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6 Ways to Decrease Sharps Injuries and Needle Sticks in the OR

By Rachel Fields

Sharps injuries and needle sticks are a significant hazard in the operating room, and providers who don't comply with prevention practices can endanger themselves, their colleagues and their patients. Mary J. Ogg, MSN, RN, CNOR, sharps expert with the Association of peri-Operative Registered Nurses, discusses six ways facilities can decrease the incidence of sharps injury in the operating room.

1. Double-glove. Ms. Ogg says double-gloving, or wearing two pairs of surgical gloves, can reduce the incidence of sharps injuries and needle

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Hand Hygiene Checklist: 5 Suggestions for Process Improvement

By Rob Kurtz

Despite significant changes in infection prevention practices since the introduction of the CMS Conditions for Coverage requirements, hand hygiene practices continue to be inconsistent and fall short of infection prevention expectations, says Phenelle Segal, RN CIC, president of Infection Control Consulting Services based in Blue Bell, Pa.

During personalized on-site visits to several ASCs for the purpose of assessing best practices either before or after facilities surveys have been conducted, Ms. Segal says hand hygiene practices range from totally lacking to various inconsistencies resulting in the possibility of compromising patient safety. "The CMS surveyor's worksheet highlights the areas that the surveyors will concentrate on during a state visit," says Ms. Segal. "However, there is a lot more to hand hygiene that should be addressed by staff members."

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10 Steps for Preventing C. Diff Outbreaks

By Laura Miller

An outbreak of *Clostridium difficile* (*C. diff*) in a healthcare facility can cause higher death rates, increased length of stay and add stress on lab testing services. "All of these factors place a higher burden on our scarce health resources," says Irena Kenneley, PhD, APRN-BC, CIC, an assistant professor at Case Western Reserve University and expert with the Association for Professionals in Infection Control. She discusses 10 steps healthcare providers can take to prevent a *C. diff* outbreak in their facilities.

1. Place patient in contact precautions for the duration of illness. When a patient is diagnosed with *C. diff*, the facility should place the patient in contact precautions at least for the duration of the diarrhea. There are some studies underway that suggest keeping patients in contact precautions for 48 hours after the cessation of diarrhea and antibiotic therapy because it has been shown that patients may continue to shed the bacteria in their stool for two days after the condition is under control, says Dr. Kenneley.

2. Monitor that hand hygiene is in compliance with CDC/WHO guidelines. Make sure your staff and facility is practicing good hand hygiene

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6 Ways to Decrease Sharps Injuries and Needle Sticks in the OR (continued from page 1)

sticks. Some providers are reluctant to wear two pairs of gloves because they feel double-gloving decreases sensitivity, so facilities should take time to educate physicians on the importance of the practice. Fortunately, a staff member's decision to double-glove does not require buy-in from another provider, meaning the practice is relatively easy to spread throughout a team even if some members remain uncommitted.

2. Use blunt-tip suture needles. Blunt-tip suture needles are proven to be safe and effective, but providers sometimes shun the practice because they are used to working with sharp suture needles. Ms. Ogg says there are some misconceptions about the efficacy of blunt-tip suture needles among the physician population. "They don't think they glide through the tissue as easily, but the newer ones do," she says. "There are many situations where [blunt-tip suture needles] would be a good alternative if the physicians will try it."

3. Close incisions without sutures. Ms. Ogg says there are various ways of closing an incision without using a suture. She says typically, when a provider closes the skin, he or she uses a cutting

needle that's sharper and more likely to injure someone. Newer adhesives can close the skin incision without a needle, and staples can also provide a safe alternative to sharps, when appropriate.


4. Implement a "safe zone." Providers can reduce the likelihood of sharps injuries by implementing a "safe zone," or an area where sharps and needles are placed to be picked up by the next provider. This "safe zone" eliminates the need to pass a sharp object directly to a staff member, decreasing the chance of injury. "Instead of handing the scalpel blade into the surgeon's hand, you put it in the neutral zone and they pick it up," she says.

