2016 CS/SPD Department of the Year
Jewish Hospital
Louisville, KY

INSIDE...
- SPD’s evolution solution
- Critical care stock reporting
- Patient monitoring’s vital signs
- Compensating infection preventionists
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1 Stated in the 2008 CDC/Healthcare Infection Control Practices Advisory Committee (HICPAC) Guideline for Disinfection and Sterilization in Healthcare Facilities
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The V word

In the byzantine world of policy and poity, the vaunter Sterile Processing and Distribution profession may be classified as victims of forced befuddlement.

Our March cover story about manufacturer instructions for use (IFUs) inspired one devout healthcare executive to comment the coverage — story and writer — but also to ask why the adjective "validated" failed to precede the term "IFUs" for clarity and emphasis.

To HPN’s credit, the coverage did raise the idea about validated IFUs — just not so overtly. Hindsight being 20/200 and all, we could spin this perceived slight as more of a sleight because the ensuing email exchange with this executive proved to be enlightening, engaging and educational.

As a service to HPN readers we will post an edited transcript of that email exchange on HPN Online as an exclusive.

Here’s the crux of the matter in a nutshell:

• To ensure device cleaning, disinfection and sterilization effectiveness, SPD staffs should use VALIDATED IFUs provided by manufacturers.

• Device manufacturers should provide VALIDATED IFUs to their healthcare organization customers so they know how to clean, disinfect and sterilize products effectively to prevent patient infections from improperly reprocessed devices.

• The Food and Drug Administration (FDA) stipulates in its guidelines that device manufacturers validate the design, functionality and end-user operation of the devices they make, including reprocessing instructions.

Yet too many questions remain.

• For starters, who serves as the final authority on the validity and reliability of validation claims? The device manufacturer? The lab testing the manufacturer uses? The FDA?

• Who actually validates that all of these devices work as intended and can be reprocessed effectively and safely in most, if not all, cases?

• Are validation requirements standardized? How can they be for myriad devices? Should they be?

• Who validates the validation testing labs’ procedures as effective?

When there’s a breakdown in any of the procedures these questions raise, who pays? The patient/victim, provider, supplier, payer and ultimately, you and I as the taxpayer who helps fund the FDA.

The FDA does not require healthcare facility SPD departments to validate IFUs but to use “validated” IFUs. Further, the FDA may require device manufacturers to validate the required IFUs but those IFUs are not standardized, and the testing labs used to validate the IFUs are not FDA-vetted and certified.

The FDA specifies the need for validated IFUs without providing standardized parameters for neither validation procedures nor instructions on how to obtain them and from whom. The FDA also does not yet certify or (it cannot endorse, of course) any testing labs performing validation studies for IFUs. So how can device manufacturers obtain validated IFUs from testing labs not vetted and certified by the very agency calling for all of this testing and validation? Meanwhile, healthcare SPD teams merely follow what they receive from manufacturers, not realizing that they will be legally and financially liable for the consequences.

Supply Chain and SPD pros (and GPOs) must demand that any and all devices and products include authentically validated IFUs as a requirement for contract consideration or they won’t be acquired. Device manufacturers must obtain validated IFUs for all products they make (past, present and future) as a condition for obtaining FDA pre-market approval (PMA) or 510(k) clearance to sell those devices. Device manufacturers must use FDA-vetted and certified testing labs that rely on standardized testing parameters — either through AAMI or ANSI — to issue validated IFUs. The FDA must establish guidelines that specify the use of certified testing labs that employ standardized validation testing parameters as a condition for device clearance, sale and use. Payers should not reimburse for clinical procedures where devices without validated IFUs from certified testing labs have been used.

Regrettably, we all will pay more for this intensified scrutiny. But we can’t afford perplexity from complexity any longer.
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An estimated 12.6 million people die from living or working in unhealthy environments each year. This fact underscores the impact of the chemicals and waste put into the air, water and earth since the end of World War II.

