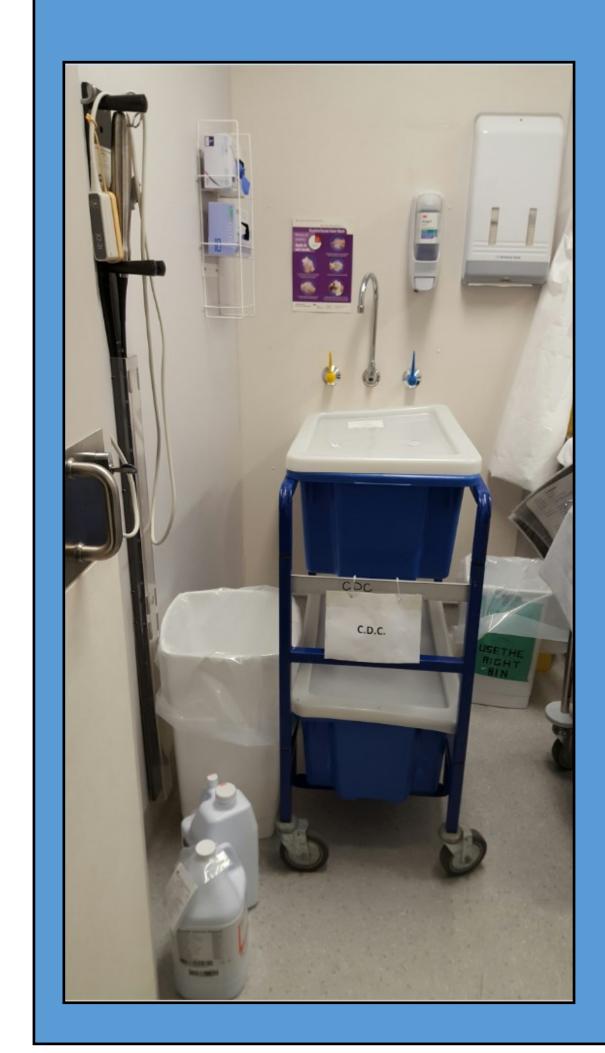
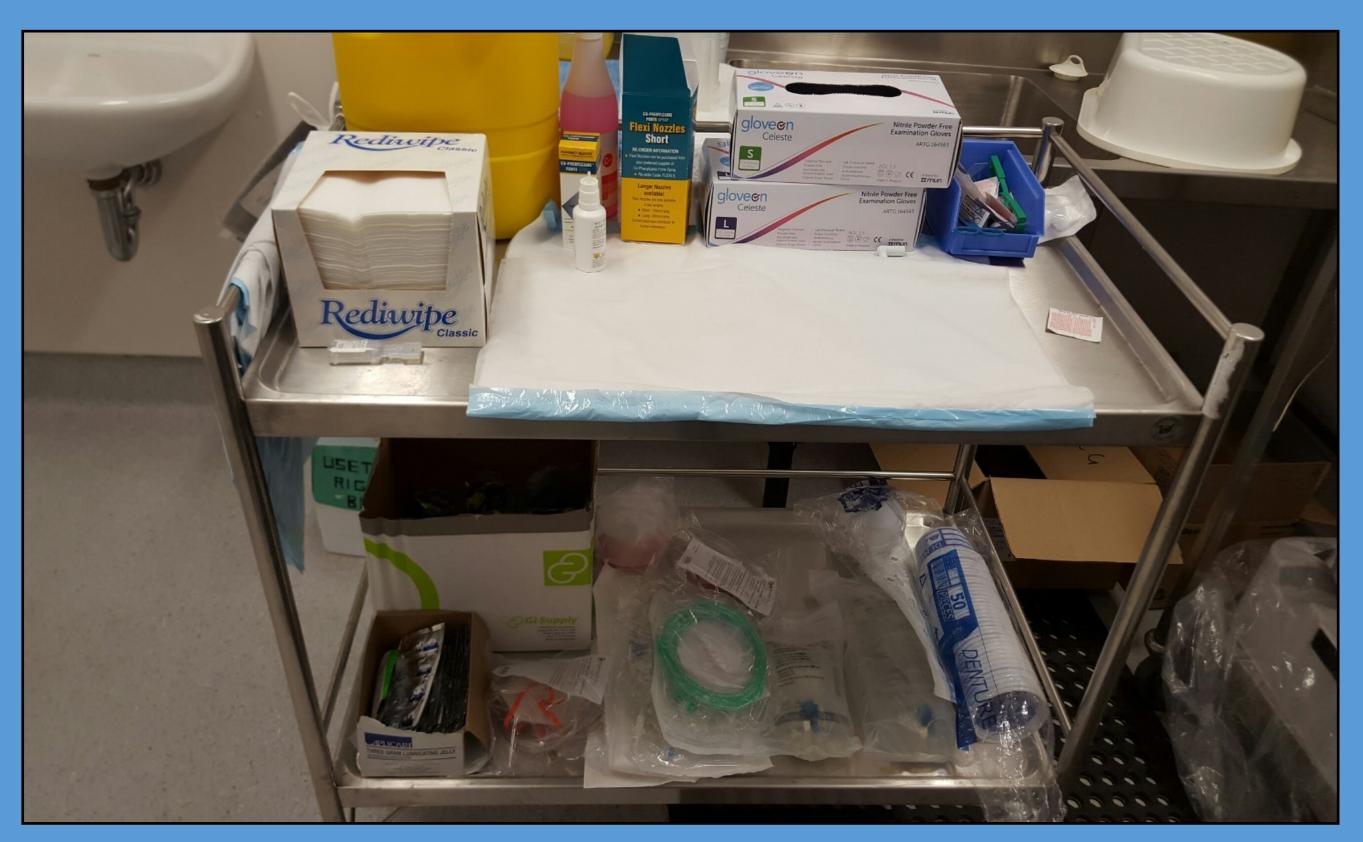
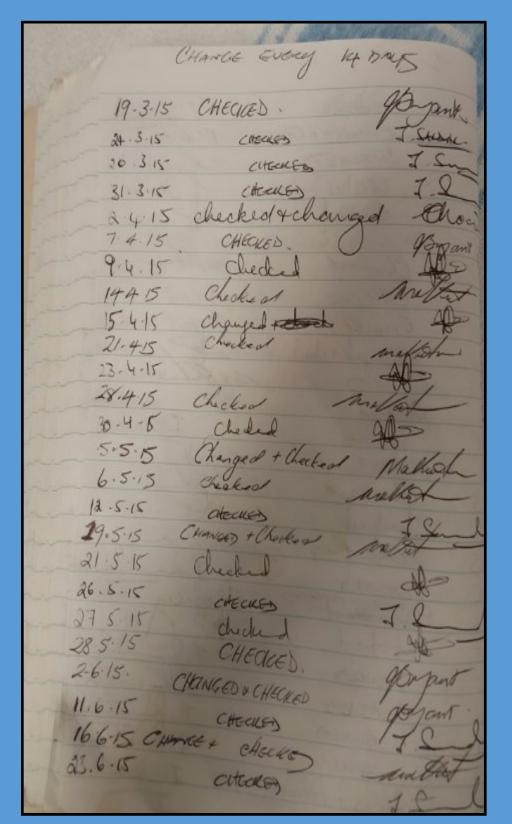
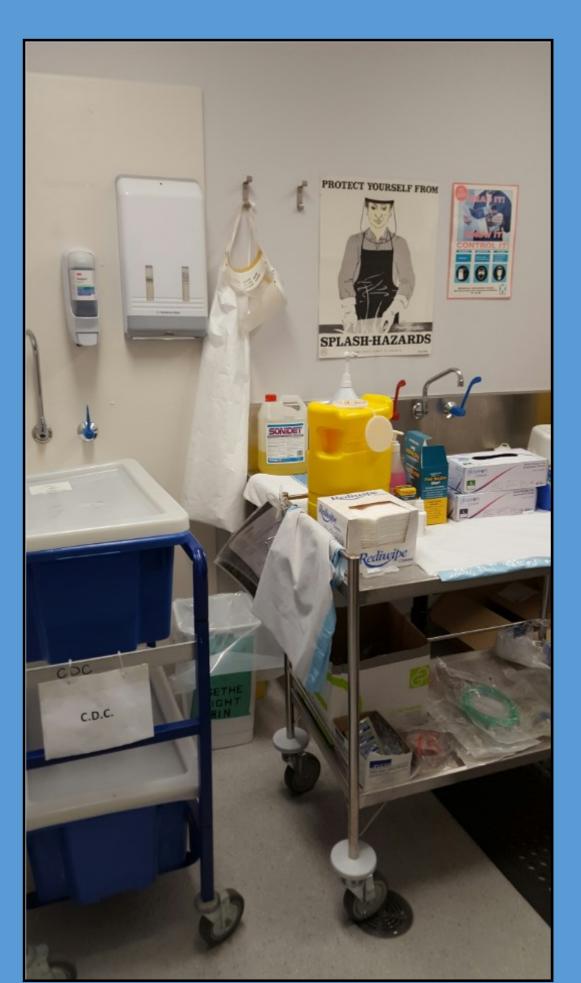
Setting the Standard:

A Collaborative Approach to Improving Reprocessing of Transesophageal Echocardiogram Probes









Pictures of the reprocessing environment on initial review where the work space was cluttered, no clear workflow was evident and unsatisfactory record keeping was taking place.

Introduction

In response to the publication of Australian New Zealand Standard 4187:2014 Reprocessing of reusable medical devices in health service organisations (AS/NZ 4187) a review of the reprocessing methods of Transesophageal Echocardiogram (TOE) probes within the Cardiac Diagnostics Unit (CDU) of a 500 bed hospital was undertaken.

The review identified a number of areas where the requirements of AS/NZ 4187 were not being met consequently posing a threat to patients, staff and the organisation as a whole. As a result a collaborative approach between CDU staff and the infection prevention and control team was used to explore and implement improvement strategies.

Method

An assessment of the environment and the available documentation occurred. This included reviews of instrument tracking records, associated policies and procedures as well as current staff education and training records.

Feedback from staff regarding reprocessing methods was also collected which indicated that current use of the product CIDEX® OPA was not the most suitable or preferred method of reprocessing.

Results

Immediate changes involved de-cluttering the reprocessing environment, establishing clear workflows and enhancing environmental cleaning.

Longer term changes included a successful transition from the use of CIDEX® OPA to the Tristel Trio Wipes system, improved instrument tracking processes, the establishment of staff education and competency based training regimes and development of policies and procedures associated with this equipment.

Conclusion

Improved reprocessing systems, enhanced staff training and education and robust equipment tracking methods have reduced the possible risks to the organisation and improved the service provided to patients.

A number of repeat audits using the AS/NZ 4187 audit tool developed by the New South Wales Clinical Excellence Commission (NSW CEC) demonstrated that improvements that were put in place after the initial review have since been maintained.







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EXAMPLE ENTRY 2

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Example ENTRY 3

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Pictures taken after the changes were implemented illustrate significant improvements including a decluttered space, clear workflows, improved storage of equipment and accurate, reliable record keeping.

Julie Rieck- Infection Prevention and Control Clinical Nurse Consultant- Illawarra Shoalhaven Local Health District