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November Cover Story

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Questions can be sent to: editor@hpnonline.com
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HPN CS Questions, 2477 Stickney Point Road, Suite 315B, Sarasota, FL 34231
Names and hospital identification will be withheld upon request.

Setting standards: handling scope accessories, SPD dress codes, culturing scopes

by Ray Taurasi

Q I am the nurse manager for Digestive Health and Gastroenterology. Our infection preventionist recently returned from a conference and claims there is now a regulation requiring that all valves, caps and other scope accessories must be kept with the endoscope throughout reprocessing and storage. I am not aware of any such regulation and since she could not provide any reference to support it I have a feeling she might have misinterpreted what the presenter said. I keep up on all the professional GI journals and have not seen anything related to this either. Can you shed some light on this matter?

A This past spring The Association for the Advancement of Medical Instrumentation (AAMI) published a new standard entitled Flexible and semi-rigid endoscope processing in health care facilities (ANSI/AAMI ST91:2015), which does state that all detachable valves should be kept together with the scope at all times. Doing so reinforces quality assurance and tracking efforts, especially in the event of a recall. To accommodate this need, various manufacturers now provide a variety of containment products for valves, caps and other removable accessories and can be easily attached to or kept with a specific scope throughout reprocessing and storage (see Figure 1).

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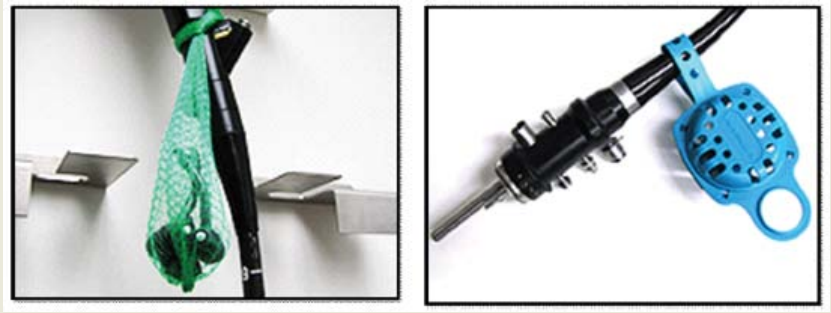

Figure 1

Q I am the infection preventionist for a large healthcare system and will be assisting our Sterile Processing Department managers in revising the personal protective equipment (PPE) dress code for the decontamination areas. Recently, a few of the facilities have started wearing wrap-around face shields with a bib that tucks in securely around the neck of their hooded jumpsuits. Now we are debating whether it is required to wear a face mask when wearing a face shield as described. I couldn't find any recommendation that specifically addresses this issue or specifically states that a mask should be worn with a face shield. What is the requirement?

A AAMI ST79, 4.5.1 states that personnel working in the decontamination area should wear general-purpose utility gloves and a liquid-resistant covering with sleeves (for example, a backless gown, jumpsuit, or surgical gown). If there is any risk of splash or splatter, PPE should include a fluid-resistant face mask and eye protection. PPE used to protect the eyes from splash could include goggles, full-length face shields, or other devices that prevent exposure to splash from all angles.

Also, the Occupational Safety and Health Administration (OSHA) blood-borne pathogen regulation (29 CFR 1910.1030) requires that each facility have in place an exposure control plan that outlines the potential hazards that personnel might encounter while on the job. Protective attire must be appropriate for the task being performed. It is up to each facility to do a risk assessment of each job task to determine what potential exposure hazard(s) might exist. The healthcare facility must then provide and require the use of the PPE that they determine is essential to provide full protection from any potential harm or exposure to contaminants. So a mask may or may not be necessary depending on the face shield's ability to provide full coverage and protection from splashes, and or aerosol contact with mouth and nose.

Q I am the clinical leader for quality assurance and education for our facility's Sterile Processing Department, which is now in charge of managing all endoscope reprocessing for the entire medical center. Endoscopy procedures are performed in approximately five different clinical areas and the scopes are processed in each of those locations by staff. It didn't take me long to discover that these procedures vary in each department, which I am working to change by implementing one standard protocol for all areas. I would like to develop a procedure that will encompass the culturing of scopes but have a few questions. What is the requirement / recommendation for scope culturing? Also, do all scopes need to be cultured or just a sampling, and how often should they be cultured?

A The consideration for scope culturing comes from the Centers for Disease Control (CDC), which applies primarily to the duodenoscopes that are used in endoscopic retrograde cholangiopancreatography (ERCP) procedures. However, the protocol may also be implemented for reprocessing other types of flexible endoscopes that have an elevator mechanism, such as the endoscopic ultrasound scope.

The CDC recommends that identified scopes be cultured at least once a month or every 60 procedures, which means each specific scope used within that time frame should be cultured at least once. Visit http://www.cdc.gov/hai/organisms/cre/cre-duodenoscope-surveillance-protocol.html for more detailed information on culturing and CDC

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recommendations.

Q I realize it would be best to quarantine my cultured endoscopes until the results of the culture are known but our current scope inventory just doesn't allow for this. Could you recommend any additional measures I could take to ensure all of our scopes are effectively cleaned?

A The first measure is to monitor and document staff competency, which includes strict adherence to all manufacturer's instructions for use (IFU). You should also visually inspect all scopes for cleanliness with a magnifier and borescope as necessary; monitor and verify the performance of all automated processing equipment (AER) at least weekly and preferably daily in accordance with AAMI and AORN recommendations; and conduct cleaning verification (soil specific detection tests) on all scopes. Monitoring and testing devices are available to detect specific residual soils that may have been missed during the cleaning process (e.g., protein, carbohydrate and hemoglobin). HPN

Ray Taurasi is Eastern Regional Director of Clinical Sales and Services for Healthmark Industries. His healthcare career spans over three decades as an Administrator, Educator, Technologist and Consultant. He is a member of AORN, AHA, SGNA, AAMI and a past president of IAHCSMM and has served on and contributed to many national committees with a myriad of professional organizations, manufacturers, corporations and prestigious healthcare networks. Taurasi has been a faculty member of numerous colleges teaching in the divisions of business administration and health sciences. In addition to this column he has authored several articles and has been a featured speaker on the international scene.