Here’s the breakdown:

- **2.5 MILLION**
  - die from stroke
- **2.3 MILLION**
  - die from ischaemic heart disease
- **1.7 MILLION**
  - die from unintentional injuries (e.g., road traffic deaths)
- **1.7 MILLION**
  - die from cancer
- **1.4 MILLION**
  - die from chronic respiratory diseases
- **846,000**
  - die from diarrheal diseases
- **567,000**
  - die from respiratory infections
- **270,000**
  - die from neonatal conditions
- **259,000**
  - die from malaria
- **246,000**
  - die from intentional injuries (e.g., suicides)

Source: World Health Organization

NEWswire

**IAHCSMM announces 2016 award recipients**

Each year, the International Association of Healthcare Central Service Materiel Management (IAHCSMM) honors Central Service (CS) professionals who demonstrate outstanding leadership, knowledge, service and skill in the CS profession.

Many highly-qualified candidates submitted nominations for the 2016 Awards. Upon careful review by the IAHCSMM Executive Board, IAHCSMM is pleased to announce the following individuals as IAHCSMM’s 2016 Award recipients:

**Confidence Builder Award:** University of Iowa Hospitals & Clinics Sterile Processing Department, Iowa City, IA.

**CS Supervisor/Manager of the Year:** Francisco Rodriguez, CRCST, Manager, Central Sterile, Good Samaritan Hospital, Suffern, NY.

**Decontaminator of the Year:** Patricia Pabon, CRCST, Central Sterile Technician, St. John’s Riverside Hospital, Yonkers, NY.

**Educator of the Year:** Patricia Pabon, CRCST, Central Sterile Technician, St. John’s Riverside Hospital, Yonkers, NY.

**Golden Slipper Award:** Katie Belski, CRCST, CHL, Supervisor, Sterile Processing, Columbia St. Mary’s Hospital, Milwaukee, WI.

**Chapter of the Year:**
- Large Chapter: New Jersey Healthcare Central Service Association
- Medium Chapter: Central Florida Association of Central Service
- Small Chapter: Mid-Ohio Central Service Professionals

The official presentation of awards will take place during the 2016 IAHCSMM Annual Conference and Expo, taking place April 24-27, 2016, in San Antonio, TX.

**FDA expands UDI training resources for medical device companies**

The Food and Drug Administration (FDA) posted five new medical device education modules to the CDRH Learn Program website. The CDRH Learn website has also been improved to allow easier navigation of the Unique Device Identification (UDI) System section.

CDRH Learn is an innovative multimedia catalog of online educational modules intended to provide information about medical device laws, regulations, and policies that is comprehensive, interactive, and easily accessible. The format for each topic is chosen to present the information in the most effective way possible.

FDA is establishing a UDI system to adequately identify medical devices through their distribution and use. The UDI rule became final in September 2013 and is being phased in over several years based primarily on device classification. When fully implemented, the UDI System will offer a range of benefits to industry, FDA, consumers, healthcare providers and healthcare systems including improved patient safety and postmarket surveillance.

Four new modules can be found in the CDRH Learn Section “Unique Device Identification (UDI) System”:

1. Unique Device Identification (UDI) System Regulatory Overview
2. Global Unique Device Identification Database (GUDID) Account Request: Preparation and Process
3. The GUDID Device Identifier (DI) Record 4. HL7 SPL Submission Option

The fifth new module is located under the CDRH Learn Section “Industry Basics Workshop Series” and consists of two presentations each followed with a moderated question and answer session.

For more information about the UDI System, visit the FDA’s UDI webpage. at www.fda.gov/Training/CDRHLearn/default.htm

**New CMIP certification for Environmental Services professionals**

A new Certificate of Mastery in Infection Prevention and Control for Environmental Services Professionals (CMIP) is being offered by the Association for the Healthcare Environment (AHE).

This new and intensive 20-hour certificate program will provide Environmental Services leaders and professionals with the requisite knowledge to meet the CMS requirements for a “trained” professional in infection prevention and control specific to the clinical environment of care.

