INSIDE

BECKER'S

Clinical Quality & Infection Control

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10 Top Patient Safety Issues in 2012

By Rachel Fields

Linda Homan, BSN, CIC, clinical and professional services for Ecolab, Jan Davidson, RN, MSN, the AORN perioperative education specialist focusing on ambulatory surgery centers, and Anne Dean of The ADA Group share 10 top patient safety issues that will impact healthcare facilities in 2012.

1. Hand hygiene. Hand hygiene tops the list of patient safety issues year after year, and 2012 is no exception. Ms. Davidson and Ms. Homan agree that despite a continued push for adequate hand hygiene, providers still fail to sanitize properly when they're in a hurry.

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11 Strategies to Address Physician and Staff Resistance to Complying With Infection Control Guidelines

By Rob Kurtz

Carol Hiatt, RN, LHRM, CASC, a licensed risk manager in Florida, AAAHC surveyor and consultant for Healthcare Consultants International, a subsidiary of AAAHC, shares 11 strategies to help surgery centers overcome physician and staff resistance to complying with infection control guidelines and policies.

1. Involve leadership before implementing changes. A critical mistake Ms. Hiatt has seen organizations make is trying to get everyone in a facility to comply with standards and new policies

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10 Leaders in the Area of Clinical Quality

By Abby Callard

Clinical quality in healthcare encompasses a vast spectrum of issues including patient safety, infection control, patient-centered care, management and cost. The following 10 clinical quality leaders have been chosen through research and consultation with healthcare professionals. Individuals were chosen based on leadership positions in quality-related organizations, research, success in raising awareness of key issues, implementation of initiatives and awards. *Note*: Names are listed in alphabetical order.

Donald M. Berwick, MD, MPP. Dr. Berwick is the former administrator of CMS. He has helped initiate patient safety initiatives such as Partnership for Patients and patient safety incentives in health reform legislation. He is also adjunct staff in the department of medicine at Children's Hospital Boston and a consultant in pediatrics at Massachusetts General Hospital. Dr. Berwick has also served as president and CEO of Institute for Healthcare Improvement, chair of the National Advisory Council for the Agency for Healthcare Research and Quality and a member of Institute of Medicine's governing council.

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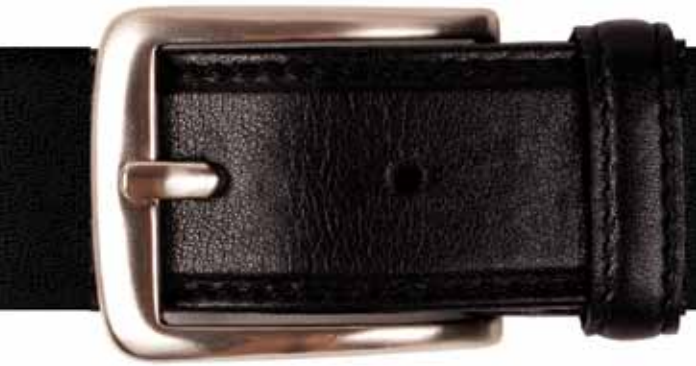

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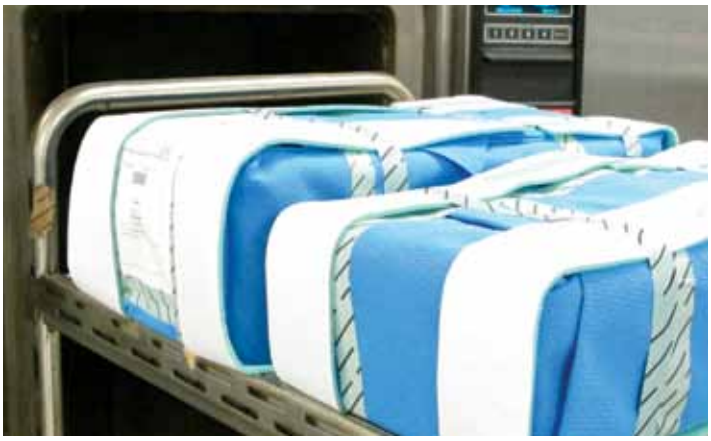

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Answering Questions Regarding the FDA Announcement on the STERIS System 1® Transition Deadline

By Barbara Trattler, RN, MPA, CNOR, CNA

On December 22, 2011 the U.S. Food and Drug Administration (FDA) announced that STERIS can continue to provide support on the STERIS System 1® (SS1) through August 2, 2012.

However, this only applies to customers who have completed the following:

- **Placed an order for a legally-marketed alternative technology to replace all SS1s**
- **Completed a "Certificate of Transition"**
- **Returned the completed certificate to STERIS corporation**

This is important for healthcare facilities that rely on the SS1 to process critical devices and must purchase a replacement option. At Advanced Sterilization Products (ASP), we have received many questions from customers regarding the December 22 FDA announcement on the SS1 transition deadline.

Q. Do I have another six months to purchase an alternative to my SS1?

A. No. The deadline to purchase a legally-marketed alternative remains February 2, 2012. However, healthcare facilities that have open orders to replace their SS1(s) and have completed the STERIS "Certificate of Transition" by February 2, 2012, may continue receiving support for their SS1(s) through August 2, 2012.

Q. What do I need to do by the February 2, 2012 deadline?

A. If you have not already, place your order for an alternative technology and fill out the "Certificate of Transition." If you have ordered a replacement system that will not be installed prior to February 2, 2012, you should also complete the"Certificate of Transition" so that there is no disruption to device processing at your facility.

Q. What alternatives to the SS1 does ASP offer?

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A. We have ample supply to help you transition in advance of the August 2, 2012 deadline. The date you receive your system will depend on the readiness of your facility and when you ordered your system. Your ASP representative will contact you with an installation date for your system. For more information, please contact your local ASP representative, visit www.aspjj.com/alternatives or call 888.783.7723.

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For more answers to your pressing questions, please visit www.aspjj.com for the ongoing ASP Video Webisode series that will address issues that your facility faces every day. You may also Like Us on Facebook.com/aspjj or Follow Us on Twitter.com/aspjj.com

* Does not eliminate bedside precleaning. Manual cleaning of medical devices (endoscopes) is not required prior to placement in the EVOTECH® ECR when selecting those cycles that contain a wash stage.
† AORN Perioperative Standards and Recommended Practices for Inpatient and Ambulatory Settings 2011 - Recommendation XVI: Quality XVi.h, p. 477-485

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Ms. Homan says ASC administrators can improve hand hygiene among their staff by tracking compliance with technology. "Staff should be practicing hand hygiene when they're moving from clean to dirty areas," she says. "We now have technology that lets you track compliance as people enter and exit a room, and you can track that information to the individual level, by geographic location and by physician versus other healthcare providers."

Outside of new technology, the old standards work too: Providers should be washing their hands for as long as it takes to sing the "happy birthday" song twice, as well as washing all the way up to the elbow with alcohol-based disinfectant (or soap and water with an alcohol-based disinfectant if hands have been grossly contaminated). Ms. Davidson recommends using a "secret shopper," or one unidentified person in the surgery center who monitors hand hygiene compliance. "If you have raw data on hand-washing that staff can see, that's a little more meaningful than just saying, 'You never wash your hands,'" she says.

2. Safe surgery checklists. CMS is expecting surgery centers to use a safe surgical checklist for the entirety of 2012, with compliance beginning on Jan. 1. Ms. Dean says because of this mandate, safe surgery checklists should be top on every ASC administrator's safety priority list. She says the use of safe surgical checklists sometimes meets with resistance from nurses, physicians and other providers, who believe that the information on the safe surgical checklist is already documented elsewhere in the patient's chart.

Ms. Dean encourages administrators to remind providers that the safe surgical checklist is a requirement — and that having all the information on one page can improve patient care. "When they're doing a chart audit, it will be easier to use the safe surgical checklist than to thumb through different pieces of paper," she says. Surgery centers can download sample safe surgery checklists at the World Health Organization website, AORN website or at SafeSurg.org.

3. Patient selection criteria. Ms. Dean says Medicare has emphasized the importance of patient selection criteria in surgery centers in 2012. Because surgery centers are not appropriate for all types of patients — including those with morbid obesity, cardiac problems and other co-morbidities — surgery centers must employ a strict patient selection criteria to prevent hospital transfers.

Ms. Dean says in the benchmarking study she conducted with her 36 ASC clients, she found that hospital transfers were frequently tied to problems that should have been identified by an ASC scheduler or consulting physician. She says she has increasingly seen surgery centers admit patients of ASA classes III and IV, compared to the recommended classes of I and II. She says ASCs should develop a strict patient selection criteria with physicians and anesthesiologists and then share that "checklist" with schedulers, OR supervisors and pre-op coordinators to make sure the ASC suffers no unnecessary hospital transfers.

4. Surface disinfection. Ms. Davidson says providers may skimp on surface disinfection because "if it's not visibly dirty to us, we forget to wipe it down." She says providers may be in a hurry and forget required steps such as wiping the blood pressure cuff down between patients. These are issues that centers are cited for in accreditation and OSHA surveys, so it's critical to remind surgery center staff of the standard.

Ms. Homan says technology can assist surgery centers in promoting environmental hygiene: Monitoring products such as fluorescent markers can identify whether an OR suite has been cleaned properly after surgery. She says surgery center administrators should also invest in tools that are proven to clean surfaces more effectively, such as microfiber, which is better at picking up organic material on surfaces but takes no more time to use.

5. Wrong-site procedures. Ms. Dean says while the incidence of wrong-site procedures has decreased between 2010 and 2011, the process for preventing wrong-site surgery still needs to improve. She says the process should start at scheduling. "When the physician scheduler calls our ASC scheduler, they should communicate about the site of the procedure," she says. Then, when the patient's history arrives at the surgery center prior to the day of surgery, the staff member putting the chart together checks the history against the information from scheduling.

