after two weeks if your previous test was not within one year. An alternative test, the QuantiFERON blood test is now approved for TB testing. This test has the advantage that only one contact is required, results are available more rapidly, and is not impacted by prior BCG (bacilli Calmette-Guerin) vaccination.

2. Individuals who were vaccinated for TB or have a history of a positive skin test should get a chest x-ray and an annual physical examination.

3. If a patient presents in your clinic with a chronic cough of unknown origin, the patient should be asked to wear a mask. It is a good policy to have masks available for any patient with a cough of unknown origin to prevent transmission of airborne pathogens, including TB.

4. If you suspect your patient may have TB, the patient must be referred to a physician for diagnosis and treatment.

Ultimately the most important component in a clinical safety program is safe practice on the part of the practitioner. The safe use of sharps, prevention of transmission of blood borne pathogens, and other appropriate risk management techniques prevent harm to the practitioner, her or his family members, and the public. An adverse event, such as a needle stick incident leading to infection, results in harm to one’s health, potentially financial harm due to loss of work, or a lawsuit if a coworker or patient is harmed, and administrative sanction by a licensing board. Safe practice remains the most important obligation for the acupuncturist. Clean needle technique is a vital part of safe practice for the acupuncturist.
Management of a Needle Stick Incident

In the event of an accidental needle stick in the AOM office, the procedure below should be followed. Note that due to the urgency to treat the victim of an accidental needle stick with antiretroviral medication within hours of the incident (should a physician recommend such therapy), this procedure must be followed as expediently as possible:

1. Wash the site of the needle stick with soap and water. There is no evidence that expressing blood from the puncture site has any positive effect, so this is not necessary.

2. Ask the source patient if he or she has a known history of HIV, HBV, and HCV. Note that the patient involved does not have an obligation to answer questions on serostatus.

3. The victim of the needlestick should be transported to an emergency room or occupational health center as soon as possible and in any case no more than a few hours after the needle stick.

4. The victim should be questioned and examined by a physician who will draw blood for baseline HIV, HBV, and HCV testing.

5. Should the physician recommend prophylactic anti-HIV antiretroviral therapy, this should commence as soon as possible on the day of the needle stick incident.

6. In the event the source patient does not know his or her serostatus with respect to HIV, HBV, or HCV, request that the patient undergo testing to determine serostatus. Note that the patient has no obligation to undergo testing, and may refuse testing.

7. The victim of the needle stick exposure should undergo counseling with a professional trained in post-exposure counseling.

8. Follow-up testing for HIV, HBV, and HCV should be done at 3 and 6 months post-exposure.

CNT

Clean Needle Technique (CNT) is the standard by which acupuncturists prevent occupational exposure to blood borne pathogens through an accidental needle stick incident. CNT consists of the following components:

1. Hand washing

2. Use of the clean field

3. Isolation of contaminated sharps

4. Standard precautions

5. Appropriate emergency procedures in the event of a needle stick incident or some other clinical accident in the course of an acupuncture treatment environment.

It should be stated at the outset that a more comprehensive risk management protocol is beyond the scope of this course. Any risk management course should be adapted to the unique requirements of the acupuncture treatment environment.
Clean needle technique must be distinguished from sterile technique. Sterile or aseptic technique, which is used in surgical procedures and many laboratory procedures, involves manipulations that are kept sterile by the appropriate use of gloves, sterile supplies, and the maintenance of a sterile field. While acupuncture involves the use of sterile acupuncture needles that must be maintained in a sterile condition during the acupuncture procedure, CNT is a clean rather than sterile procedure. The insertion site is clean, rather than sterile. Hands are in a clean condition rather than covered with sterile gloves. Gloves do not need to be worn except under specific conditions where exposure of the practitioner to blood or other potentially infected body fluids is possible. Gloves are worn:

1. When bleeding occurs, or is likely to occur (e.g.: during bleeding techniques and seven-star hammer treatments)
2. When needling in the genital region or in the mouth
3. While palpating near an area where there are lesions on the patient’s skin
4. In the event that there are skin lesions or open wounds on the acupuncturist’s hands

Hand washing is a critical component of the CNT protocol. Hand washing should be done between patients, before and after performing acupuncture or other clean clinical procedure such as seven-star hammer treatments. Ideally, hand washing is done with soap and running water, by thoroughly washing the hands and rinsing them in running water. The provider’s hands are then dried with disposable paper toweling that is then discarded. In the event that hand washing facilities are not available, an alcohol-based hand cleaning preparation may be used.