Three distinct phases comprise this comprehensive program which explores the most important topics in infection prevention:
- Microbiology and epidemiology
- Patient and healthcare worker safety
- Surveillance, risk assessment, outbreaks
- Antimicrobial stewardship
- Evidence-based cleaning practices and environmental monitoring
- Preventing infection during construction and emergencies.

The CMIP is a robust certificate program which requires online pre-work and offers an optional post-conference capstone project/assessment. www.ahe.org/ahe/conference/2016/IPMasteryCertificate.shtml.

**AAMI Foundation looks to industry, healthcare facilities to back device training initiative**

The AAMI Foundation is laying the groundwork for a new national initiative aimed at improving how clinicians are prepared to use infection prevention and control specific to the clinical environment of care.

This new and intensive 20-hour certificate program will provide Environmental Services leaders and professionals with the requisite knowledge to meet the CMS requirements for a “trained” professional in infection prevention and control specific to the clinical environment of care.

Three distinct phases comprise this comprehensive program which explores the most important topics in infection prevention:
- Microbiology and epidemiology
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because of the rising number and growing complexity of medical devices.

The Foundation is now reaching out to industry and other partners to determine how much support exists for such an initiative, which would follow the basic model of earlier campaigns that focused attention on a specific patient safety issue through the prism of healthcare technology.

The possible two-year initiative on complex technology preparation stems from the AAMI Foundation’s first Industry Council meeting this past January during which attendees talked about how daunting this preparation can be when time is scarce and new devices are constantly being introduced into the healthcare setting.

During this event, participants agreed that improving education and training was just one part of any long-term solution. There also was acknowledgment that creating lasting change would require the input and participation of a number of different stakeholders—nurses, device manufacturers, patient safety advocates, hospital administrators, professional organizations, regulators, and others. To move this effort forward, the AAMI Foundation is offering to help these diverse groups find common ground.

Funding for such a coalition is crucial because the challenge is so complex that it will take a coordinated and sustained effort to bring about real change. In general, the coalition would:

• Develop recommendations and/or guidelines for ways to assess competency in the use of complex technology.
• Build a repository of best practices for educating and assessing competency of caregivers who use healthcare technology.
• Create recommendations and/or guidelines to assist in the purchase of complex healthcare technology.
• Build a business case for allocating financial resources to this initiative and training.
• Identify current models for device technology education.
• Develop guidelines and/or standards pertaining to the training materials included with medical devices.
• Standardize training across all care settings, units, devices, brands, and users.

With sufficient financial support, the Foundation would launch this new initiative with a coalition kick-off meeting in the fall. For more information or to pledge your support for this initiative, please contact Marilyn Neder Flack at mflack@aami.org.

AHIMA launches petition for national voluntary patient safety identifier

The American Health Information Management Association has launched a petition to ask the White House to address the need for a national voluntary patient safety identifier by removing legislative language that has prevented open discussion between the government and others, who are seeking a solution to this critical patient safety issue.

AHIMA believes a possible solution is a voluntary patient safety identifier that could allow patients to create a way for medical systems to recognize them quickly and accurately. An identifier will help ensure each patient’s health information is kept together and is complete, all the while remaining under the patient’s control.

The petition aims to encourage federal government leaders to engage experts in the private sector who have experience in accurately identifying people, as they do in banking and other financial businesses, along with security experts. With 80 percent of doctors and 97 percent of hospitals currently using an electronic health record, having a way to accurately and safely exchange information can make healthcare more safe and effective.
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SPECIAL FOCUS

Jewish SPD bolsters package deal within regional IDN

Winning team weathers past, present and future in positive flux

by Rick Dana Barlow

After several years of performance and process improvements that help you finally engineer your Sterile Processing & Distribution (SPD) department to operate more effectively and efficiently you might wonder what to do next beyond maintaining the quality status quo.