Ms. Dean says the patient should never be in the operating room when the surgeon discovers the information on the consent form doesn't match the information on the H&P. "That's not the time to be having that conversation," she says. "That conversation needs to be stopped at the front desk and should definitely go no further than pre-op." She says the pre-op coordinator should be involved in talking to the OR supervisor and the scheduling coordinator to determine the correct site of surgery before the patient enters the OR.

6. Dependence on safety tools. Ms. Davidson says a major issue for 2012 is the "lack of critical thinking skills" among OR providers. "By that, I mean we have checklists before the patient goes into surgery — to make sure they've removed their dentures, used the bathroom and emptied their bladders — and I think sometimes we become so dependent on these tools that we forget to think for ourselves," she says.

With the introduction of mandated safe surgical checklists, Ms. Davidson says providers should be even more aware of the need to evaluate patients based on experience and instinct. "If an elderly patient is having surgery that will require intubation, do we think ahead about positioning devices that may be needed for anesthesia to safely place the endotracheal tube without compromising the patient's cervical spine?" she says. She says these critical thinking skills depend on ongoing staff education. At the beginning of every shift, a good practice would be for the surgery center staff to go over any "near misses" that happened the day before, such as a medication error that was caught before it reached the patient.

7. Burns. Ms. Dean says she has seen a recent increase in the number of burns in her client surgery centers, with one center reporting three burns in the last two years. She says all the burns were electrosurgical-related, and the problem should be a "quick fix" for most surgery centers. She says surgery centers should re-train physicians not to set hot holsters on the patient's drapes.

Physicians and other providers should also understand that inadequate contact between the grounding pad and the skin can cause fires. The grounding pad should be placed so that the entire surface of the pad is in uniform contact with the pad site, and providers should avoid any tenting or gaps where parts of the pad are not in contact with the pad site. The pad site should also be free from lotions, oils or other fluids. "Our center's physicians had a lot of in-service education and competency evaluation, and we also did a study to evaluate the degree to which the patient got wet with irrigating solutions during the surgery," she says.

8. Distractions in the operating room. Distractions in the OR can result in numerous issues that jeopardize patient safety, such as wrong-site procedures or misuse of medication. Ms. Dean says she frequently sees providers using their cell phones, watching movies or simply failing to pay attention during crucial moments like time-outs. In one busy multi-specialty surgery center, she noticed that when the circulator announced the time-out, the rest of the staff — the surgeon, the scrub tech, the radiology tech and the equipment tech — kept performing their individual tasks without stopping for the time-out.

She encouraged the circulator to raise her voice and really insist on the time-out because of the event's importance in promoting patient safety. "As the circulator, you are the patient's advocate, and you are also protecting the surgeon by ensuring that you're performing surgery on the correct site and that nobody is going to end up hurt," she says.

9. Housekeeping. ASC administrators should look over their current housekeeping services in 2012 to make sure housekeeping staff are compliant with ASC standards, according to Ms. Dean. She says some housekeeping staff members may not be aware that they have to do things like clean the wheels on the OR equipment by rolling them through a germicidal solution. They may have even been told not to touch the equipment, which Ms. Dean calls a "huge, huge problem." She says administrators should also completely eliminate the practice of home laundering from their facilities. "Some surgery centers still have staff wearing scrubs home and laundering them at home," she says.

She says OSHA standards dictate that housekeepers must be proficient in English so that they can understand the instructions on solutions and equipment. "According to OSHA, housekeeping staff have to be able to read and speak English so they can read the labels and protect themselves," she says. She says she also sees housekeeping staff failing to change water in their buckets when they move from room to room — a big problem, since failing to change water can spread bacteria.

10. Properly trained staff. Ms. Dean says Medicare has expressed concern over the prevalence of improperly trained OR staff in the surgery center industry. She said she did not believe the problem was that serious until she began to see unqualified staff in the surgery centers she worked with. "In a surgery center I no longer work with, they hired as an OR supervisor a girl who is a nurse practitioner but who is not OR-trained," she says. "She's been in some ORs, but she doesn't have the experience to be an operating room supervisor." She says in this case, she would expect 3-5 years of OR experience for an OR supervisor.

She said she has also seen surgery centers hire housekeeping staff with no healthcare experience in order to save money. "They might have cleaned offices, but they've never cleaned operating rooms before, and nobody is training them," she says. She says if an ASC is planning to hire housekeeping staff with no healthcare experience, the staff needs to undergo extensive training before they can clean the ASC. She says ASC leaders should also conduct audits by coming to the surgery center after-hours and observing whether the cleaning staff follows protocols. ■

11 Strategies to Address Physician and Staff Resistance to Complying With Infection Control Guidelines
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before "selling it at the top." "By that, I mean they don't involve leadership before they start the implementation, so they don't lay the groundwork for success," she says. "It's important that they get in front of the physicians and governing body and explain the goal of needing to maintain accreditation and Medicare certification."

It is helpful to explain the need for maintaining accreditation and Medicare certification in a way that will catch the attention of leadership — by tying it to financial stability of the facility.

"By tying it to the bottom line, sometimes all of a sudden, things seem a little more important," Ms. Hiatt says. "This can be done by sharing some examples of surgery centers they have heard about that have suffered from difficult consequences as a result of not being compliant. There are a number of centers that have been closed because of a condition-level deficiency and lost revenue for a period of time. Some of these centers have been closed for months. So the last thing [leadership will want] is to find itself in that position as well."

2. Educate leadership on quality reporting requirements. In the fourth quarter of 2012, Medicare-certified ASCs will be required to begin reporting quality data to CMS. Five of the eight outcomes CMS will require for reporting (phased in through 2015) are either directly or indirectly related to infection control, Ms. Hiatt says.

Surgery centers that fail to report data to the Medicare program in 2012 will receive a 2 percent reduction in Medicare payments in 2014, and failure to report in subsequent years will affect future years' payments in the same way. While the program does not currently stipulate basing payments on performance on these quality measures, a pay-for-performance system that penalizes ASCs as low performers is "coming sooner than we think," Ms. Hiatt says.

"Hospitals already don't get paid when an infection develops that's unrelated to the patient's admitting hospital diagnosis. If a patient comes in for an appendectomy and develops a secondary infection that's unrelated to the primary diagnosis, the hospital doesn't get paid for that," she says. "This will happen to ASCs in the future. When we start having to return patients to the OR for an irrigation and debridement because an abscess developed, if we're billing it now, we won't get paid for treating the infection once this all kicks in. Educating physicians and leadership about this change is going to make it a little bit easier to get buy-in from the top."

3. Appoint an infection preventionist "champion." To meet infection prevention and control standards, organizations need to appoint an infection preventionist and the governing board needs to approve the appointment. But all too often, Ms. Hiatt sees organizations relegating this role to the willing, and oftentimes it's a part-time person who doesn't work in the operating room environment.

"That person is probably not going to be respected by the doctors and the staff," she says. "I believe it's important that when you select your infection preventionist, that you select a 'champion.' They don't have to be the most knowledgeable person in the organization at the point they are selected as long as they're a member of the staff who is respected by all staff members and doctors. You can train them — that's part of this process — they're supposed to be properly trained. If you pick the right person, then staff and doctors are going to respond better when this person starts reinforcing some of the points in infection control that are important."

Ms. Hiatt says she has visited Medicare-certified organizations that have not updated their infection control program policies and procedures since the 1990s because these organizations lack such a champion.

"Someone has to own the process, show leadership how important it is and get them to buy into it," she says. "When we miss that piece, it's destined to fail."

4. Identify and overcome obstacles to buy-in. Once selected, this infection preventionist champion needs to identify key leaders in the organization and ask them what is necessary to get their support for the organization's infection prevention and control program, Ms. Hiatt says. These are leaders such as the chief of surgery, director of anesthesia, pre-/post-op leader or surgical tech leader.

"The infection preventionist needs to ask them what they need in order to comply with the standards that affect their area, and once they answer, [the infection preventionist] needs to take time to research and learn what can be done to eliminate the obstacles that stand in their way," she says. "Once you ask them and take some steps to remove the obstacles they have identified, it's a lot easier to hold them accountable in the future."

Sometimes those obstacles may require simple fixes. For example, anesthesia providers may need to take on and off gloves multiple times during the course of initiating and administering general anesthesia, and the World Health Organization says anesthesiologists are supposed to follow certain hand hygiene practices when removing and putting on gloves in the OR.

"I'll go into an OR and guess what: There's no alcohol-based rub or hand hygiene product close to where [the anesthesiologist] is," Ms. Hiatt says. So it's impossible for him/her to be in compliance without stepping away from the patient, and they can't do that because that's not safe.

"Or you tell him/her that they have to label their syringes and yet we haven't provided labels that make this easy," she says. "These are some basic obstacles that sometimes get overlooked."

5. Expect resistance, then educate. Change is never easy, whether the change is positive or negative. Remember, if you're asking physicians or staff members to change the way they've done something for many years, you may face resistance because they're comfortable with their outcomes and don't want to change their practices. To bring about change that will become the new norm will likely require education.

"You have to introduce them to what the current standards are, and you have to remind them that if they had a bad outcome and these were not the standards they had used at the time of surgery, it wouldn't be defensible," Ms. Hiatt says. "People don't always understand the why, and if they don't understand the why, it's hard to get them to cooperate. Make sure they have the knowledge they need to do these processes in a manner that meets these standards."

6. Train and document the training to emphasize importance. One of the requirements of a compliant infection control program is the education of employees on infection prevention and control when they are hired and then annually thereafter. This training needs to be documented to meet requirements, but documentation performed in such a way can also help hit home the importance of the training.

"After you present on something, you should have the staff members sign for their accountability [on the presented information] or have them take a quiz at the end of that training so they realize it isn't just a talking point," Ms. Hiatt says. "Now you're having the staff understand they are accountable to what was just presented, so they may take it more seriously.

"However you do it, you have to train the staff, invest that time and help them realize it's important enough that you're investing the time to train them," she says. "If a staff member tells you they haven't been trained in infection prevention and control, you can't expect them to be in compliance with the program."

