Who Goes in and Out of the Hospital Patient Room?

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METHODS: In August 2015, the State Health Department (SHD) de-veloped a standardized 3-page data collection worksheet to assess cleaning, high-level disinfection, and sterilization practices in am-bulatory care. The worksheet included questions on instrument design (e.g., hinged, plastic), timing of cleaning, biological moni-toring, instrument packaging, staff training, and maintenance records. The tool included yes/no, multiple choice, and free text fields. SHD staff administered the tool to clinic staff via phone interview or during a SHD site visit. Rationale for tool administration were prior reports of lapses in reprocessing and sites requesting a voluntary, consul-tative infection prevention visit. Data from the completed worksheets were imported into Excel and frequencies calculated.
RESULTS: From August 2015 to May 2016, SHD conducted a total of 26 assessments in standalone and hospital-affiliated clinics. The majority were completed via telephone (84.6%) and prompted by reports of infection control lapses (84.6%). Telephone interviews ranged from 20-45 minutes and on-site visit assessments from 30-60 minutes. Cleaning practice gaps included lack of instrument drying (15.4%) and visual inspection (34.6%). Infrequent staff train-ing was reported with 42.3% of the clinics offering training only upon hire. Additional gaps discovered were insufficient autoclave main-tenance, spore testing, and biologic testing.
CONCLUSIONS: Implementation of a data collection tool to capture cleaning, high-level disinfection, and sterilization practices is an ef-ficient way to identify reprocessing gaps in ambulatory care. Knowledge of these gaps can target education for ambulatory care. Administering the tool through the SHD allows for a broader char-acterization of community practices.

Session ADS-026
12:30-1:30 p.m.

What Happens When the FDA Recalls Frequently Used, High Risk Equipment?

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BACKGROUND: High level disinfection (HLD) is indicated for semi-critical items, such as endoscopes, that come in contact with mucous membranes and nonintact skin. Due to multiple outbreaks implicat-ing ERCP scopes, there was an increased focus on reprocessing and the role of the Automated Endoscope Reprocessors (AERs). On November 13, 2015 the FDA recommended that hospitals transition from using Custom Ultrasonics reprocessors for HLD of endoscopes. We describe the response to a recall of AERs used for HLD.
METHODS: Our first step in the response to the FDA recall was to conduct a Risk Assessment of all scopes reprocessed using the re-called AERs. The Risk Assessment focused on: volume and type of scopes reprocessed per AER; communicating with vendor and re-viewing Instructions For Use (IFU) for alternate ways to reprocess the scopes; feasibility of using alternative AERs or manual repro-cessing of scopes. Both short and long term interventions were initiated based on findings.
RESULTS: After careful review of the IFU for alternative HLD options it was determined that new AERs would need to be purchased. The new AERs did not fit into the old decontamination room. A long term plan was developed to relocate the decontamination and clean storage spaces to a renovated space in the existing Endoscopy suite, improving the overall workflow. An interim plan was developed to continue reprocessing lower risk scopes on existing AERs with ad-ditional QA checks to ensure sufficient HLD. All ERCP scopes were reprocessed using a rented FDA-approved AER.
CONCLUSIONS: Responding to an FDA recall is multi-faceted and requires coordination from Infection Prevention, Engineering, En-doscopy staff, Central Sterile, Leadership, as well as outside vendors. A recall can take many months of coordination, planning, and incur unexpected expenses. In order to ensure safe patient care, all identified risks must be mitigated prior to implementing a permanent solution.

Session ADS-027
12:30-1:30 p.m.

Who Goes in and Out of the Hospital Patient Room?

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BACKGROUND: The objective of this study was to determine what percentage of entries and exits (E/E) in and out of the patient room should be attributed to healthcare workers (HCWs) in a wide variety of hospital units. This is a critical question for hospitals consider-ing an automated monitoring system (AMS) to measure hand hygiene performance (HHP) as a complement to data from visual observa-tion. HCWs often implicate others and do not perceive a need to change their HH behavior because they are convinced that visi-tors, patients, and others are responsible for very low HHP data.
METHODS: Events (defined as patient room E/E) were observed and recorded by nurses not employed by the hospital. Observations were made in US and Canadian hospital units including emergency, ICU, medical surgical, oncology, and pediatrics. Observers classified events by: HCWs (e.g., nursing staff, aides, doctors, EVS, etc.), patients plus visitors, and other (e.g., clergy, hospice workers). Logistic regression was used to determine who was responsible for the most E/E events by category of individuals.
RESULTS: Observers recorded a total of 14,876 E/E events in 29 units of 16 hospitals with units varying in size from 10 to 41 beds. 84.3%of all E/E were attributed to HCWs; 15.0% were from patients plus visitors and 0.7% from others. The odds are 6 to 1 that an E/E into a patient room is by a HCW ($P < .0005$). Pediatric units had the lowest percentage of HCWs E/E (76.7% total).
CONCLUSIONS: This study demonstrates HCWs account for the greatest proportion of hospitalized patient room E/E. Further, the data show that others share a very small percentage of room E/E countering the argument that those individuals are responsible for the low unit HHP measured by AMS. This study demonstrates that other categories of individuals are not a deterrent to increas-ing unit-level HHP.