Fortunately, the Sterile Processing team at Louisville, KY-based Jewish Hospital really doesn’t have to do that. As part of the statewide regional integrated delivery network KentuckyOne Health, which also includes the University of Louisville Hospital several blocks away, Jewish’s SPD team already knows where it’s heading next and how: unification in two locations.

With a newly constructed footprint scheduled to debut next month, Jewish Hospital’s SPD team will be poised to function as the heart of reprocessing services for itself and its KentuckyOne “downtown campus” partner University of Louisville Hospital.

Even though KentuckyOne Health formed in 2012, Jewish Hospital’s construction project predated the IDN’s launch with the new organization’s staffers and patients clearly benefiting from the foresight. “Only afterwards was [it] considered as a piece of the unification in two locations.”

With a newly constructed footprint scheduled to debut next month, Jewish Hospital’s SPD team will be poised to function as the heart of reprocessing services for itself and its KentuckyOne “downtown campus” partner University of Louisville Hospital.

Both hospitals are pursuing greater collaboration as the duo continues to integrate, according to Robert “Bobby” Parker, CRCST, CIS, CHL, SPD Manager, Jewish Hospital.

But Balch acknowledged that complete integration remains a few years away. “Our vision for integration is divided into the three tiers of ‘People, Processes, and Surgical Assets,’’ Balch said. “A successful integration will be a campus where every SPD employee is competent at each facility, all processes are standardized, and surgical assets are utilized to their full potential.”

Jewish’s SPD team certainly is no stranger to assisting other local hospitals and medical centers with staffing and projects. Last June, the team helped their colleagues and counterparts at Sts Mary and Elizabeth Hospital as it underwent an SPD renovation. “Their team continued to wash and assemble their instrument trays, but they did not have access to their steam sterilizers during the project,” Parker recalled. “All their packaged items were transported to Jewish Hospital for sterilization, and all their loaner trays were delivered to University of Louisville Hospital for assembly and sterilization.”

The capabilities and skills of Jewish’s SPD team not only to support its facility’s Operating Room department but also the needs of other facilities within its IDN is just as important as how it arrived at its position to deliver high-quality, reliable service. Their five-year journey to self-discovery and self-improvement proved challenging but ultimately successful as they established and solidified a strong bond of trust with the OR. To add an “extra layer of customer service,” SPD created a dedicated OR Liaison position to bridge the gap. They started small, bobbed and weaved through choppy operational waters, and positioned themselves to expand with perhaps less intense growing pains than they would have experienced otherwise.

For these reasons, Healthcare Purchasing News named Jewish Hospital’s SPD team its 2016 SPD Department of the Year.

Full-service SPD

Historically, a large number of HPN’s award-winning SPD departments during the last 23 years earned accolades after undergoing massive construction/renovation and/or process re-engineering. A larger footprint for breathing room as well as the installation of new technology and tools can inspire and motivate just about any SPD crew. Jewish’s SPD team upended that trend. Their construction project, several years in the making, should be complete next month, which enables them to shift more of their focus toward integrating with their downtown Louisville partner, according to Parker.

The new SPD area at Jewish will expand its storage capacity and increase its throughput capacity as well, Parker noted. “The plan for the new department is to centralize more of the instrument storage in SPD, and for SPD to begin pulling case carts for all surgical areas in the hospital. This will free up time in the OR, hopefully improving room turnover and first case on time starts, and it will give SPD more information for prioritizing instrument processing for our Hand and Outpatient Care Center. “The increased processing capacity will also open up the option for us to function as a processing center for neighboring KentuckyOne facilities, if necessary,” Parker continued. “Our current department has already
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Although workload will be reallocated to the department’s satellite center,” Balch told instrumentation kept on-site and processed in the integrated ‘hub,’ and 20 percent of critical processing centers follows the 80/20 rule, with 80 percent of instrumentation processed at processing centers follows the 80/20 rule, with 80 percent of instrumentation processed at processing centers follows the 80/20 rule, with 80 percent of instrumentation processed at processing centers follows the 80/20 rule, with 80 percent of instrumentation processed at processing centers follows the 80/20 rule.