7. Catch and highlight staff members doing things right. While it is certainly important to catch non-compliant actions (see strategy #8), it can also be beneficial to catch compliance. "You should try to catch [staff members] doing things right, like complying with good hand hygiene practices," Ms. Hiatt says. "Then brag about them. Praise them for it in front of their peers and leadership. This will help make them a champion in the organization."

8. Encourage accountability in an appropriate manner. "Ask the staff to allow their peers to hold them accountable," Ms. Hiatt suggests. "If they see someone doing something that's not in compliance with the WHO good hand hygiene practices or safe injection practices, ask them to hold each other accountable at the right time, presented the right way, and it will really help an organization."

For instance, the OR circulator and the anesthesia provider can work together by monitoring hand hygiene practices, medication practices and syringe usage as a team — things that would certainly be identified during a survey, says Ms. Hiatt. "Too often, we fail to give permission to our coworkers to help us improve our infection prevention awareness by reminding us of breaches in our practice," she says. "When one member of this team fails to meet the standard, the whole team fails — and we fail the patient. When we welcome constructive observations, in regards to any infection prevention practice, I believe we demonstrate to all those around us that we are committed to best practices and best outcomes for the patient and the surgery center."

9. Create friendly competition to improve compliance. One effective way Ms. Hiatt has seen organizations improve their compliance efforts is through friendly competition between departments within an organization. For example, if a facility wants to improve hand hygiene, it could use a monitoring tool to track hand hygiene compliance by different groups within the organization, such as surgeons, anesthesia staff, RNs and scrub techs. After a period of time, the compliance rates by group can be published for everyone in the facility to see.

"This creates a little friendly competition between departments," she says. "I saw one surgery center take its hand hygiene compliance from 67 percent to over 95 percent by doing this as a contest. It was very successful and a great tool to get everyone to comply."

10. Provide the tools necessary to meet objectives. Sometimes organizations fail to ensure their staff members have the tools necessary to accomplish the mission of the infection prevention and control program while still meeting the expectations of the surgeons. This can be as simple as providing surgical techs with an additional instrument tray.

"Physicians are looking for faster turnover time — they don't want to stand around waiting between cases," Ms. Hiatt says. "They want their instruments and the patient ready to go for the next case. But if the equipment [staff members] have is not capable of what the doctors are expecting them to do, the staff feels pressures to cut corners. That's when they may fail to do something important because they feel such great pressure to not upset the surgeons.

"Sometimes it's as simple as [surgical techs] needing another instrument tray to keep up with the pace a surgeon is asking for," she says. "It's important that the ASC's leaders — the director of nursing or administrator or both — understand what it is those surgical techs that are back there in the trenches need to accomplish the goals of the organization."

11. Remind physicians and staff what infection prevention and control is about: people. "Sometimes in healthcare, we forget this is about people; we forget this is about people that come to us at our ASCs because they're sick or they have a problem, and they need our help," Ms. Hiatt says. "We forget infection control is about not adding a problem by being neglectful of something that we could have done better.

"The most recent studies show 70 percent of the infections that patients get could have been prevented by better infection prevention and control practices by healthcare workers," she says. "We don't want to be responsible for 70 percent. We want to be responsible for 0 percent. The way we do that is by improving these infection and control practices. It's not about rules. It's about saving lives and decreasing morbidity. It's about doing the best we can to give patients the best care we can." ■

Learn more about Healthcare Consultants International at www.hciconsultants.com.

10 Leaders in the Area of Clinical Quality
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Dr. Berwick was previously a clinical professor of pediatrics and healthcare policy at Harvard Medical School and a professor of health policy and management at Harvard School of Public Health. Dr. Berwick has studied using scientific methods, evidence-based medicine and comparative effectiveness research to improve tradeoff between quality, safety and costs in healthcare. In 1997 and 1998 he was appointed by President Clinton to serve on the Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. Dr. Berwick won the 1999 Ernest A. Codman Award, the 2006 John M. Eisenberg Patient Safety Award and the 2007 William B. Graham Prize for Health Services Research.

Maureen Bisognano, RN. Ms. Bisognano is the president and CEO of the Institute for Healthcare Improvement. She took over the position from Donald Berwick, MD, after serving as the organization's executive vice president and COO for 15 years. She has been elected membership to the Institute of Medicine and appointed to the Commonwealth Fund's Commission on a High Performance Health System. Ms. Bisognano advises healthcare leaders around the world and is a frequent speaker at major healthcare conferences on quality improvement. She is also an instructor of medicine at Harvard Medical School, a research associate in the Brigham and Women's Hospital Division of Social Medicine and Health Inequalities and serves on the boards of the Commonwealth Fund, ThedaCare Center for Healthcare Value and Mayo Clinic Health System–Eau Claire.

Prior to joining IHI, she served as CEO of the Massachusetts Respiratory Hospital and senior vice president of The Juran Institute, an international consulting company focused on quality improvement, lean management and Six Sigma certification. The *Wall Street Journal* said Ms. Bisognano is "known in the industry as an expert on the nuts and bolts of improving healthcare systems while lowering costs."

Joseph L. Cappiello. Mr. Cappiello is the COO of the Healthcare Facilities Accreditation Program. He previously served as vice president of accreditation operations at The Joint Commission and led his own consultancy to help healthcare facilities improve and maintain compliance with accreditation standards. At The Joint Commission, he oversaw the surveyor cadre of more than 500 people and the sentinel event unit that focuses on preventing "never events" such as patient suicide and fatal medication errors. He also directed the office of quality management that served as a "care complaint department" for the organization and would investigate reports. In his consultancy, Mr. Cappiello worked with facilities to develop a process to ensure they were knowledgeable and compliant with all accreditation requirements. Although he has only worked at HFAP for a few months, Mr. Cappiello has significant plans for the agency that include increasing public awareness, focusing on care coordination and including patient-centered care principles in the accreditation process.

Mr. Cappiello started his career in healthcare as a Navy nurse, and it was there that he acquired an interest in clinical quality. "I realized that you can be the best nurse or the best physician or the best respiratory therapist, but you end up dealing with only one patient at a time," he says. "I thought if I could get to a position to make my influence felt on a grander scale, that I had the chance — along with those that are likeminded with me — to change healthcare for the better on a national scale. We do have a chance to make things better if we understand what the challenges are, and we find reasonable and workable solutions."

Mark R. Chassin, MD, FACP, MPP, MPH. Dr. Chassin is the president of The Joint Commission and of the Joint Commission Center for Transforming Healthcare, which he established in 2009 to address quality and safety issues in healthcare. The Center for Transforming Healthcare is currently working on developing solutions through the application of the Robust Process Improvement methods and tools that other industries use. He previously served as the Edmond A. Guggenheim Professor of Health Policy and founding chairman of the department of health policy at Mount Sinai School of Medicine and executive vice president for excellence in patient care at Mount Sinai Medical Center in New York City. While at Mount Sinai he formed a quality improvement program that focused on safety, clinical outcomes, patient and family experiences and the caregiver working environment. He also conducted research on healthcare quality measures and health policy. Dr. Chassin has also served as the commissioner of the New York State Department of Health and practiced emergency medicine for 12 years. He was part of the Institute of Medicine committee that published "To Err is Human" and "Crossing the Quality Chasm." He has received the Founders' Award of the American College of Medical Quality and the Ellwood Individual Award of the Foundation for Accountability.

Jack Egnatinsky, MD. Dr. Egnatinsky has served as a surveyor for the Accreditation Association for Ambulatory Health Care since 1996 and currently serves as president of the AAAHC board of directors. Dr. Egnatinsky has been an instructor for the AAAHC Surveyor Training Program and he has served on the accreditation committee and chaired the surveyor training and education committee. He is also a member of the board of directors for AAAHC's Institute for Quality Improvement.

He is a board-certified anesthesiologist and received his medical degree from the State University of New York, Upstate Medical. He completed his anesthesia residency at the U.S. Naval Hospital, Philadelphia, and Children's Hospital of Philadelphia. He served in the U.S. Navy Medical Corps from 1963-1971, achieving the rank of lieutenant commander. "Healthcare is not static," he says. "In order to move in the right direction, we need to measure what we are doing and see how we can improve it to achieve the best outcome possible. Quality improvement studies and projects, benchmarking, continuing education and continual attention to internal policies and procedures must be part of your everyday activities."

Linda Groah, RN, MSN, CNOR, NEA-BC, FAAN. Ms. Groah is the CEO and executive director of the Association of periOperative Registered Nurses. Ms. Groah has focused on improving patient safety throughout her career. While a volunteer member of AORN, Ms. Groah served as AORN's representative to the professional and technical advisory committee of The Joint Commission where she was on the task force that developed the procedure for side and site verification, the task force that developed the Universal Protocol and the CMS steering committee for the Surgical Care Improvement Project that focused on reducing surgical site infections by 25 percent. As the director of hospital operations at Kaiser Foundation Hospital San Francisco Medical Center, she introduced and piloted several patient safety initiatives including the "Just Culture" concept, an environment where actions are analyzed to ensure that individual accountability is established and appropriate actions are taken.

Ms. Groah was awarded AORN's Award for Excellence in Perioperative Nursing in 1989 and inducted in 2000 as a fellow of the American Academy of Nursing. She currently serves on the board of directors of the Nursing Alliance for Quality Care, is a member of the editorial board of *Nursing Spectrum* and a member of the board of directors for the Anesthesia Foundation for Patient Safety. "As a young professional I was very concerned about the gaps in care that I observed," Ms. Groah says. "The gaps included short cuts, lack of adherence to policies or procedures and practitioners lacking current competencies. I knew that I wanted to impact these behaviors and that required being in a leadership position."

Gary S. Kaplan, MD, FACP, FACMPE, FACPE. Dr. Kaplan has been the chairman and CEO of Seattle-based Virginia Mason Health System since 2000. He implemented the Virginia Mason Production System to reduce costs and improve quality, safety and efficiency. Virginia Mason was named a distinguished hospital for clinical excellence by HealthGrades in 2011, a top hospital by The Leapfrog Group for five consecutive years and was one of two hospitals named a Leapfrog Top Hospital of the Decade for patient safety and quality.