5. Use safety-engineered devices. Ms. Ogg says new and improved safety-engineered devices are constantly being manufactured. Safety-engineered devices are designed to prevent injuries and exposures to blood borne pathogens in the healthcare setting, and the list includes injection devices, IV insertion equipment, surgical scalpels, lancets and a host of other devices. Ms. Ogg says there has been some resistance from surgeons when trying to introduce safety-engineered devices, in part because the devices are different from the instruments the physicians are used to. "The first generation [of devices]

didn't have the same look and feel of the more typical scalpel with the blade," she says. However, she believes the devices are improving with every release, and physicians willing to try the instruments will find they are pleasantly surprised.

6. Use data to convince physicians. Physicians may be hesitant to adopt practices that decrease the incidence of sharps injuries and needle sticks, but Ms. Ogg says providing hard numbers in support of the practices can help. AORN has developed a 30-slide educational PowerPoint presentation that demonstrates the effectiveness of the practices with data. "Surgeons are more receptive to seeing evidence rather than just being told they should do this," Ms. Ogg says. The AORN toolkit on sharps injuries and needle sticks also includes a letter from retired surgeon Mark Davis, MD, that explains when a physician ignores best practices for preventing injuries, he or she puts every member of the surgical team at risk. Ms. Ogg recommends using data and testimony from other respected physicians to convince providers that the prevention practices are worthwhile and necessary. ■


AORN toolkits on sharps injuries and needle stick prevention are available to members. Learn more about AORN membership at www.aorn.org/membership/.



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Hand Hygiene Checklist: 5 Suggestions for Process Improvement (continued from page 1)

She says it is critical for staff members to assess systems in place to ensure adequate hand hygiene. This includes recognizing and identifying barriers. Ms. Segal has identified issues in three main areas of the facilities that she has visited — the preoperative or holding area, the anesthesia staff within the operating room suite and the post-procedure recovery area. She identified the following barriers:

- Lack of availability of hand hygiene products (alcohol hand sanitizer dispensers or individual pump bottles) and handwashing facilities (sinks, running water and soap)
- Misconception that staff members who scrub on a case are the only ones required to perform hand hygiene
- Ignorance of guidelines or lack of ongoing education
- Forgetfulness or “I just wasn’t thinking”
- Rapid turnover of procedures and high workload
- Inadequate monitoring (covert or overt) and subsequent feedback to staff

Here is a checklist from Ms. Segal of five suggestions ASCs can follow to help ensure processes are in place (or strategies for improvement) to ensure patient safety from the time that patients enter the facility to the time they leave.

1. Provide ongoing education for all staff members including competencies. Education can be undertaken in many different ways including live in-services, webinars, audio-conferences or online training, Ms. Segal says. Facility determined competencies/ assessments for clinical staff should include a skills checklist addressing hand hygiene knowledge and practices. Education should include all clinical staff and those providing direct patient care.

2. Provide staff with The World Health Organization's “My 5 Moments of Hand Hygiene”, which defines the key moments when healthcare workers should perform hand hygiene. This includes the following:

- Before touching a patient
- Before clean/aseptic procedures (such as anesthesia services)

- After body fluid exposure/risk
- After touching a patient
- After touching patient surroundings

3. Make hand hygiene easy by providing adequate opportunities for handwashing and use of alcohol based hand sanitizers. Sinks should be placed in strategic locations and supplies such as soap and paper towels should be provided at all times, Ms. Segal says. “Alcohol hand sanitizer products should be user friendly, available at all times and strategically placed throughout the facility, particularly in clinical areas and high demand locations,” she says.

4. Introduce hand-hygiene monitoring programs. Tools for monitoring hand-hygiene compliance are available in various forms and include the use of “secret shoppers,” i.e., a covert observation whereby no one but the person appointing the observer and the observer him/herself knows who is conducting the monitoring, or an overt observation whereby all staff members are aware of the person conducting the observation, Ms. Segal says.

5. Holding staff accountable by providing feedback from monitoring programs. “Staff should be informed of the findings from ongoing monitoring programs and should be provided the opportunity to improve practice by providing resources, educational opportunities and one-on-one consultation,” Ms. Segal says. ■

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10 Steps for Preventing *C. Diff* Outbreaks (continued from page 1)

practices that comply with the Center for Disease Control and Prevention and World Health Organization guidelines. Ensure that all medical professionals and family members who are in contact with the patient or patient's environment are practicing good hand washing technique and infection control protocols.