Not for Jewish or even University of Louisville’s SPD team, Balch assured. “The goal for most multi-site to single-site processing centers follows the 80/20 rule, with 80 percent of instrumentation processed at the integrated ‘hub’ and 20 percent of critical instrumentation kept on-site and processed in the department’s satellite center,” Balch told HPN. “Although workload will be reallocated and streamlined under this integrated model, there will be additional logistical staffing related to packaging, transport and data management that would ensure no positions are on the line. There is also a long-term vision to move our instrument repair program in-house, which would provide additional opportunity to our team for career advancement.”

Parker identified several strategies and tactics necessary for successful integration. “First, our staff needs to be competent to work at both locations,” he stated. “We have already begun doing some cross-training between hospitals, and it is becoming part of our orientation process for new employees to spend a couple weeks at the other facility. Second, our processes need to be aligned. Both hospitals are looking at their processes to make sure they are both AAMI compliant and match as closely as possible with each other.”

The third and greatest challenge, Parker continued, is the standardization and optimization of instrument sets. “From a processing standpoint, the instrument trays would be much easier for technicians to process if the most commonly used trays were identical at both facilities,” he indicated. “Additionally, surgeons who work at both campuses would benefit from having the exact same instrument setup during procedures.”

Jewish’s SPD recruited Aesculap’s Surgical Asset Management Team with their Clinifiscal Model™ to facilitate optimization meetings between service line specialists and surgeons at each hospital for standardizing instrument trays, he said. They also worked with Materials Management Microsystems’ SPM team for data management and device tracking and are formulating loaner management, labor management and supplier-SPD relations with such companies as CaseChek and ReadySet Surgical, he added. “With the integration of the two campuses, the Sterile Processing Departments would have the ability to float staff between campuses depending upon surgical schedules, vacations and callouts, and staffing shortages without the use of travelling agency staff or high overtime rates,” Parker noted. “Surgeons would find it easier to work at both facilities because of the uniformity of surgical instruments, and so the two KentuckyOne facilities would have greater capacity and flexibility for scheduling cases. Finally, the campuses could more effectively utilize their instrument assets, since they could be used at either facility when needed.”

Process-driven quality

To achieve such a seemingly lofty goal, Jewish’s SPD team had to achieve another lofty goal: producing the “highest-quality sterile goods possible,” according to Parker. “Our goal is for there to never be an instrument set returned because of a defect,” he said. “Achieving perfect quality is a struggle, however, because we are human beings prone to error. No matter how much education, training, and resources a person is given, they will still make mistakes.”

So Parker and his group strove to “create processes that are workflow conducive and make it impossible — or at least difficult — to make an error.” For an example of a “tweaked” process, visit www.hpnonline.com/inside/2016-05/1605-SF-LiveLinks.html and click on the “Rigid container redesign” live link.

To achieve unity within the department before unification with any other departments, Balch, his predecessor Karen Owens, RN, MSN, CR CST, CIS, CHL, FCS, and Parker had to build the team and empower each staffer to accept additional responsibility to help one another versus claim something “isn’t my job.” To promote teamwork and avoid a segmented staff specialized in one particular area, they rotate responsibilities. The OR Liaison, who reports to Parker, remains constant as the dedicated channel between the two departments. For more on Joel Benge, CR CST, CIS, CHL, SPD’s OR Liaison, visit www.hpnonline.com/inside/2016-05/1605-SF-sidebar1.html.