Dr. Kaplan is also a clinical professor at the University of Washington, secretary-treasurer of the Institute for Healthcare Improvement and chair of the National Patient Safety Foundation's board of directors. Dr. Kaplan is a founding member of Health CEOs for Health Reform. In 2009, Dr. Kaplan won the John M. Eisenberg Award for patient safety and received a Harry J. Harwick Lifetime Achievement Award from the Medical Group Management Association.

Denise Murphy, RN, MPH, CIC. Ms. Murphy is vice president for quality and patient safety at Main Line Health System in Philadelphia. She handles patient safety, risk management, clinical performance improvement, infection prevention and control, medical staff peer review and credentialing, regulatory compliance, bioethics and performance measurement. She entered the field of infection prevention and control in 1981 and has served as an epidemiologist in hospitals ranging from 100-1,200 beds in rural and urban settings. Ms. Murphy is an active member of the Association for Professionals in Infection Control and Epidemiology, the Society for Healthcare Epidemiology of America, the American Society for Healthcare Risk Managers as well as a past president of the APIC board of directors. She was the 2010 winner of the Carol DeMille Achievement Award. She has served as a long-time member of the CDC's hospital infection control practice advisory committee, The National Quality Forum's patient safety advisory committee and SHEA's patient safety committee. She recently co-authored the patient safety chapter for ASHRM's Risk Management Handbook for Healthcare Organizations (Sixth Edition).

Ms. Murphy previously served as the vice president and chief safety and quality officer at Barnes-Jewish Hospital at Washington University Medical Center in St. Louis. She spent seven years as director of healthcare epidemiology and patient safety for BJC Healthcare, a 13-hospital system and parent company of Barnes-Jewish Hospital. Ms. Murphy went to nursing school in Philadelphia, received her BSN in Portland, Maine, and received a master of public health degree from St. Louis University, School of Public Health.

Peter J. Pronovost, MD, PhD, FCCM. Dr. Pronovost is a professor at the Johns Hopkins University School of Medicine, the Bloomberg School of Public Health and the Johns Hopkins University School of Nursing. He created and currently directs the quality and safety research group at Johns Hopkins University School of Medicine and directs the Center for Innovation in Quality Patient Care at Johns Hopkins Medicine. He chairs the ICU advisory panel for quality measures of The Joint Commission and the ICU physician staffing committee for The Leapfrog Group. He also serves on the quality measures work group of the National Quality Forum and leads patient safety monitoring and evaluation efforts at the World Health Organization.

He wrote "Safe Patients, Smart Hospitals: How One Doctor's Checklist Can Help Us Change Health Care from the Inside Out" as well as more than 200 articles and chapters on patient safety. He won the 2004 John M. Eisenberg Patient Safety Research Award and was named a MacArthur Fellow in 2008. One of Dr. Pronovost's greatest contributions to patient safety is his checklist of basic safety practices, such as handwashing, that has been shown to greatly reduce catheter-related bloodstream infections. It is estimated that his program, first tested in Michigan, saves 2,000 lives and $200 million annually. Forty-four states have implemented Dr. Pronovost's checklist.

Lisa Schilling, RN, MPH. Ms. Schilling is the national vice president of Health Care Performance Improvement and director of the Kaiser Permanente Improvement Institute. She is currently heading the deployment of an enterprise-wide performance improvement and execution system and leads strategic partnerships with external organizations. "Kaiser Permanente has focused on developing capacity to improve and using data as information to understand where variation in care and clinical practice is happening across care delivery," she says. "We plan to continue to focus in this area and identify the most significant opportunities to reduce variation in care to improve overall patient clinical outcomes, safety and care experience."

Ms. Schilling previously served as the director of clinical performance at VHA, where she led clinical care initiatives with more than 100 organizations focused on improving clinical outcomes and patient safety. She also served as director of health improvement at Fletcher Allen Health Care, and led the surgical critical care service line at Fletcher Allen's Level 1 Trauma Center. Ms. Schilling serves on the editorial board of the *Joint Commission Journal for Quality and Patient Safety*. ■

Contact Abby Callard at abby@beckershealthcare.com.

12 Questions to Ask to Ensure an Effective Hand Hygiene Program

By Rob Kurtz

Bernard McDonnell, DO, a retired physician and current surveyor for Healthcare Facilities Accreditation Program, identifies 12 critical questions ambulatory surgery centers and other providers need to ask themselves to help ensure an effective hand hygiene program in their institution.

1. Are you washing your hands? "Cut things to the core — that's the first thing to look at," Dr. McDonnell says. "Does your staff know about the importance and need for handwashing?"

2. Does your program include hand hygiene policies? "What's in place at your ASC?" he says. "You need to have some guidelines, some policies. You just can't go out and say 'wash your hands.' You have to look at what you're doing. Are you doing hand antisepsis? Are you allowing artificial nails in the OR — I hope you're not. [Do your staff members] have their nails clipped no more than ¼ of an inch? Are you changing gloves and using alcohol-based sanitizers? Have you addressed surgical scrubs?

"Now, do you have all of that in your policies?" Dr. McDonnell says. "These are basic things you should do but sometimes for the basic things you have to state the obvious and you should address these in your [policies]."

Think about the signs you see in restaurants reminding employees about the requirement to wash their hands before exiting a restroom, he says. You not only might want to use similar signs (see question #9) but you may also want to consider having a policy stating that after staff members use the bathroom in your facility, they have to wash their hands.

3. Do you have a surveillance program in your ASC? Just as important as having hand hygiene policies is a program is to ensure staff members, including physicians, are following your rules. "Are you watching to see if people are doing it?" Dr. McDonnell says. "Are they doing it more than 80 percent of the time? 90 percent? Close to 100? Someone needs to be monitoring that."

4. Are your people empowered to identify deficiencies? There needs to be a policy in your facility stating anyone can and should share their observations when someone fails to follow your hand hygiene program. "I always say the cleaning person can say to the surgeon, 'You need to wash your hands,'" Dr. McDonnell says. "There has to be that kind of a culture where people are empowered to say that."

5. Have you considered a quality program for hand hygiene? Hand hygiene compliance makes a terrific quality program, he says. "It can be all-encompassing of the institution — every part of the institution," Dr. McDonnell says. "The PACU, the OR, recovery. Even things like registration. Make it a quality project, report on it every month. Do graphs on it and figure out if you are getting better or getting worse, and if you're getting worse, figure out why."

Such a quality program must include the surveillance element asked about in question #3. Consider trying the "secret shopper" approach where you choose someone to observe your team on hand hygiene compliance without staff members knowing the person has this responsibility. "Even with this [surveillance approach], everyone should still be empowered to watch each other — empower everyone," he says.

6. Do you know the proper guidelines for placement of alcohol-based hand rub sanitizers? You can receive this information from your local fire marshal and some of them you can obtain from the National Fire Protection Association. "Make sure they are installed in accordance with state and local codes," Dr. McDonnell says. "They're afraid the alcohol is going to be set on fire."

The CMS Condition of Participation for hospitals, per the Federal Register, is found under standard 482.41(b)(9), which can be viewed at www.law.cornell.edu/cfr/text/42/482/41. You can also find guidelines in the CMS "State Operations Manual — Appendix L - Guidance for Surveyors: Ambulatory Surgical Centers" which can be found at www.cms.gov/manuals/downloads/som107ap_l_ambulatory.pdf.

"The most important thing is you have them and do you have them in the right places," he says.

7. Does your staff know about the need to do alcohol rubs going in and out of rooms? "The hardest thing to remember is you have to do [alcohol rubs] going *into* the room and going *out of* the room, and that's what should be done by everybody," he says. "People forget that, especially when going in — it needs to be done both going *in* and *out*."

8. Have you reviewed the CDC's and WHO's guidelines for hand hygiene? Both the CDC and World Health Organization have published hand hygiene guidelines, and they are worth reviewing. You can download the CDC's "Guidelines for Hand Hygiene in Healthcare Settings" (published in 2002) by visiting www.cdc.gov/mmwr/PDF/rr/rr5116.pdf. You can download the WHO's "WHO Guidelines on Hand Hygiene in Healthcare" (published in 2009) by visiting http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf.

9. Do you use visual reminders? A good hand hygiene program will use posters and other visual reminders that address the issues of proper hand hygiene, Dr. McDonnell says. You will want to make sure these displays are changed on a regular basis to ensure staff members do not become accustomed to them and ignore their messages.

10. Are disposable gloves readily available? Make sure disposable gloves are available to everyone on your team, Dr. McDonnell says.

"And make sure they change their gloves," he says. "Don't try to save money and use the same gloves. Always change them after you finish a task. And be sure to wash you hands after removing gloves."

11. Include patients and their families in hand hygiene education. Educating patients and their families on proper hand hygiene not only when they are in your facility but also when they leave can help prevent post-surgical infections, spread of disease, etc.

"It could be part of your pre-op and post-op instructions," Dr. McDonnell says. "And remind them that since they're going to have surgery, they should get cleaned before they come in. Do you have instructions for these people before they arrive? You're still going to perform a surgical cleanse on them but they should come in clean."

It is worthwhile to not only have hand hygiene posters and signs in the staff bathrooms but it is worth including them in patient and visitor bathrooms as well.

12. Do you cater to the needs of your customer? "Make sure you have your [hand hygiene] information posted in a language your patients and employees understand," Dr. McDonnell says. "Know your customer." ■

Learn more about HFAP at www.hfap.org.

Treating Patients With MRSA in an ASC: Q&A With Regina Dolsen of Blue Chip Surgical Partners

By Rob Kurtz

Regina E. Dolsen, RN, BSN, MA, is vice president of operations for Blue Chip Surgical Center Partners.

Q: How should our ambulatory surgery center treat patients with MRSA? What action protocol should we follow in the operating room?

Regina Dolsen: The identification of whether your ASC will do MRDO (multidrug-resistant organisms) cases is the first question I would ask. If you do, then the OR should follow contact precautions if the situation is known. The OR should be terminally cleaned following the case, staff should follow all contact precaution practices and usually the case should be scheduled at the end of the day.