3. Cleaning and disinfection of equipment in the environment. Pay extra attention to ensure the proper disinfection processes are followed with the equipment that come in contact with a *C. diff* patient. "Generally speaking, if we know that the patient's had *C. diff*, we use bleach for the duration of the patient's stay," says Dr. Kenneley. It's important to use bleach instead of soap and water rather than an alcohol rub for combating *C. diff* because the organism is able to form spores which allow it to survive in hostile environments.

"Bleach has been shown to eliminate spores," says Dr. Kenneley. "There is some debate as to this topic, but it's been generally accepted by most practitioners."

4. Have a lab-based alert system in place. The sooner everyone knows a patient has *C. diff*, the sooner they can take the necessary precautions to prevent it from spreading further. Depending on the size and type of facility, the alerts may be issued through an electronic system or initiated by the laboratory personnel. "Everyone should be alerted when a patient has *C. diff* as soon as possible so they can take the appropriate precautions and place them in isolation," says Dr. Kenneley.

5. Appoint infection preventionists to promote *C. diff* education. Surgical facilities should have an infection preventionist or staff member who is an expert in infection control to ensure compliance with protocol and administer education about infection prevention. These staff members should provide education for the housekeeping staff, administration, patients and families about *C. diff*. They may want to use charts or picture to illustrate the infection and disinfection and hygiene process to decrease the risk of spreading the infection.

"APIC has produced some tremendously valuable education materials," says Dr. Kenneley. "You can also provide housekeeping and nursing staff with check lists detailing whether surfaces have been cleaned or not."

6. Evaluate and optimize surveillance and testing for *C. diff*. When nurses detect symptoms of *C. diff* in undiagnosed patients, they should have the ability to collect specimens and send them to the lab for testing. "Nurses need to be empowered to collect these specimens, and many times they are not," says Dr. Kenneley. "The institutions need to realize this and streamline the process of sending the specimens down to the lab." Once the specimens are in the lab, there should be an internal process for a swift and efficient evaluation. If the situation warrants, many times patients with diarrhea are placed in contact isolation based on a presumptive diagnosis pending confirmation by the microbiology lab.

7. Implement soap and water hand hygiene. Strategically place sinks or washing stations with soap and water near the entrance or just inside the patient's room so it's available for anyone entering and exiting the room. Newer facilities are often designed with sinks right next to the door, while some older facilities have placed hand washing stations just outside of the rooms.

"If it's not economically feasible for a facility to rearrange their sinks, they can post reminders around the area so staff members remember to wash their hands," Dr. Kenneley says.

8. Use bleach for cleaning the room. Cleaning staff should use bleach when cleaning the rooms of patients with *C. diff*, especially when the patient is discharged, known as terminal cleaning. Facilities can often mix their own bleach and water combination to prevent spreading the disease. To ensure the employees are cleaning the rooms appropriately, use a fluorescent light to detect surfaces that are still infected after an area has been "cleaned."

"When employees know how well they are or are not doing, they have a way to know whether they need to improve or continue doing their good work," says Dr. Kenneley.

9. Execute an antimicrobial stewardship program. *C. diff* often occurs when patients are prescribed an antibiotic within the past three months. Healthcare facilities can create a multidisciplinary program to ensure patients are being administered the appropriate types and amounts of antibiotics. "For these programs, the infections disease physician, infection preventionist, pharmacist, medical director and the director of nursing all get together to make sure antibiotics are used appropriately at the institution," says Dr. Kenneley.

10. Enforce a universal glove policy on high risk units. High risk groups for contracting *C. diff* are elderly and young patients, surgical wards and those who have been hospitalized for an extended period of time. Facilities can implement a policy to make sure everyone is wearing protective gloves in these units or other high risk areas as a further way to combat an outbreak. ■

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Peer Review: 10 Things to Know

By Rob Kurtz

Nancy Jo Vinson, RN, BA, CASC, of NJM Consulting recently joined the consulting team of Healthcare Consultants International, a subsidiary of the Accreditation Association for Ambulatory Health Care.

She discusses 10 things ambulatory surgery centers should know about peer review.

