



Two teams, one shared goal

Gastroenterology and infection prevention colleagues partner for patient safety

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Gastrointestinal (GI) endoscopes represent a valuable diagnostic and therapeutic tool for our patient populations. Within the United States, approximately 11 million GI endoscopies are performed yearly, and this number is expected to increase.¹ Due to the intricate design (e.g., long narrow lumens, hinges), endoscopes can be difficult to clean and high-level disinfect or sterilize.²⁻⁵ More healthcare-associated infections (HAIs) have been linked with the use of contaminated endoscopes than to any other medical device, and endoscope contamination has been listed in ERIC's top 10 technology hazards for patients over the last several years.^{2,6}

In order to prevent HAIs associated with contaminated endoscopes, special attention to reprocessing technique is required, as cleaning represents a multistep process and is critical to ensure that subsequent processing steps can be effective.^{1-3,7,8}

Unfortunately, recent audits and outbreak scenarios have shown that lapses continue despite the existence of reprocessing and infection prevention and control guidelines.^{9,10}

To ensure that reprocessing personnel are properly trained, initial infection prevention and control orientation and reprocessing competency should be completed. Competency review

and infection control updates should be validated and documented annually. For new models of endoscopes, accessories, valves, and automatic endoscope reprocessors, competency reviews should occur as soon as they are introduced in the facility.^{1-3,7,8}

A unique program and a model of teamwork

Appropriate knowledge and skills are not the only critical factors to prevent infections in GI settings. Establishing a comprehensive reprocessing program can be challenging; however promoting teamwork and building partnerships will provide the necessary structure for a successful infection prevention program. APIC acknowledges the significance of teamwork and partnerships to guide current and future practice. This concept is expressed in Domain 4 of the Competency Model for Infection Preventionist (IP), stressing the importance of performance improvement and implementation science in achieving goals and accomplishing improvements.¹¹ The Society of Gastroenterology Nurses and Associates (SGNA) also recognizes the same value of teamwork and partnerships, and created the Infection Prevention Champions Program to ensure the safest and most current





The Infection Champions team from Northside Hospital carefully examine the endoscope storage cabinets.

reprocessing practices are being followed.

The SGNA Infection Prevention Champions Program presents a systematic approach to evaluating current practices and formulating an improvement plan for each participating facility. SGNA Champions, who are selected to the program, serve as ambassadors who are committed to educating themselves and their staff on infection prevention topics. They are charged with maintaining high quality control within the endoscopy arena, and addressing performance improvement needs.¹² Because no two healthcare organizations are operated in the same manner, healthcare organizations that want to become involved in the program have flexible options for participation. More information on the program is available at www.sgna.org/Issues/Infection-Prevention/Become-A-Champion.

APIC and SGNA interviewed an Infection Prevention Champion team at Northside Hospital in Atlanta to understand what features of the program have contributed to success.

The impetus for applying

Betty McGinty, MSHSA, RN, CGRN, director of gastroenterology services, knew that the program was “a must” for Northside Hospital’s seven endoscopy unit GI service line after having a positive experience with the pilot program in 2013. “Although I



Betty McGinty

was originally assigned one champion to the entire service line, the benefit of having a champion to represent each endoscopy unit was soon realized, especially in the wake of transmission risks associated with carbapenem-resistant Enterobacteriaceae (CRE) and duodenoscopes used during endoscopic retrograde cholangiopancreatography, or ERCP,” she said. Participating facilities generally choose one champion at a time. However, participating facilities may choose to designate more than one champion. Each champion must fulfill certain criteria (e.g., RN, LPN or GI tech working at



Beth Morrow

in planning the care of infectious patients from the waiting room through the GI Lab process. Through this collaboration, the staff is able to focus on components that increase patient and staff safety, as well as staff satisfaction.”

The focus on infection prevention in conjunction with the attention to endoscope reprocessing education has resulted in increased satisfaction of the staff, said McGinty. “Additionally, there has been a reduction in endoscope repairs at Northside.”

The SGNA Infection Prevention Champions Program outlines the importance of taking responsibility for one’s own practice within the endoscopy setting, leadership skills, and the desire and ability to teach others. McGinty proudly shared: “The staff in the champions role have grown in their abilities to make in-service and poster presentations, and to have a higher level of accountability for their practice. They receive recognition for their participation through a merit process, and the collaboration has strengthened the relationship and ties with our infection prevention department.”

Betty McGinty reviews a key function of the automated endoscope reprocessor (AER) with fellow Infection Champion team members Beth Morrow and Kelly Shields.

least part-time in the field of GI/endoscopy, completion of SGNA validation education modules, etc.).¹²

Kelly Shields, BS-B/M, interventional GI coordinator, noted, “The idea of partnering with an organization like SGNA, as well as working with the hospital’s infection prevention department, was very appealing to me. With such a busy GI lab and so many moving parts, a focus on infection prevention would be exactly what our department needed!”