Since it is a sterile environment, and since OSHA requires specific management of communicable disease exposures, it would be appropriate to maintain those protocols in the OR. The entire perioperative experience for the patient should follow contact precautions.

Some organizational considerations would be the identification of high-risk patients that would not be good candidates in the center. Preoperative nursing assessments should be completed and physician involvement should be part of the decision to do the case in the first place. All of these are fairly standard.

Follow-up calls or an infection post-op call should be completed for all patients but these should have some special follow-up and notations. As always, we would expect all measures be employed to prevent the spread of infection.

I would also suggest reading "Multidrug-Resistant Organisms: Practice Considerations in the Ambulatory Surgery Setting — Part One" from the *Journal of PeriAnesthesia Nursing* (Vol. 26, Issue 4, Aug. 2011). At the end of the article there are also many other references that are very helpful. ■

Learn more about Blue Chip Surgical Center Partners at www.bluechipsurgical.com.

10 Things I Would Do Now If I Were Preparing for a Survey

By Sheldon S. Sones, RPh, FASCP, President, Sheldon S. Sones and Associates

1. Ensure your recall process is working as evidenced by a trail that demonstrates communications from vendors/manufacturers in a prompt manner, and reveals action taken by the facility.

2. Ensure allergies (drugs, food and latex) are well documented as declared by patients, and, importantly, a brief documentation of the kind of reaction the patient claims is experienced.

3. If you use malignant hyperthermia triggers that the facility can demonstrate, mock codes utilizing dantrolene and other strategies for reversal.

4. If a patient presents on an insulin pump, have a policy and a physician order that addresses the procedures that the facility will follow.

5. Ensure your biennial controlled drug inventory has been completed and is readily available.

6. Ensure you have a formulary of approved drugs for use in the facility, including code cart contents, which have been reviewed at the medical staff level at least annually.

7. Ensure the anesthesia record is clear as to the drugs administered as well as tallied as to amount administered, explicit as to mg., mcg., ml., etc.

8. Ensure you have a current "Look-Alike/Sound Alike" list of drugs (Here is a link to ISMP's "List of Confused Drug Names": www.ismp.org/Tools/confuseddrugnames.pdf).

9. Ensure you have emergency preparedness and evacuation plans.

10. Ensure medications are discarded appropriately. ■

Learn more about Sheldon S. Sones and Associates at www.sheldonsones.com.

Preventing Bloodborne Pathogen Violations in the ASC: Q&A With AORN's Mary Ogg

By Rachel Fields

In a recent report, the Occupational Safety and Health Administration listed the most frequently cited bloodborne pathogen violations in surgery centers. According to the report, OSHA has increased medical facility inspections in the last several years, meaning citations for bloodborne pathogen violations are on the rise in ASCs and physician offices.

Such violations made up the majority of OSHA medical citations in recent years — a significant cause for concern, since violations can expose patients and healthcare workers to serious diseases such as HIV and hepatitis B and C. Mary Ogg, MSN, RN, CNOR, perioperative nursing specialist with AORN, discusses how bloodborne pathogen violations occur and what ASC providers can do to avoid violations in their facilities.

Q: Why do bloodborne pathogen violations constitute such a high percentage of medical facility citations?

Mary Ogg: The Bloodborne Pathogens Standard, 29 CFR 1910.1030, is the most frequently cited OSHA standard in healthcare. As to why it is the most frequently cited standard, it may be the broad scope it encompasses. The standard applies to all occupational exposures to "blood or other potentially infectious materials (OPIM)."

Q: What are the main causes behind these violations? How can facilities take action to prevent them?

MO: The most frequently cited paragraphs of The Bloodborne Pathogens Standard 29 CFR 1910.1030 since the passage of the Needlestick Safety and Prevention Act in 2000 are: engineering and work practice controls, annual update of the exposure control plan, documenting annual considerations of sharps with engineered sharps injury prevention (SESIPs), sharps injury log and accessibility to regulated waste containers.

Engineering and work practice controls are primary controls that can eliminate or minimize a hazard and must be used:

SESIPS — engineering controls:

- Examples of specialized surgical equipment include safety scalpels and blunt-tip suture needles, which provide a safer alternative to traditional sharp-tip suture needles.
- No one device is appropriate for all uses. Device selection may differ depending on procedures.
- Evaluation of devices should involve a mixture of staff members.

Work practice controls:

- Providers should practice double-gloving.
- Providers should use a predetermined "neutral zone" for placing or retrieving used sharps.
- One-handed or instrument-assisted suturing technique should be used to avoid contact with the needle.

Exposure control plan — annual update:

- The exposure control plan is a key provision of the bloodborne pathogens standard because it requires the employer to identify the employees who will receive the training, protective equipment, vaccination and other protections of the standard.
- *Model Plans and Programs for the OSHA Bloodborne Pathogens and Hazard Communications Standards*-OSHA Publication 3186:
  - Available from OSHA Publications Office or on OSHA website at www.osha.gov
  - Can be used as a template
  - Must be made specific to each workplace
  - Contains all elements required in the plan.
- Must be reviewed every year

Documentation of annual considerations of SESIPs:

- Safety devices must be reviewed and evaluated yearly by front line users of the device.
- Workers must be responsible for direct patient care and be potentially exposed to injuries from contaminated sharps.
- The solicitation of employees who have been involved in the input and evaluation process must be documented in the exposure control plan.
- A key element in choosing a safer medical device — other than its appropriateness to the procedure and its effectiveness — is its availability on the market.
- If there is no safer option to the medical device that you are using for a particular procedure, you are not required to adopt a device different from the one currently being used.
- With advances in medical technology, more devices are becoming available for different procedures. If no engineering control is available, work practice controls shall be used, and if occupational exposure still remains, personal protective equipment must also be used.

Sharps injury log — recordkeeping:

- Facilities should maintain a log of occupational injuries and illnesses under 29 CFR Part 1904.
- Facilities should maintain a sharps injury log for recording percutaneous injuries from contaminated sharps:
  - Sharps injury log must contain, at a minimum, the type and brand of device involved in the injury (if known), the department or work area where the exposure incident occurred and an explanation of how the incident occurred.
  - Injuries must be recorded and maintained in a manner that protects the confidentiality of the injured worker (e.g., removal of personal identifiers).
- Forms:
  - OSHA Form 300 — Log of Work-Related Injuries and Illnesses
  - OSHA Form 301 — Injury and Illness Incident Report

- OSHA Form 300A — Summary of Work-Related Injuries and Illnesses

- Use data as a device for surveillance.

Accessibility to regulated waste containers:

- Sharps containers must be closable, labeled/color coded, leak proof, puncture resistant.
- Waste containers must be located close to the point of use (e.g., anesthesia cart, OR use).
- Waste containers must be maintained upright.
- Waste containers must be replaced routinely and not allowed to overfill
- Waste containers must be an adequate size to accommodate large disposable instruments, such as trocars and graspers.

Q: What should training around bloodborne pathogen violations involve?

MO: Before employees can be trained on the bloodborne pathogens, the employer should become knowledgeable about all facets of the BBP standard-hazard evaluation, record keeping, hepatitis B vaccinations, hepatitis B declination forms and recordkeeping and responsibility to provide personal protective equipment.

Training for BBP violations should be specific to the violation and [discuss] why it is important to follow the standard. The standard's purpose is to protect the worker and indirectly our patients from exposures and injuries. The educational PowerPoint in AORN's Sharps Safety Tool Kit includes the evidence for using engineering and workplace controls such as double-gloving, neutral zone and blunt suture needles.

[Facility leaders should] include facility examples of sharps injuries and their consequences and perform a root cause analysis with the staff of why the injury occurred and what could be done in the future to prevent it. Make the training pertinent to the employees in your facility and their specific job functions. For example, blunt suture needles and the neutral zone are not relevant to PACU nurses, but safety needles and syringes and needleless connector systems would be.

Involving front-line users of SESIPs in the selection and trialing of the products may increase acceptance and use of the products.

Q: What is the potential effect of bloodborne pathogen violations — both in terms of safety and accreditation issues?

MO: Violations of the BBP standard put the worker and potentially the patient at risk for transmission of HIV and hepatitis B and C. Additionally, the worker is at risk for injuries from scalpels, needles and other surgical items.

[In regards to accreditation], I cannot speak for the accrediting agencies and would advise checking with the individual accrediting bodies … to see if they check the public record for a facility's violations before inspections or if a violation would trigger an inspection. During their inspection process, a citation may be discovered during employee interviews or as part of document and process reviews. ■

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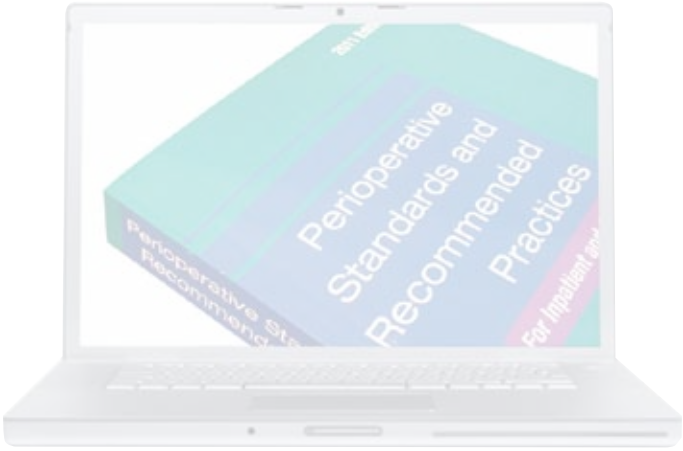

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Sterile Processing of Eye Instruments: Q&A With Nancy Jo Vinson

By Rob Kurtz

Nancy Jo Vinson, RN, BA, CASC, of Healthcare Consultants International (a subsidiary of the Accreditation Association for Ambulatory Health Care) and NJM Consulting, addresses four reader questions relating to sterile processing of eye instruments.

Q: What are the steps ambulatory surgery centers should take to ensure proper sterile processing of eye instruments?