1. More than just retrospective clinical review. The most common misconception about peer review is that it's just a retrospective clinical review. "It's really a process that's an interrelated series of actions, events and steps," says Ms. Vinson. "It has to be goal-directed to evaluate the provider."

2. Needs to involve the medical staff in the establishment of peer review activities. When developing a peer review policy and procedure, physicians must look and provide feedback on the criteria that will be used for peer review. "They need to be involved in the establishment of the process," Ms. Vinson says. "They have to identify acceptable or unacceptable occurrences that effect patient outcomes."

3. Many elements should be considered as criteria. ASCs should consider many different elements during the peer review process. Ms. Vinson says these can include the following:

- Post-op infections
- Adverse drug utilizations
- Improper drug utilizations
- Surgical and unplanned outcomes
- Hospital transfers or admissions within 24 hours
- Sentinel events
- Malpractice claims
- Patient/staff complaints
- Cancellations on day of surgery (an excessive number might show inappropriate scheduling of patients)
- Unplanned returns to the OR

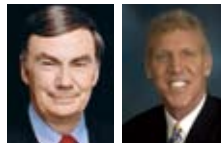
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Here are comments from 10 attendees of previous ASC conferences:

1. John Fontana, MD, Surgery Center of Beaufort: "I attended the June conference with our center's administrator. It was a GREAT conference! We found the topics relevant and more importantly they stimulated thoughts about improving our center. I have not previously been to an ASC Communications conference but will be attending another soon."

2. William Maloney, MD, MPH SportsHealth: "I was impressed by the wide range of topics for the beginner to the experienced, and the many well-known experts who presented them. I highly recommend the conference to any individual or organization in the ASC space."

3. Ramon Garcia, MD, Chicago Endoscopy Center: "I had a very enjoyable time at the conference, met very interesting and important individuals who I am now starting to do business with. I plan to be back."

4. Lee Carlisle, MD, MARC Day Surgery Center: "I have to tell you that the ASC Communications conferences are my favorite. I find it the perfect combination of clinical and administrative topics. It has been so beneficial to attend

these conferences to ensure that the direction is which we are going is the correct one. The ASC Communications conferences reinforce my facility's current practices as well as help identify opportunities for improvements. I am already planning on attending the conference in October."

5. Kenneth Pettine, MD, Loveland Surgery Center: "I have reviewed the meeting itinerary for October and have concluded if you are going to attend one meeting of the year to learn how to make your ASC function better and anticipate the future, THIS is the meeting. The chance to network will be unsurpassed!"

6. Basil Besh, MD, Precision SurgiCenter: "This is the ambulatory surgery center conference to attend! All others pale in comparison. Perfect combination of economics, operations and predictions for the future, not to mention great guest speakers."

7. Vicki Aten, First SurgiCenter: "This was one of the best, if not the best conference I have attended. I came back and told our medical director he really needed to go to this next year. I have tons of notes I now need to find time to go through!"

8. Rose Lopez, Midtown Outpatient Surgery Center: "I come from a hospital setting and am new to the ASC environment. The conference provided some helpful ideas on how to run the center in a more efficient and profitable way. I'm looking forward to the next conference."

9. Victoria Caillet, Wooster Ambulatory Surgery Center: "I attended the conference three years ago prior to our ASC opening; the physician-owners thought it would help me get started. I returned this year and it was great to see what we do here reinforced with how other ASCs run. It makes me feel good that we are doing things right!"

10. Joy Moore, Oak Surgical Institute: "The presenters always provide professional and meaningful information. The opportunities for networking are endless at these events!"

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"These all could be included in peer review," she says. "That's why the medical staff has to identify what they want to look at to be comfortable with their peers to continue to have privileges at their center.

"Clinical record review is one element that is important because it can show if [the reviewed physician] is complying with the requirements of documentation," she says. "But it's important to remember that this is just one element and too many people look at that as the only element."

4. Criteria are tracked on a consistent basis. For effective peer review, ASCs must track the elements included in the peer review process on a consistent basis. "Being consistent means it is ongoing and not just at the time of reappointment to try to get just a recommendation," Ms. Vinson says. "Whether it's a risk management issue or you're tracking to see if a physician is complying with policies and procedures, you must be able to gather all of this together at the time of reappointment. You want to look at everything that affects how the healthcare professional is functioning."