Kelly Shields

practice changes. This concept is also conveyed in the APIC IP Competency Model and in the SGNA Infection Prevention Champions Program as a

baseline review to identify gaps in reprocessing. Equally important, according to the APIC IP Competency Model, is the selection of a clinical champion and executive sponsor whose responsibilities include removal of barriers and allocation of resources.⁶

“The increased infection prevention focus of the staff has motivated them to gain more knowledge regarding HAIs and infectious diseases,” said Beth Morrow, MSN, RN, CIC, GCNS-BC, Northside Hospital’s clinic nurse specialist for infection prevention and APIC member. “The GI staff has engaged infection prevention to assist

Positive changes in practice

Performing an assessment of the existing reprocessing program and identifying the current needs are important in order to sustain positive

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In addition to strengthening infection prevention relationships, Shields also noted that resources and support provided by SGNA were critical. It influenced the amount of success and positive practice changes they experienced. The guidelines and structure of the program allowed for a thorough evaluation, based on needs, as well as providing the tools to implement changes. As a result, Northside has implemented many changes, including a higher focus on scope handling and reprocessing, and standards for the care and transport of isolation patients.

Barriers and challenges

As with any program implementation project, barriers and challenges exist. According to the APIC IP Competency Model, it is imperative to identify barriers in order to successfully implement

and provide innovative approaches. This is accomplished by the identification and critical analysis of scientific evidence, and through synthesis of interventions with the greatest benefit.⁴ Morrow found that one such barrier was the historical perception of the infection prevention department. People perceived infection prevention staff members as “individuals who rounded once in a while and told us what was wrong.” By embracing the Infection Prevention Champions Program, Northside Hospital paved the way for a great partnership between the infection prevention department and the GI team.

Shields also expressed the importance of leadership support in overcoming barriers related to finding time to work on the program in a busy GI lab, “With the support of leadership this [barriers] can easily be overcome!”

Supporting collaboration

Great partnerships are the building blocks of collaboration; they pave the way for successful implementation and promotes sustained change.

McGinty has embraced collaboration by inviting an infection preventionist to be part of the GI leadership meetings held at Northside each month. “Having the ability to address specific questions or issues related to infection prevention within the practice environment is helpful to our specialty, further enhancing the collaborative arena,” she said.

From the infection prevention perspective, Morrow believes the whole team has been empowered to collaborate. “This collaboration has enabled the infection prevention champion to promote policy or procedure changes in keeping with evidence-based guidelines,” she noted.

Shields truly appreciates the team mentality aspect and feels supported by the infection prevention department at Northside Hospital. “Through a partnership, we have learned to work collaboratively in determining infection prevention processes that are not only effective, but also efficient and realistic,” she said.

As partners in collaboration, both APIC and SGNA serve as champions to ensure a safe culture to prevent HAIs, paving the way for implementation and sustained change. As part of APIC’s commitment to collaboration and partnering with relevant stakeholders such as SGNA, an APIC Practice Guidance Committee liaison has been established for dialogue and brainstorming on how the organizations can work together. **B**

Darlene Carey currently serves as the vice chair of the APIC Practice Guidance Committee and coordinator of infection prevention and control at Mayo Clinic Florida. Cynthia M. Friis, MD, BSN, RN-BC, serves as SGNA’s associate executive director of clinical affairs. Silvia Quevedo, MS, CCC-SLP, CAE, serves as APIC’s director of practice guidance.

References

1. Association for the Advancement of Medical Instrumentation. (2015). Flexible and Semi-Rigid Endoscope Processing in Health Care Facilities (ANSI/AAMI ST91: 2015). Arlington, VA.
2. 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. Accessed Feb. 24, 2016.
3. Society of Gastroenterology Nurses and Associates. (2015). Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes. Chicago, IL.
4. Edmiston C & Spencer M. (2014). Endoscope reprocessing in 2014: Why is the margin of safety so small? AORN Journal, 100(6), 609-615.
5. Rutala WA & Weber DJ. (2015). ERCP scopes: What can we do to prevent infections? Infection Control and Hospital Epidemiology, 36, 643-648.
6. ERI Institute. (2015). Top 10 Patient Safety Concerns for Healthcare Organizations. Plymouth Meeting, PA.
7. American Society for Gastrointestinal Endoscopy. (2014). Guidelines for safety in the gastrointestinal endoscopy unit. Gastrointestinal Endoscopy, 79(3), 363-372.
8. Society of Gastroenterology Nurses and Associates. (2015). Standard of Infection Prevention in the Gastroenterology Setting. Chicago, IL.
9. Barbosa JM, Souza ACS, Tipple AFV, Pimenta FC, LSNdO Leao, Silva SRMC. Endoscope reprocessing using glutaraldehyde in endoscopy services of Goiania, Brazil. Arq Gastroenterol 2010; 47:219-24.
10. Langlay AM, Ofstead CL, Mueller NJ, Tosh PK, Baron TH, Wetzler HP. (2013). Reported gastrointestinal endoscope reprocessing lapses: The tip of the iceberg. American Journal of Infection Control, 41(12), 1188-1194.
11. Murphy DM, Hanchett M, Olmstead RN, Farber MR, Lee TB, Haas JP & Streed SA. (2012). Competency in infection prevention: A conceptual approach to guide current and future practice. American Journal of Infection Control, 40, (4), 296-303.
12. Society of Gastroenterology Nurses and Associates. (2015). Champion Job Description. Retrieved from http://www.sgna.org/Portals/0/Issues/PDF/Infection-Prevention/Championjobdescriptionfinal_12_16_13.pdf



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