Nancy Jo Vinson: The cleaning and sterilization of ophthalmology instruments has been a topic brought to the forefront by toxic anterior segment syndrome. There are several very good resources that can be utilized for reference. It is extremely important to understand that national guidelines should be adhered to when developing your facility's policies.

Some of the references, although not all-inclusive, you may utilize are the following:

- An excellent article was written in the ASCRS Eye World News Magazine (Week No. 37) found at www.eyeworld.org/ewsupplementarticle.php?id=200. The article is "Recommended Practices for Cleaning and Sterilizing Intraocular Surgical Instruments."
- ASORN has published the "Care and Handling of Ophthalmic Microsurgical Instruments," which can be purchased and utilized as your foundation reference.
- Manufacturers such as *Bausch + Lomb Storz Ophthalmic Instruments* have published instructions for cleaning, decontaminating and sterilizing of their instruments that also reference not routinely flashing.
- AORN's Perioperative Standards and Recommended Practices (2012 edition is now available) provides information for pre-cleaning, cleaning, washing/decontamination and sterilization of surgical instruments.
- ANSI/AAMI S79 Sections 7.5 (1), 7.5.3.1-7.5.3.3 (1), 7.5.6 (1), 7.5.4 (1) and 7.5.5. (1) provide recommendations regarding appropriate cleaning, methods of cleaning, rinsing and verification of the cleaning process.

Q: What are surveyors going to look for relating to sterile processing of intraocular surgical instruments when they visit an ASC? Are there particular types of trays that are not acceptable to surveyors?

NJV: Surveyors will survey for compliance with current accreditation standards. Specifically, they will identify that there is an infection control program based on nationally recognized infection control guidelines and a process in place for high-level disinfection and sterilization of medical equipment, accessories, instruments and implants. If the AORN Perioperative Standards and Recommended Practices are adopted by the governing body as the nationally recognized infection control guidelines, then the surveyor will be looking to see if the processes being utilized within the center are in compliance with their own infection control program, including sterilization of instruments.

Immediate-use sterilizers are frequently located in ASCs. Immediate-use sterilization is appropriate in emergency situations, as when a one-of-a-kind item is dropped on the floor during surgery or otherwise becomes contaminated and is needed immediately. However, AORN and CMS do not support the use of immediate-use sterilization as a substitute for a sufficient inventory of surgical instrumentation. Major issues associated with immediate-use sterilization are insufficient time to correctly clean the devices before sterilization and the potential for contamination of the device after sterilization (because there is no packaging or container to protect it). Furthermore, many manufacturers no longer provide immediate-use sterilization instructions for their devices; therefore, compliance with manufacturers' instructions cannot be determined.

Immediate-use sterilization should not be attempted without the device manufacturer's written instructions for cleaning and sterilization. The sterilization instructions must be replicated exactly, meaning that if only a gravity-displacement immediate-use cycle was validated for the device, then the device must be sterilized in a gravity-displacement immediate-use cycle (not a dynamic-air-removal immediate-use cycle).

Historically, immediate-use sterilization was usually performed with the device unwrapped and in a perforated, mesh-bottom, open tray. It is now performed with the device in a containment device such as a rigid sterilization container.

Surveyors will not be looking for a particular type of tray for short cycle or terminal sterilization. However, they will want to know you have investigated the compatibility of the trays you have purchased with the type and model of autoclaves you are utilizing as well as utilizing the trays correctly.

Q: What have you seen as common mistakes ASCs make concerning sterile processing of these instruments? What are the ramifications of these mistakes?

NJV: During my career and not specifically as a surveyor, I have been exposed to ASCs that only wipe off and clean instruments on the back table and do not clean eye instruments according to the same processes that they do all other instruments.

Frequently, the processes utilized for cleaning eye instruments is based on what someone else is doing instead of independent research and verification of current data published from nationally recognized agencies. Information being utilized is not always correct and does not adhere to the principles of infection prevention.

Additionally, utilizing single-use products such as blades or phaco tubing for multiple cases is routine in many facilities based on history of practice of healthcare professionals (physicians, nursing, etc.) rather than adherence to current national guidelines and regulations.

Not following nationally recognized infection control guidelines including sterile processing frequently results in non-compliance with CMS Conditions for Coverage, accreditation standards and state licensure requirements.

Q: What can ASCs do to help reduce the likelihood of these errors?

NJV: Be prepared to be able to produce manufacturers' instructions for instrument and supply sterilization, and to describe and demonstrate how instruments are being cleaned and decontaminated according to those written instructions.

Be prepared to explain your process for cleaning instruments, remembering that rinsing is rarely enough to properly remove soil from instruments.

Be prepared to identify the nationally recognized guidelines that your governing body has adopted for your infection control program and how these correlate to your instrument cleaning and sterilization processes.

Be prepared to produce any scientific literature that supports processes that your ASC follows outside of the nationally recognized guidelines adopted by your governing body such as not utilizing any detergent for the cleaning of instruments. ■

Healthcare Hotspots: Top Places to Protect Against Pathogens

By Kim LaFreniere, PhD, Associate Research Fellow, Clorox Professional Products Co.

Infection preventionists and environmental services professionals are stationed on the frontlines of the infection prevention battleground and they understand that environmental surface disinfection is a key defense strategy against healthcare-associated infections (HAIs) and multi-drug resistant organisms (MDROs). Yet even seasoned professionals may find it challenging to quickly identify target areas where microorganisms hide and the products needed to help remove them.

Research is constantly conducted in the field to determine better cleaning and disinfecting protocols and to create effective educational materials and product recommendations. Although these recommendations are regularly evaluated, the CDC and the Healthcare Infection Control Practices Advisory Committee's (HICPAC) "Guideline for Disinfection and Sterilization in Healthcare Facilities"[1] serves as a great resource for healthcare professionals to quickly assess how to clean and disinfect environmental surfaces.

The CDC and HICPAC guideline spells out a few levels of environmental surface disinfection based on the type of microorganism contamination. For example, intermediate-level disinfectants destroy all vegetative bacteria including tubercle bacilli, fungi, lipid and some nonlipid viruses, but do not destroy bacterial spores. Low-level disinfectants are similar to intermediate-level disinfectants except they do not destroy tubercle bacilli, some fungi and bacterial spores.[1]

It is important for professionals to understand the differences between different products and when to apply the correct procedure. The following overview highlights some key healthcare areas requiring disinfection and the appropriate products to use to help prevent the spread of infections.

Intermediate-level disinfection areas

MDROs and HAIs can be found on high-touch surfaces in patient rooms, operating rooms, emergency rooms, isolation rooms and intensive care units. According to CDC and HICPAC, items requiring intermediate-level disinfection are those that either come into contact with intact skin, but not mucous membranes (non-critical items) or broken skin and mucous membranes (semi-critical items). In general, the areas that see the most daily interactions from patients, visitors and staff are the most easily contaminated and require disinfecting on a frequent basis.

High-touch non- and semi-critical items to disinfect include the following:

- IV stands
- BP monitors and cuffs
- Stethoscopes
- Glucometers
- Bedrails and bathroom handrails
- Bedside tables
- Drawer, door, cabinet and toilet seat handles
- Light switches
- TV remotes and nurse call buttons

What products to use

Intermediate-level disinfection requires the use of an EPA-registered hospital disinfectant cleaner such as sodium hypochlorite (bleach). Bleach-based disinfectant wipes or sprays are generally effective against a broad range of microorganisms and have short contact times. In fact, the Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America recommend a 1:10 bleach solution to kill the pathogens which are of most concern to healthcare facilities such as *C. difficile*.[2]

Low-level disinfection areas

Although it's important to keep every area of a healthcare environment clean, not every surface requires intense disinfection. Less-frequently touched items and surfaces in non-patient areas are considered lower-risk areas for spreading infections throughout the healthcare environment.

Low-risk items to disinfect include the following:

- Wheelchairs
- Crutches
- Computers
- Patient furniture
- Counters
- Carts
- Walls
- Floors

What products to use

For daily cleaning of these types of hard, non-porous surfaces, use an EPA-registered quaternary disinfectant cleaner. Low-level disinfectants such as dilutable quaternary ammonium compounds succeed in killing many deadly healthcare pathogens, but are gentle enough to use daily on common surfaces. Look for products that are registered to kill many pathogens in the shortest amount of time possible. One-step products that do not require a pre-cleaning step can also save staff valuable time.

Important cleaning and disinfecting tips

According to the CDC's "Guidelines for Environmental Infection Control in Health-Care Facilities," healthcare professionals should remember to adhere to the following general guidelines[3]:

- Always select EPA-registered disinfectants, if available.
- Follow the manufacturer's instructions for all products, paying particular attention to the recommended dwell times needed to kill specific microorganisms.
- Educate healthcare workers to pay close attention to hand-washing procedures and don the appropriate personal protective equipment. ■

Learn more about Clorox Professional Products Co. at www.cloroxprofessional.com.

Footnotes:

1 Rutala WA, Weber DJ, Healthcare Infection Control Practices Advisory Committee, (2008). Guideline for Disinfection and Sterilization in Healthcare Facilities. Retrieved from: http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf

2 Stuart H. Cohen , MD, Dale N. Gerding , MD, Stuart Johnson , MD, Ciaran P. Kelly , MD, Vivian G. Loo , MD, L. Clifford McDonald, MD, Jacques Pepin , MD and Mark H. Wilcox , MD (May 2010). Clinical Practice Guidelines for Clostridium difficile Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA). Infection Control and Hospital Epidemiology Vol. 31, No. 5 (May 2010), pp. 431-455. Retrieved from: http://www.cdc.gov/HAI/pdfs/cdiff/Cohen-IDSA-SHEA-CDI-guidelines-2010.pdf

3 Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC), (2003). CDC - Guideline for Environmental Infection Control in Health-Care Facilities. Retrieved from: http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf

Bacteria on Healthcare Workers' Uniforms: Q&A With APIC President Russell Olmsted

By Rob Kurtz

A study published in the September issue of the American Journal of Infection Control *indicated more than 60 percent of hospital nurses' and doctors' uniforms tested positive for potentially dangerous bacteria. Russell Olmsted, MPH, CIC, APIC 2011 president and director of infection prevention and control services at St. Joseph Mercy Health System in Ann Arbor, Mich., discusses the attention the study has received, what healthcare workers can learn from the study's results and the questions the study raises that require more attention.*

Q: The study has received quite a bit of media attention and buzz in the healthcare industry. Why do you think that is the case and is the attention justified?