5. Not just for physicians. For example, an RN who is giving conscious sedation should undergo peer review for that competency, Ms. Vinson says. "Peer review should be done for anyone

involved in specific privileges outside of a normal job description, such as conscious sedation," she says. "Peer review is utilized for appointment or reappointment for anyone who's privileged." Peer review for personnel may be included in their competencies or performance review.

6. Does not require same-specialty review. Ms. Vinson says there is a common misconception that peer review of a physician must be performed by someone in the same specialty as the reviewed physician. "That would be the optimal goal from a standpoint of familiarity, knowledge and the type of cases being reviewed," she says. "But if an ASC has just one physician in each specialty, then that's probably not going to be possible unless they incur a cost to hire someone and that is not a requirement. I know some centers have incurred those costs because they thought it was a mandate."

7. Understand requirements. ASCs should review their state regulations to see how peer review is protected and how it should be reported if there are issues, Ms. Vinson says. ASCs should also check their accreditation and licensure requirements concerning peer review.

8. Must be communicated to the governing body. CMS and the accreditation bodies check to make sure the ASC's governing body

is included in the peer review process. "The governing body needs to review [the peer review results] and make decisions if necessary for them to give final approval for reappointment of privileges," Ms. Vinson says. "For example, the governing body must decide if somebody is approved for knee arthroscopies. If that surgeon hasn't done one for three years, should that surgeon maintain those privileges?"

9. Documentation is critical. ASCs must document peer review and do so according to their state requirements, Ms. Vinson says. "ASCs are at-risk because of exposure and confidentiality," she says. "Sometimes it's required — or at least worthwhile — to get a legal opinion for how and when to document and how much documentation to provide at a meeting?"

10. Should be a positive experience. "Peer review is looking at how well a physician performs," Ms. Vinson says. "Peer review, at any level for a healthcare professional, is a positive input into the qualities the center is providing and one of the important ways to maintain that quality. The end to all of this is continuation of the provision of quality care." ■

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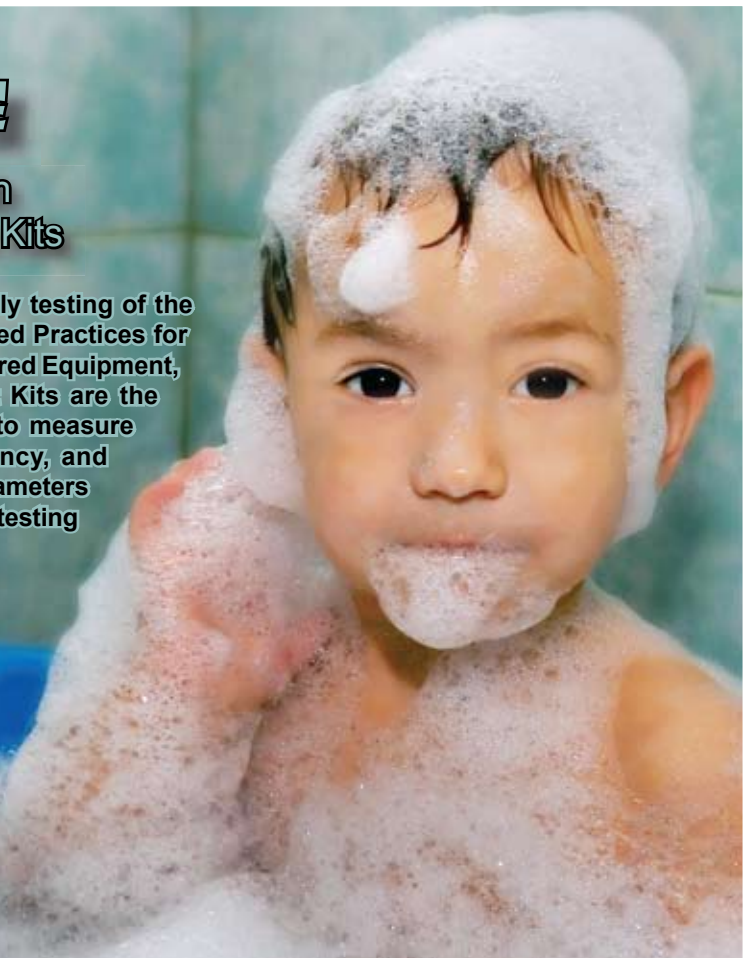
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14 Questions to Ask to Ensure Effective Patient Identification

By Rob Kurtz

Bernard McDonnell, DO, a retired physician and current surveyor for Healthcare Facilities Accreditation Program, identifies 14 questions surgery centers and other providers need to ask themselves to help ensure they perform proper patient identification before a procedure.