Another critical component of CNT is the isolation of used sharps. Sharps should be isolated in a sharps container specifically designed for this use. Appropriate containers are available commercially. Sharps containers are made of a material impervious to needles and fluids, such as plastic, and are designed to receive contaminated sharps without being able to retrieve them after the sharps are placed in the container. These containers are labeled as to contents and bear the biohazard symbol.

The basics of CNT are outlined below:

1. The provider washes her or his hands with soap and running water, drying them with paper toweling.
2. A clean field is set up near the treatment table. The clean field may consist of a piece of paper toweling or a clean field purchased for this purpose.
3. Needles are placed on the center of the clean field.
4. Non-sterile cotton balls and swabs are placed on the periphery of the clean field.
5. Sharps and trash containers are placed away from the clean field.
6. The practitioner’s hands are then rewashed or cleaned with the appropriate hand cleaning agent.
7. Once the hands of the practitioner are rewashed, the acupuncture points should be swabbed-with an alcohol swab using 70% isopropyl alcohol. Use a new swab whenever the alcohol swab becomes dirty or contaminated or is too dry to leave a thin layer of alcohol solution on the skin. The insertion point can then be palpated with the washed finger.
8. The needle should be inserted without touching its sterile shaft. Should the needle be long, such as a three or six inch needle, the shaft may be held with sterile gauze between the fingers and the needle shaft. Insert the needle only once. In the event that the needle location is changed, the
needle should be withdrawn and placed in the sharps container. A new needle must be used for each insertion.

9. The needle is then stimulated for therapeutic effect.

10. After the appropriate amount of time, the needle should be withdrawn and placed in a sharps container. Do not place the needle in a tray for later transfer to the sharps container as this increases the risk of an accidental needle stick. Do not hand the used needle to an assistant. This transfer also increases the risk of exposure by accidental needle stick.

11. At the end of the treatment, the practitioner washes her or his hands and cleans up the clean field, including replacing or disposing of unused supplies. In the event that the practitioner has used some, but not all, of the needles in a multi-pack of acupuncture needles, all unused needles must also be disposed of in the sharps container. Opened needle packs may not be used for a different patient or a treatment at a later time.

Standard precautions are outlined by the Centers for Disease Control. (18)
(For those used to the term “universal precautions”, STANDARD PRECAUTIONS combine the major features of Universal Precautions (UP) and Body Substance Isolation (BSI) and are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. 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. These include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. The CDC switched from the term “universal precautions” to “Standard precautions” in 2007.)

Standard precautions are widely used to prevent exposure to potentially infectious materials in the course of clinical work, including acupuncture. These precautions are summarized below:

1. Assume all patients are a potential source of infection.

2. Correct and frequent hand washing.

3. Appropriate use of personal protective equipment such as gloves, eye protection and masks.

4. Use of appropriate engineering controls, such as properly equipped hand washing stations.

5. Isolation of sharps in appropriate sharps containers.

6. Isolation of contaminated medical waste in a red bag or other appropriate container.

7. Correct use of disinfectants.

8. Appropriate caution when handling sharps, including acupuncture needles, seven-star hammers, and lancets.
References:


2. CDC HIV SurveillanceReport 2010:


7. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm


Student Name: ________________________________

Complete the questions below and return this worksheet to the CCAOM with your application form and payment. The assessment will be emailed to you upon receipt of these documents.

1. List the three premises on which risk reduction is based.

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

2. What are the six steps that should be taken in the event of occupational exposure to HIV through a needle stick accident?

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3. Summarize universal precautions as outlined by the Centers for Disease Control.

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_____________________________________________________________________

4. What are the five major components of clean needle technique (CNT)?

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_____________________________________________________________________
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