Russell Olmsted: Studies that identify which microorganisms are recovered from a variety of surfaces, attire and equipment (stethoscope, blood pressure cuff, hospital bed rails, etc.) do elicit a lot of attention from healthcare professionals and the general public. This probably reflects our (human population) desire to maintain good hygiene and appeals to our collective "yuck factor radar" and fascination that a surface or uniform that looks clean can be contaminated with microbes (germs). However, infection preventionists/healthcare epidemiologists and clinical microbiologists are not as surprised as microbes are on and inside humans and we actually depend on them for our survival and maintaining normal health status. It's when these microbes get into an area where we don't want them to, e.g., the bloodstream or on an implanted prosthetic hip or knee joint, and cause infection, that endangers the safety of the patients we serve.

This latest study by Dr. Wiener-Well is well done and a useful addition to the scientific literature but is only one piece of the "puzzle" involving cross-transmission of microbes to patients. The additional pieces include whether the microbes on the healthcare worker's uniform can be picked up on their hands — survive on the hands — and then be transferred to the patient. Even once these arrive to the patient, they may or may not cause infection. There are multiple steps involved in transmission and development of infection and the mere recovery of microbes on the uniform do not necessarily mean they are going to cause infection in a patient. There are laboratory techniques to help show the microbe on the uniform is the same as that causing an infection in a patient. This is harder to do, however, as there is an incubation period between exposure to a microbe while in a hospital and onset of infection that can range between two days and several weeks, depending on the specific organism. In most instances the transfer of a microbe to a patient's skin does not cause infection, so this is a harder study to perform.

Q: You have previously stated these study results needed to be put into perspective. What then do you see as the key takeaways from the study?

RO: Yes, perspective and consideration of other studies on the role of the uniform in cross-transmission is important. I've mentioned previously that a systematic review [extensive analysis of the strength and quality of peer reviewed studies] of the role of HCW attire in causing healthcare-associated infections has been done by Dr. Jennie Wilson and her colleagues in the UK [*Journal of Hospital Infection* 2007;66:301-307]. After analyzing several studies that had been published they concluded, "Although it has been hypothesised that contaminated uniforms are a potential vehicle for the transmission of pathogens, no studies demonstrated the transfer of micro-organisms from uniforms to patients in the clinical situation."

One of the factors that prompted this study by Dr. Wilson was the UK's "Bare below the elbows" initiative that the National Health Service launched wherein physicians were not to wear white coats, long sleeve shirts or neckties. A more recent study by Dr. Willis-Owen and others [*Journal of Hospital Infection* 75 (2010) 116–119] cultured the hands of physicians who adhered to the bare below vs. another group that did not and found no difference in the concentration of microbes on their hands nor any multidrug-resistant organisms like MRSA.

Last, Dr. Marisha Burden and her co-investigators published a study of medical residents examining the level of contamination of freshly laundered, short sleeve uniforms vs. a traditional white coat [*Journal of Hospital Medicine* 2011;6:177-82.]. Their findings were, "Bacterial contamination occurs within hours after donning newly laundered short-sleeved uniforms. After 8 hours of wear, no difference was observed in the degree of contamination of uniforms versus infrequently laundered white coats. Our data do not support discarding long-sleeved white coats for short-sleeved uniforms that are changed on a daily basis."

Takeaways from the new study in *AJIC* and these other ones are as follows:

1. HCW need to continue to place an emphasis on hand hygiene just before providing patient care and after, e.g., as they leave a patient's room.

2. Wear clean uniforms, keep them laundered and change them if they become soiled with blood or body fluids during the course of care.

3. There is no evidence that wearing scrub attire outside the operating room presents a risk of bringing microbes back into the OR. The primary reason is that anyone who wears scrub attire during the course of their work shift in the OR is going to put on a new, sterile gown for each case. This gown goes over the scrub attire and protects the patient from microbes that might be present on the scrub attire. Prior investigations of use of a cover gown (put on when leaving a patient care area) for personnel who care for newborns in the nursery found it had no impact on risk of infection and has therefore largely been abandoned.

4. HCW are not likely to carry microbes home on their uniforms and there is little, if any, evidence that the uniform represents a risk of exposure to other family members. Likewise, IPs and HEs know that we see a substantial proportion of patients being admitted with infections caused by MDROs like MRSA — meaning these are being transmitted in the community. It is very unlikely that MRSA on a uniform of a HCW would cause a MRSA infection in someone in a community setting, e.g., at a grocery store. Instead these strains of MRSA are present on skin and are being transmitted between people in situations where there might be breaks in the skin allowing the MRSA to get past the normal skin barrier, e.g., during a team sport like wrestling, soccer or football.

5. Keep your hands, uniform, and environmental surfaces around a patient or the equipment used during care clean and don't spend undue amount of worry about what might be on your uniform.

Q: Should organizations do anything different with their HAI prevention efforts considering these study results?

RO: More study is worthwhile but healthcare professionals and organizations need to avoid disproportionate attention on uniforms or creating an unrealistic expectation that uniforms be sterile. Instead they need to continue to work with their IP/HE to address prevention of HAIs that has a broad focus, e.g., hand hygiene, use of "prevention bundles" aimed at stopping central line-associated bloodstream infection, catheter-associated UTI and ventilator-associated pneumonia. Collaborate with the perioperative care professionals on preventing surgical site infections and, last, make sure there is attention paid to environmental hygiene.

Q: You have stated the study raises additional questions that need to be investigated. What questions do you see it raising, and how would answering these questions help with future HAI prevention efforts?

RO: As highlighted above, we need to assure that "microbe discovery studies" do not allow us to take our eye off the primary prevention strategies. Additional questions remain on techniques and strategies from experts such as social scientists on how we can embed hand and environmental hygiene into almost an automated approach when caring for patients in healthcare facilities. We have lots of effective products — the human behavioral element remains perhaps one of the more challenging factors however. Can microbes on the uniform survive, for how long and what is the critical dose needed to move them from one location to another? What's the relative contribution of microbes on a HCW's uniform in the cross-transmission of microbes to patients? Last, can we show using more advanced laboratory tests that the microbe on the uniform is transmitted and causes an infection? These are continued questions that IPs and HEs have. ■

Learn more about APIC at www.apic.org.

10 Essentials for an Infection Control Program at Spine Centers

By Laura Miller

Valerie Maxam-Moore, RN, MN, vice president of ASC operations and quality at Laser Spine Institute, discusses 10 critical components of strong infection prevention programs at spine centers.

1. Follow AORN and AAMI standards and the APIC guidelines. The best way to begin building a foundation for good infection control and prevention programs at spine centers is by applying the Association of periOperative Registered Nurses and Association for Advancement of Medical Instrumentation standards and the guidelines put out by the Association of Professionals in Infection Control and Epidemiology. "These programs outline very clearly the best practice recommendations for all surgical centers," says Ms. Maxam-Moore. "You can meet your state's minimum requirements, but if you want a superior infection prevention program, you need to commit yourself to industry best practices, particularly given the inherent risk associated with spine surgery."

A few examples of best practices outlined in the AORN standards include the use of an antimicrobial soap with CHG for patient preop showers, meticulous skin preparation measures, hair clipping versus shaving and all OR personnel going through a hand scrub in the morning instead of just the surgeons and surgical technologists.

2. Document each case well. Clear and thorough documentation of each case is extremely important in case you need to track back to find the potential source of a surgical site infection and track potential trends in how patients are acquiring infections at your center. For every case, the center should record serial numbers on equipment, lot numbers of the materials used during the case, tray identification numbers and the names of all the medical professionals who were in the room and/or worked perioperatively with that patient. "Keeping good records is essential because if you do have an infection, you can track everything back for a surgical site infection workup," says Ms. Maxam-Moore. The staff, supplies or surgical equipment used could all be a potential source of a patient's infection.

For example, if the center experiences multiple instances of surgical site infection, staff members can trace back the patients' steps and potentially isolate the source of the problem, which could be as simple as the way a staff member performs a dressing change postoperatively. "If you are documenting everything along the way with the cases, when you do have a surgical site infection you can have all the information to go back through," she says.

3. Empower an infection prevention resource person. An RN at the surgery center should serve as the leader of the infection prevention program and point person for quality-related issues. This person undergoes additional infection prevention education from an outside source, such as APIC. The infection prevention resource person also coordinates internal audits, performs assessments, arranges training for other staff members and ensures audit results are reported clearly to the staff and Patient Safety and Quality Assurance/Performance Improvement teams.

"This person needs to be able to say 'we looked lousy [or great] in our handwashing audits'," says Ms. Maxam-Moore. "They should be given the resources to implement the infection control program and make recommendations based on the audits and assessments."

4. Have committed leadership. The most effective infection prevention programs have a leadership team committed to infection prevention. "It's expensive to follow infection prevention best practices, and there has to be an expectation of excellence and a goal of approaching an infection rate of zero," says Ms. Maxam-Moore. "If that doesn't start at the top, it won't trickle down."

The administration needs to stand behind the staff members working on the infection prevention program to optimize its resources. If the infection prevention team identifies a more expensive biological indicator for monitoring effective sterilization, or a more frequent use of a BI as a best practice, even though it isn't required, committed administrators will understand the importance of the recommendation and be willing to foot the bill.

5. Regularly assess and audit the QI program. A strong quality and infection control program should include regular audits and assessments to make sure staff members are following protocol. These assessments could include appointing someone to watch staff members while they complete their handwashing routine to see who is following the rules and who isn't. The center should also complete audits on the night cleaning crew. Create a checklist for the night staff so they know their part in your center's infection prevention program. Complete surgery center annual assessments are also necessary and can help you identify new and different problems at the center.