1. Do you use at least two identifiers? “The baseline is you always need to have a minimum of two identifiers,” says Dr. McDonnell. “You can’t just look at the patient’s bracelet. You need a name, maybe an ID number, phone number, date of birth, an address. There has to always, be at minimum, two identifiers.”

2. Do you always use the same identifiers? Standardize the identifiers you will use with every patient. “Don’t have everybody doing whatever they want to do,” he says. “Have a policy. Do it the same way every time. If you’re going to do name and ID number, do name and ID number each time.” *Note:* Never use room numbers as an identifier. This is because patients often change rooms, Dr. McDonnell says.

3. Are you involving the patient in the process? A critical component of an effective patient identification program is having the patient confirm the procedure and the side. It is important to note that this does not replace your identifiers. Confirming with the patient is in addition to the two or more identifiers.

4. Do you mark the site? “There needs to be patient involvement in that as well,” Dr. McDonnell says. “Use a thin marker and write ‘yes’ on, for example, the knee you’re going to do.”

5. Do your surgeons mark the site? “The surgeon must be involved — he or she must also mark that knee,” Dr. McDonnell says. “Often they put their initials.” *Note:* He says it’s also not a bad idea to have the nurse mark the site as well. “It might seem like overkill but it would never hurt.”

6. Are you taking additional steps to confirm proper site and side? This includes looking at the patient’s H&P, boarding and x-ray or MRI. “These will serve as further confirmation that it’s, for example, the right knee,” Dr. McDonnell says.

7. Do you have a policy that addresses what you do if there is a discrepancy? “What if everything says the right knee but the patient says it’s the left?” says Dr. McDonnell. “What do you do? You need to have a policy for that. You must be able to resolve that. If you can’t resolve it, cancel the case. If everything says right side and patient insists it’s the left side, I would say to bring the patient back another day. It’s better to have a canceled case than a wrong site surgery.”

8. Are you performing procedural timeouts for every case? This needs to happen in the OR before the patient is touched. “I would say the first thing you do is turn off music and don’t have any distracters,” he says. “Then you call the timeout. The timeout has to be called formally and that can’t vary. You can’t just have people not paying attention.

Everyone is quiet, everyone is paying attention to this. You go over the identifiers, confirm the side and the site, everybody agrees to the procedure you’re doing. Confirm you have what you need to do the case — do you have any implants you need, any special equipment, special drills? When everyone agrees, you can then start the case.”

9. Do you have a timeout policy? This should provide the exact steps the OR team will follow to ensure a proper timeout, steps that should never be deviated from.

10. Do you have a policy if there is a discrepancy during the timeout? Do you know how you would handle any disagreement about site or side? At this point the patient may be sedated. What steps will you take? You should have a policy to address this as well, Dr. McDonnell says.

11. If you do spine cases, how do you identify levels? Most cases will involve the left or right side but that is not the case for levels of the spine. “How do you note that you’re going to do an injection at L2/L3 or at L4/L5?” Dr. McDonnell says. “The identifier and verification has to include multiple levels in the spine. How do you make sure you’re going into the right area?” You need a policy addressing these cases.

12. Are your anesthesiologists involved in patient identification? Anesthesia should do its own identification when the patient is in receiving. “Anesthesiologists usually come and interview the patient and they do their own method of identifying the patient then,” Dr. McDonnell says. “But anesthesia should also then be a critical part of the formal timeout process. Everyone in the room should be a part of the timeout: surgeon, scrub nurse or scrub tech, circulating nurse, the anesthesiologist or CRNA, a resident — everyone is a part of it and everyone agrees on site and side before the procedure starts.”