Jewish SPD responsibilities include four primary assignments: Decontamination, Prep

<table>
<thead>
<tr>
<th>Fast Facts on Jewish Hospital’s SPD team</th>
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<tbody>
<tr>
<td>SPD FTEs</td>
<td>26.9</td>
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<tr>
<td>% FTEs certified</td>
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<td>(Will be 100% after new employees complete certification within 1 year)</td>
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<td>Inventory line items</td>
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& Pack (Assembly), Sterilization and Dispatch. The Sterilization Tech operates the four steam and two low-temperature sterilizers as well as helps process smaller sets in Prep & Pack. The Dispatcher is primarily responsible for answering phones, pulling cases, unloading washers, tracking loaner instruments and managing the prioritization.

“Employees are rotated almost every day to keep their skills sharp and to keep people from getting burned out on a particular task” Parker said. “Our team is happy that their rotation through decontamination is spread out. For those employees who look to excel above their expected standard, we work with them to find additional responsibilities, like helping with supply ordering and tracking instrument data.”

Because they rotate the dispatch position, too, “each of our techs is comfortable delegating responsibilities to their peers and functioning as the ‘quarterback’ of the department,” he added.

**Super-staffed**

While the dispatcher may serve as the SPD quarterback, each team member participates in the staff-led handoff.

As a 24-hour department whose staff remains on call, any shift change can lead to dropped balls. In the hustle and bustle, maybe some important information might not get passed along to the right person on the next shift. In past years, the shift supervisor would come in before the shift starts, gather all the data from all the processing areas, and try to communicate all the information in a staff huddle at the beginning of the next shift, according to Parker.

So this year Jewish SPD tried something different. They altered their staffing structure to allow a 30-minute overlap on all three shifts (6:30 a.m.-3:00 p.m., 2:30 p.m.-11 p.m., 10:30 p.m.-7 a.m.), and created structured lists for employees to communicate, Parker explained. “The oncoming shift still huddles briefly with the supervisor to get assignments and any educational in-services, then the staff disperse to their assignment to get a one-on-one handoff with the previous shift,” he continued. “We have found that the one-on-one employee-led handoffs have increased our level of detail in handoffs and provide the opportunity for questions and feedback. The handoffs are good for our team culture as well, as it further reinforces the ‘passing of the baton’ from one shift to the next.”

Recognizing a 30-minute overlap per staffer means twice the staff is active for any one shift; number crunchers may wonder how this strategy affects budgets, employee compensation and productivity.

“The productivity impact was considered when making the switch,” Parker responded. “Prior to the change, staff still had a 10-15 minute huddle with their supervisor. Now, staff come in and huddle with their supervisor for 10 minutes while the previous shift is still working on the floor. After the huddle, the oncoming shift dispenses to the workstations to receive a handoff that is no more than five minutes long. Then the two employees work together for the remaining 10-15 minutes. This overlap allows for us to catch up on tasks such as processing peel packs, organizing decontamination during the busy 2:30 p.m.-3 p.m. shift change, and pulling cases. The staff have been diligent to make the most of this ‘super-staffed’ 15 minutes, and it has been a productive time to help boost our shifts off to a great start.”

**Gaining trust**

Today, the SPD crew of 32 employees (roughly 27 full-time equivalents) at the 462-bed Jewish Hospital reprocesses surgical instruments for the facility’s four surgical centers, including Main Surgery, the Rudd Heart & Lung Surgery, and the Hand and Outpatient Surgery Center. SPD also reprocesses and delivers instruments to other departments, including the Emergency Department, Cath Lab, Endoscopy and Vascular Radiology. Beyond sterilizing surgical instruments, SPD houses the majority of sterile storage for the hospital in its department and manages the distribution of instruments for case carts for surgery.

“SPD initiated the change to move sterile storage,” he said. “We saw the benefits of having sterile storage in one place, handled by one team of trained staff. The process took place in stages over a number of years, as little-by-little more teams began to trust the excellent work of Sterile Processing.” One SPD side benefit? Staff became more familiar with tray names, inventory levels and service lines, he added.

Four years ago, that would have been unfathomable by the OR. In 2011, hiding instruments was commonplace, Parker admitted.