"Take a look around and make sure there aren't any issues with facility design or flaws in the process and protocols that contribute to infection," says Ms. Maxam-Moore. Once the audits are complete, share them with the staff. "You can't just do the audits and assessments and keep them to yourself. You have to report the results to the leadership team and staff, and challenge them to improve."

6. Frequent checks on instrument sterilization practices. Ms. Maxam-Moore believes, for example, that it's important for spine centers to identify the best biological indicators for monitoring sterilization and to use them more

than the minimum requirement. If the minimum requirement for a particular monitor is daily, but AORN and AAMI suggest best practice is to run the indicator with each load, the center should opt to follow the more intensive best practice.

7. Incentivize best practices and improvements. You can create friendly competition among employees or multiple surgery centers to promote quality improvement and adherence to best infection prevention practices and protocols. Laser Spine Institute challenges each of its four surgery centers to outperform the others in quality assessments. "We see who is doing better in which areas and look at ways to award those with the best results," says Ms. Maxam-Moore. "Sometimes, friendly competition is a good thing."

8. Build in constant reminders of best practices. It's important to keep constant reminders around the surgery center detailing the best practices for infection control. Hanging posters, such as those from the Centers for Disease Control and Prevention's "One and Only Campaign," around the center can keep staff members on their toes. Laser Spine Institute is considering a program where all staff wear buttons that say "Ask me if I washed my hands."

Internally, Laser Spine Institute publishes a monthly infection prevention newsletter and holds infection prevention meetings to keep quality issues at the forefront of their staff members' focus. The newsletters include tips and reminders, such as "no hoodies in the OR," and field anonymous staff questions about infection control. A typical question might be, "How long can you have a room open before the case," and the newsletter can run the answer without reprisal to the inquirer.

9. Involve everyone in licensure and accreditation efforts. Whether your surgery center is pursuing accreditation or facing re-licensure or re-accreditation, proving you have a strong infection prevention program is essential. Laser Spine Institute recently went through a licensure survey at one of its centers and the surveyor was very impressed by the specificity and detail in its case documentation and the SSI work-up the center did for the one SSI it had in the prior year. This is also a good time for you to review any updates that may be needed in your infection prevention best practices.

"Reviewing the best practice requirements and guidelines for infection control is important because they change so often," says Ms. Maxam-Moore. "Overhaul the infection prevention protocol in your policy and procedure manuals so it matches the best practices updates. When you make the changes, alert staff members so they know changes have taken place."

10. Hold yourself to highest standards. Even if your surgery center isn't planning on seeking accreditation or Medicare-deemed status, your center should still refer to those standards when building its infection prevention programs. "Licensure bodies will often follow what CMS and the accrediting organizations are doing," says Ms. Maxam-Moore. "So it's better to be prepared." ■

Learn more about Laser Spine Institute at www.laserspineinstitute.com.

6 Quality Measures GI Centers Should Track

By Abby Callard

Medicare and Medicaid will soon start requiring that ambulatory surgery centers report on various quality measures such as burns, transfers to hospitals and patient falls. The American Society for Gastrointestinal Endoscopy has said that many of those quality measures aren't relevant to GI centers and recommended more specialty-specific measures.

Brian Jacobson, MD, FASGE, associate director of endoscopy services at Boston Medical Center and associate professor of medicine at Boston University School of Medicine, helped author the comment letter to CMS for the GI societies.

"Beginning Oct. 1, 2012, ASCs will be required to submit data on five quality measures to avoid a payment adjustment in 2014. CMS had proposed a reporting start date of Jan. 1, 2012, but finalized a later start date in response to concerns expressed by the GI societies and other stakeholders about the proposed aggressive timeline. Therefore, GI surgery centers need to be paying attention to the same quality measures that all surgery centers need to be paying attention to, even if they think they don't apply," he says.

But there are other measures not yet required that GI ASCs should consider tracking, such as patient satisfaction.

"This is the kind of thing that payors, including CMS, are going to be looking toward," he says.

He says there are also measures that apply specifically to GI centers. Here he outlines six measures that GI centers should consider tracking to benchmark and keep up with the competition.

1. Cecal intubation rates for colonoscopy. Dr. Jacobson says tracking cecal intubation rates is important to prove the skill level of the ASC's endoscopists. Cecal intubation is defined by the ASGE as the "passage of the colonoscope tip to a point proximal to the ileocecal valve so that the entire cecal caput, including the medial wall of the cecum between the ileocecal valve and appendiceal orifice."

2. Adenoma detection rates for colonoscopy. Measuring adenoma detection rate is key in determining the success of a colonoscopy. The ASGE has linked higher adenoma detection rates to better and longer examinations, better colonic distention and better colon cancer prevention.

3. Detailed colonoscopy report. Dr. Jacobson says this should include things such as depth of insertion, quality of bowel preparation and number and location of polyps detected and removed. Poor bowel preparation is a major obstacle to quality in colonoscopies, so the quality of the preparation should be noted in the records. The report should also include photos of abnormalities and identification of biopsy specimens.

4. Proper endoscope reprocessing. ASGE guidelines on reprocessing endoscopes recommend the operating channels and external portions of the endoscope be washed, wiped with detergents that contain enzymes and brushed with special cleaning instruments. The guidelines also recommend the endoscope be soaked with an FDA-approved liquid chemical, rinsed with water and alcohol and that the channels are dried with forced air. The guidelines were updated this year and now include guidelines on how long an endoscope can be stored without having to be processed again, as well as additional details on other processes.

5. Proper screening intervals. Dr. Jacobson says the standard interval is at least three years after a polyp has been found. In the future, he says, CMS may measure how often an endoscopist recommends a 10-year interval between colonoscopies with no polyp detected.

6. Belong to a GI registry. "I do think ASCs should think about reporting things through a registry," he says. "I think it makes it easier to participate in quality reporting endeavors that are being set up by CMS and private payors as well. If you get the electronic systems now, you can work out the kinks before it's required."

Two that he recommends considering are the GIQuIC registry, organized by the American College of Gastroenterology and ASGE, and the American Gastroenterology Association's Digestive Health Outcomes Registry. ■

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5 'Cs' for Addressing Infection Control in Design & Construction

By Sabrina Rodak

The commitment of time and resources to design and construction of healthcare facilities can provide value in creating larger and more aesthetically-pleasing facilities, which may help attract patients, retain employees and accommodate new equipment. One value that may be under-recognized is the ability of design and construction choices to influence infection control. Approximately five percent of all healthcare-acquired infections are due to construction within the healthcare facility, according to Dan Lee, architect, interior designer and president of Lee Design Group. Mr. Lee, who was the first president of the American Academy of Healthcare Interior Designers, offers the following five tips for improving infection control through construction and design.

1. Create an integrated team. Managing construction plans of a healthcare facility with a multidisciplinary team can help assess how construction will affect different parts of the organization and how to minimize safety and health hazards. "It's extremely important to have an integrated delivery team approach rather than a design, bid and build approach," Mr. Lee says. "Bring in an epidemiologist and other gatekeepers, from internal stakeholders as well as the contractor/architect delivery team, from the very start. When you have an integrated team of folks at the front end, you're more likely to develop a strategy that allows you to maintain business activities and equip the architect and designer with information they need to create a more process-oriented solution."

2. Confirm infection control guidelines. Healthcare organizations should discuss infection control regulations with the architect and designer in the beginning of the planning process to ensure everyone is aware of the limits and requirements of construction. "Understand the protocols and procedures you have to follow," Mr. Lee says.

While the policies may interrupt or complicate workflows, the procedures need to be followed to mitigate the risk of infection, Mr. Lee says. "[Under] no circumstance let your guard down on infection control guidelines and processes."

3. Conduct a risk assessment. A key step in reducing infection control in construction is to develop a risk assessment matrix that identifies the level of risk associated with each type of construction. A Joint Commission's policy states, "For all construction projects in a healthcare facility, the risk of construction-induced infection shall be assessed and potential patient impact identified and controlled," Mr. Lee says.

The assessment should include fire safety, air quality, utility impacts, noise, vibration and other hazards. "[This] is a critical part of the process. It's not just a process for the architect or the contactor or users of the facility, but the whole team," Mr. Lee says.

4. Choose materials wisely. The materials healthcare organizations choose for renovations, expansions or new buildings can significantly impact the organizations' ability to prevent and control infections. For example, copper is safer than stainless steel because superbugs cannot live in any scratches, as they do with stainless steel, according to Mr. Lee. One recent study found antimicrobial copper surfaces in intensive care unit rooms reduced the amount of bacteria in the rooms by 97 percent and resulted in a 41 percent reduction in hospital-acquired infection rates. Although copper is not appropriate for an operating room, it can be used as countertops, sink areas and other areas outside the OR.

In addition, carpets can be cleaned as easily and thoroughly and contain as little bacteria as hard surfaces, Mr. Lee says. Choosing carpets instead of hard surfaces may thus create a more comfortable environment for patients without increasing the risk of infection, he says.

As health IT systems such as electronic medical records and computerized physician order entry become more prevalent in healthcare facilities, healthcare leaders should consider materials designed to facilitate cleaning of electronics. For example, Mr. Lee says there are keyboards that can completely detach from equipment and computers and that these keyboards can be laundered at high temperatures or put in an autoclave for sterilization. "So many germs and bacteria are transmitted by hands, so for this reason, hospitals should be looking at these keyboards," he says.

5. Consider infection control-friendly designs. Design of healthcare facilities can also aid infection control efforts by making infection control resources easily accessible. "[It's] important that the architect and designer work together to plan medical space that supports and encourages frequent handwashing," Mr. Lee says.

Besides strategic placement of hand sanitizers, the location and number of sinks may affect infection control. "Too often sinks are put back in corners and not where physicians want to go to wash their hands," Mr. Lee says. "They want to be talking to the patient and within eyesight and [hearing] of the patient, so the location of sinks within patient rooms is extremely important." ■

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