13. Do you document that the timeout has been completed? “That’s always documented in the OR record,” Dr. McDonnell says. “While you’re not going to put every little detail in the OR record, you’re going to want to put that the timeout was completed and the time it was completed.” The OR record should also always have listed the people in the OR.

14. Is everything you do concerning patient identification standardized? “Standardization helps prevent mistakes,” Dr. McDonnell says. “And you can’t become complacent with this, ever. People do make mistakes and it’s because they’re cutting corners and they’re not following the steps listed here.” ■

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10 Good Ideas for Great Quality Improvement Studies

By Daren Smith, RN, Director of Clinical Services, for Surgical Management Professionals

Are you in charge of coming up with meaningful quality improvement studies for your facility? Has the idea well run dry? QI studies can be as simple or as complicated as you want to make them. Sometimes it just takes a spark to start the fire and positively impact quality of care or efficiency of your center.

Here are 10 good ideas topics your organization can turn into great, valuable QI studies. Remember, a good study becomes a great study by establishing clear goals, identifying measurable topics and producing a clean finished product full of visual data, which are components your accrediting body will likely look for when assessing your QI performance.

1. Employee satisfaction survey. Happy employees can correlate to happy patients and, in turn, happy investors. Query your staff on their satisfaction with the many aspects of their job. There are even reasonably priced vendors that manage the entire process for you. Your goal could be to increase the level of overall satisfaction of your staff or identify a couple of areas of concern and set a goal to improve in those areas.

2. Case costing. Identify a high-volume or high-cost procedure and perform a detailed case costing analysis. The goal of the study could be to reduce the supply cost of that particular case by certain percentage.

3. Instrument loss. Analyze your instrument replacement trends. A possible goal of the study would be to reduce instrument loss by a certain percentage.

4. Physician satisfaction survey. Measure the level of satisfaction with the many aspects of service you provide at your center. Once again, there are reasonably priced vendors that manage the entire process for you. The goal could be to identify areas of concern and increase the satisfaction level in those areas through process improvement.

5. Going green. Select an area of your center (business office, break room, housekeeping, etc.) and examine the environmental impact of the products used in the area. Craft a goal that reduces waste or converts a percentage of products to environmentally friendly products.

6. Inventory practices. Investigate your inventory processes (ordering, receiving, physical count, etc.). You can do a time study or a cost study and make a goal to improve either or both.

7. Registration time. Explore your registration process. Create a goal to reduce the time a patient spends in registration.

8. Instrument repairs. Examine your instrument repair expenses. Create a goal reduce the expense by a certain percentage or dollar amount through process improvement or contract renegotiation.

9. Formulary reduction. Do you have medications in your formulary that are taking up valuable shelf space? Are they rarely used or are you stocking several medications that serve the same purpose? Conduct the investigation and set a goal to reduce your inventory.

10. Freight cost. Complete a freight cost analysis on your supply chain. The goal could be a simple as reduction of freight costs to the center. ■

Daren Smith RN is the director of clinical services for Surgical Management Professionals (www.surgicalmanprof.com), an organization of physicians and healthcare executives who have created a successful model for ambulatory surgical centers and physician owned surgical hospitals that embrace the concept of physician ownership and clinical leadership.

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Hand Cream Use in Instrument Reprocessing Department

By Rob Kurtz

Sharon A. Van Wicklin, MSN, RN, CNOR/CRN-EA, CPSN, PLNC, is perioperative nursing specialist with the Association of periOperative Registered Nurses.

Q: Can you tell me if hand cream is allowed in the instrument reprocessing department?

Sharon A. Van Wicklin: According to AORN's 2011 Standards and Recommended

Practices, "Recommended practices for hand hygiene in the perioperative setting,"

Recommendation 1: "All health care personnel should follow established hand hygiene practices for maintaining healthy skin and fingernail condition..."

• Health care organization-approved hand lotions should be readily available and used frequently

to maintain good hand skin condition following surgical hand hygiene. Skin irritation and dermatitis from frequent hand washing can increase the risk of infection for both the health care worker and the patient. Failure to follow practices that maintain intact skin may create breaks in intact epithelium, which compromises the barrier properties of the skin and presents the opportunity for microbial transmission into the tissues.

• Lotions selected for use in the perioperative setting should be evaluated and approved by an interdisciplinary group that has the designated authority to evaluate and select hand lotions.