Back then SPD faced an ever-growing list of instruments missing from sets, compounded by a disorganized supply of back-up instrumentation, according to Parker. In fact, they recorded nearly 1,000 instruments as missing from sets facility-wide. “This was not possible until SPD was able to consistently show that we could take care of their needs and that trust was built,” said Karen Owens, RN, MSN, CRCST, CIS, CHL, FCS, former System Director of Sterile Processing (Balch’s predecessor), who initiated performance improvement initiatives and process changes when she joined the organization in 2011. “This also occurred in baby steps, taking a little at a time and making sure that the staff were well-educated on the new instruments being stored and what cases they would be used for. With that success then we would move a bit more, and so on. Overall, we were able to give the OR back 2,000 square feet of storage space that they could use for their own equipment as well as reopen an OR suite that had only been used for instrument storage for several years. Now they find things they don’t want to keep and bring them to us!”

In March 2015, Owens joined STERIS Corp. as an SPD consultant.

Bennie Thornton, Clinical Nurse Manager of Heart & Lung Surgery, remembered the tension between OR and SPD.

“It took many months for the SPD management team to gain the trust of the OR and only because of their hard work and proving themselves time and time again did we allow it to happen,” Thornton told HPN. “This was a very hard transition for the OR because of the years of mistrust that the OR had with SPD. When I look back there were many, many sets and instruments that were processed here in the OR. There was no trust between the OR and SPD. There were many times that the OR would send down instruments to SPD never to see them again. A story that comes to my mind is when we very first started do liver transplants. We had ordered a special clamp to be used for the procedure. The surgeon had to keep it in his locker, just to ensure that we would have it every time for his cases.

“It’s totally different now,” she added. “We feel like we can trust SPD to get us the right instruments when we need them.”

The OR Liaison (Joel Bengt), who reports to SPD and works closely with the supervisors, OR managers, coordinators and the OR rooms as well, represented an additional boost, according to Parker.

“Big strides had already been made with gaining OR trust before the OR Liaison position was created,” he said. “SPD was already storing most of the sterile instruments, already pulling the cases and was making big strides in improving quality. The OR Liaison position did not start the process of gaining OR trust, but it certainly helped advance it. The OR began to feel like they had an ‘expert’ they could call on, who has advanced knowledge of SPD’s inventory and has some knowledge of the OR cases. The position has also been crucial in making sure that the day’s case carts are 100 percent correct every time.”

**Detective work**

Because SPD’s backup instrument bins were generally sorted, but not labeled or able to be easily seen, techs had to open dozens of small
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pull drawers to find a replacement for a broken or missing instrument. Parker called the manual process disorganized. So they created a “backup instrument wall” that includes open bins behind glass doors, grouped categorically and alphabetically with name labels and bin location numbers.

“We were receiving multiple complaints from the OR needing instrumentation that was marked missing in sets,” said John Rowe, CRCST, CIS, CHL, Instrument Coordinator. “The OR continually called for additional sets. CRCST, CIS, CHL, Instrument Coordinator. The OR continually called for additional sets in order to have the required instrumentation easily.”

Parker raved about the wall.

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Digital digging
Rowe admitted they had used an electronic tracking system for years but it was “poorly maintained.” Four years ago, they initiated a “massive data clean-up” so that inventory and instrumentation were reorganized in databases, count sheets, sterile sets on shelves and instruments on the backup wall.

SPD limited the number of people with editing capabilities in the tracking system, which eliminated data duplication. Then they reorganized the count-sheets in a standard format and photographed instrumentation to speed up completion and enhance workflow. They also refined the instrumentation names and classifications in the database to allow for easier cross-referencing and the construction of equivalency groups. Finally, they laid out a physical organizational plan that allowed staff to locate both sterile sets and unsterile backup instrumentation quickly with just a few clicks in the electronic tracking system, according to Rowe.

