Heemstra, Sarah

From: Heemstra, Sarah
Sent: Tuesday, February 19, 2019 1:28 PM
To: Heemstra, Sarah
Subject: Infection Prevention Champions Program: Breaches - Part 2

Dear Champion,

Breaches in reprocessing and disinfection of endoscopes may result in transmission of viral and bacterial infections to patients. A breach is a failure to do what is expected or required, and in the endoscopy setting includes missed or improper reprocessing steps, use of improper chemicals, incorrect temperature or concentration, improper reprocessing of accessory equipment, re-use of single use items and faulty or improperly programed disinfection reprocessors (FDA, 2009; ASGE, 2016). While it is important to note that endoscopes can be a source for pathogenic cross-contamination, the environment is also a factor as disinfectants and cleaning materials can be contaminated or ineffective if not used according to manufacturer recommendations (SGNA, 2015). Also refer to the previous letter named Breaches- Part One.

What should you do when a breach is discovered? All breaches regardless of how minor should be reported to your manager/supervisor and infection control department who will investigate the event and determine if a breach did, in fact, occur. Once a breach has been verified, these individuals and departments must report breaches to local/state public health agencies, the Center for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA) and manufacturers of involved equipment and determine the risk to the patients involved. The ASGE Reprocessing Failure Guideline (2007) suggests that in cases where the risk is minimal, the institution should weigh the patients right-to-know with the possibility of causing unnecessary patient distress when determining if patients should be notified. It is important to keep a log to be able to identify patients in case notification is necessary. This log should include (SGNA, 2015):

a. the procedure date and time
b. the patients name and medical record number
c. the endoscopist
d. the endoscopes model and serial number or other identifier
e. the AER (if used) model and serial number or other identifier
f. the staff member(s) reprocessing the endoscope

Once the need for patient notification is established the following steps should be taken (ASGE, 2007):

1. Notify patients of breach and estimation of risk of infection in a timely manner
2. Develop a script to be used in the notification which includes information regarding risk, symptoms, transmission to others, treatment, and medical follow up
3. Document successful or attempted notification
4. Provide early baseline serologic testing and notification of results
5. Establish a toll free helpline to provide information to patients at risk
6. Offer personal counseling
7. Provide patient education regarding blood donation and prevention of transmission to others
8. Provide follow up testing

Infection Prevention

Infection Prevention Resources

Infection Prevention Breaking News

Pass It On!

SGNA

Connect with SGNA

Every effort should be made to follow reprocessing guidelines and avoid breaches. However, in the event that a breach is discovered, it is our ethical responsibility to report the event to our manager/supervisor and infection control department or contact person and take actions to correct the breach. Processes should also be put in place to prevent the breach from happening in the future. While endoscopy is considered safe, it is not without risk and it is up to us to ensure safe patient care by following best practice guidelines, identifying reprocessing breaches and reporting them in a timely manner.

Requirements should either be emailed to Champions@sgna.org or faxed to 312-673-6694 as due. The the upcoming assignments are as follows:

1. Review the ASGE *Reprocessing Failure Guideline* (2007) document on the Professional Society Guidelines page.
2. Review the Reprocessing Error and Event Reporting document under Tools for Champions (login needed) on the Best Practice Tools page.
3. Continue to develop and implement infection prevention education for your peers (total of 120 minutes)
4. Seek opportunities to educate yourself on infection prevention topics (total of 180 minutes).

These bi-monthly letters will be archived for you to access as needed. As always, SGNA is available for any questions or difficulties you may have.

Sincerely,
The SGNA Infection Prevention Work Group

References:

Multisocieyty guideline on Reprocessing Flexible GI endoscopes: Update 2016 https://www.sgna.org/Portals/0/MS_guideline_reprocessing_GI_endoscopes.pdf retrieved 2.10.2018

Federal Drug Administration (FDA), (2009). Preventing Cross-Contamination in Endoscope Processing Safety Communication from FDA, CDC, and the VA. Retrieved from http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm190273.htm.

Reprocessing failure [Guideline]. (2007). Gastrointestinal Endoscopy, 66(5): 869-871. Retrieved from http://www.asge.org/assets/0/71542/71544/CBC73C8C-6B81-4891-95CF-EEFB97C3A0B2.pdf.

SGNA.Standards of Infection Prevention in Reprocessing of Flexible Gastrointestinal Endoscopeswww.sgna.org.. retrieved 2.9.2018

The Infection Prevention Champions Program is generously supported by Boston Scientific.

Society of Gastroenterology Nurses and Associates, Inc.
330 North Wabash Avenue, Suite 2000 | Chicago, IL 60611-7621
P: 800/245-7462, In Illinois: 312/321-5165 | F: 312/673-6694