• Hand lotions used in the perioperative setting should

o be compatible with antiseptics and barrier products in use,

o list water as the first ingredient on the label,

o contain no anionic-based materials or chemicals, and


o contain no petroleum or other ingredients with a demonstrated detrimental effect on the barrier properties of gloves in use.

Many lotions found in over-the-counter products contain an anionic based ingredient that interferes with the residual effect of chlorhexidine gluconate and chloroxylenol. Chlorhexidine gluconate and chloroxylenol are in many hand antiseptic products used in health care organizations for their antiseptic properties. Petroleum may affect the barrier properties of latex gloves that may be worn by health care personnel. A study on latex glove compatibility has shown petroleum to have adverse effects on the integrity of latex gloves. Some gloves have been demonstrated to be compatible with some lotions" (pp. 74-75).

However, using hand lotion in the instrument reprocessing department may be problematic if it is transferred to surgical instruments during handling and subsequently prevents the sterilizing/disinfecting agents from penetrating and killing the microorganisms.

This situation should be approved by the facility infection prevention personnel. If lotion is determined to be acceptable, it should be stored away from designated instrument reprocessing areas and near areas where hand hygiene is performed. Many of the alcohol foams contain skin protective agents. ■

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8 Ways for Surgery Centers to Reduce Look-Alike/Sound-Alike Drug Errors

By Rob Kurtz

Blue Chip Surgical Partners Vice President of Operations Regina E. Dolsen, RN, BSN, MA, outlines eight steps ambulatory surgery centers can take to reduce the likelihood of errors with look-alike/sound-alike drugs.

1. Establish color-coding system. It is worthwhile for ASCs to put in the time and efforts to create a labeling system with a variety of color codes to help ensure visual identification of medications and reduce the likelihood of mix-ups, Ms. Dolsen says. "The use of a labeling system in all areas within the ASC, such as carts, cabinets, narcotic cabinets, etc., provides consistency for staff and clarity," she says.

2. Separate medications similar in appearance. ASCs should identify the medications that are packaged in a similar manner or are similar in coloring and appearance, she says. "I would recommend [ASCs] organize these medications in locations such that items of the same color or packaging are not next to each other," Ms. Dolsen says.

3. Don't default to alphabetical organization. While it might be the easiest way to organize medications, using an alphabetical system could potentially increase the chance of errors. "Often, use of alphabetic organization is not the best practice," says Ms. Dolsen. "Organization of medications on the shelves, drawers, etc., so that items with the same or similar names are not next to each other is helpful."

4. Use online resources. The Food and Drug Administration and Institute for Safe Medication Practices websites (www.fda.gov and www.ismp.org) are great sources for examples and listings of the medications commonly referred to as look-alike/sound-alike drugs, Ms. Dolsen says. "The listings help ASCs identify their confusing medications and their specific look-alike medications," she says. "The Joint Commission website (www.jointcommission.org) also has information related to this topic."

5. Use "tall man" letters. The use of tall man lettering is another recommendation from Ms. Dolsen for highlighting medications that are similar. "Several studies have shown that highlighting sections of drug names using tall man letters can help distinguish similar drug names, making them less prone to mix-ups," she says. "FDA, ISMP, The Joint Commission and other safety-conscious organizations have promoted the use of tall man letters as one means of reducing confusion between similar drug names."

6. Make center-specific list of drugs. ASC leadership should work proactively to educate its staff to the center's specific medications that may appear confusing or are on the ISMP list. "Post a list that you have tailored to your specific center-approved medications in your medication area," Ms. Dolsen says. "This list, not the list you obtain from FDA or ISMP, will be pertinent to your center and your staff. Make a concentrated effort to keep this list accurate and current."

7. Seek out and utilize additional educational resources. Ms. Dolsen says ASCs should proactively educate their staff and physicians by finding and using resources available outside the facility. "There are a variety of alerts and resource articles that you can post to help educate staff and physicians," she says. "These postings help keep the information in front of the staff and keep them current."

8. Include medication errors in your QI program. "Medication error reduction programs and monitoring medication errors, included as part of the ASC's quality improvement program, are opportunities for ongoing management of this patient safety issue," says Ms. Dolsen. ■

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