Rowe diligently worked with clinical coordinators, scrub techs and doctors in the OR to find out exactly what the surgeons need in each set. He learned that they routinely were purchasing replacements for instruments that the OR did not even use. If a particular instrument only was used by one surgeon, and there was a limited amount of that instrument on hand, Rowe removed the instrument from the sets and peel-packed it for the one surgeon.

Techs also started recording every time instruments were marked missing and initial that they looked for a replacement in backup instruments were marked missing and initial. They looked for a replacement in backup storage locations were entered into the electronic tracking system and are now available as a quick reference to locate replacement instrumentation easily.”

Parker raved about the wall.
contract on site in repair vans or off-site at repair labs, Rowe said. “This keeps our training expenses to a minimum and also does not require us to manage a supply of replacement parts, screws, springs, etc., for the multitude of instrumentation used at our facility,” he added.

To prepare sets for the surgery cases the next day, SPD techs check the library of digital physician preference cards in the OR’s electronic medical record, which is Cerner’s Surginet. “The preference cards for the next day’s surgery cases automatically print to Sterile Processing in the early afternoon, giving SPD adequate time to pull cases for the next morning and identify the exact sets needed to be prioritized,” Parker said. “In the event of schedule changes or add-on cases, Sterile Processing techs are trained in Cerner to be able to go and print off updated schedules and any added preference cards.”

Parker acknowledged that SPD’s SPM system can interface with Cerner to eliminate the need to manually print preference cards, and they hope to implement that feature in the near future.

SPD’s efforts, however, freed up the OR to focus on patient care and turning over rooms, according to Owens.

“The savings in OR turnover time has come in the form of the OR staff not having to pick some of their own instruments, constantly look for missing items and calling for things that did not get on their case cart,” she noted. “An OR improvement project focused on decreasing turnover times also added to a total overall reduction of 26 percent in turnover time. Some of this was due to other factors as well as SPD having control of the instruments and OR nurses and techs not having to spend their time pulling instruments that were stored in the OR.”

Redesigning workflow
Jewish’s SPD recognized that to improve productivity they needed to standardize the workflow, according to Parker, reducing the amount of time it takes to find supplies and move products.

Consequently, SPD is standardizing all workstations to look exactly the same and be organized in a “left-to-right” order, according to Owens.

“This will help us spend less time looking for set indicators, as the technician’s muscle memory knows exactly where it is on every work station,” he said. “Also, the organized process helps our quality, since a ‘left-to-right’ organization of supplies makes it more difficult to accidentally skip a step, leaving an indicator out of the tray.”

SPD also reorganized their rigid container collection to improve workflow. To read what they did, visit www.hpnonline.com/inside/2016-05/1605-SF-LiveLinks.html and click on the “Island on wheels” live link.

Working smarter
Parker called SPD’s commitment to continu- ing education and certification one of the department’s “proudest achievements.” It’s easy to see why.

SPD requires that all of its employees earn their CRCST certification within the first 12 months of the hire date, not only to promote professionalism but also to set a standard of knowledge for the staff, according to Parker. Of 32 SPD employees, 25 are CRCST certified, seven are in the process of earning their CRCST designation, but nine also have earned their CIS and CHL designations through IAHCSSM, too. This reinforces their reputation within the hospital as instrument and sterilization experts.

“Our technicians gain exposure to in- dustry standards, and they’re given the bigger picture of what it takes to be a great department,” Parker said. “We are excited as a team to continue gaining certifications; we’re out to be the best-trained, most-certified department of Sterile Processing Technicians in the country.”

Jewish also prides itself in engaging employees to show that their work makes a difference, Parker insisted.

They discuss quality improvements at weekly staff meetings and during vendor inservices with such companies as Aesculap, CareFusion, IMS, Integra, Karl Storz, Stryker and Symmetry Surgical.

SPD provides “Process Improvement Forms” for techs to submit ideas on how to make the department better. Staffers compete in the department’s annual Sterile Processing Olympics. They can attend “Professional Development Day” events hosted by Balch and can enroll in SPD’s Leadership and Practical Experience (LeaPe) training program for career growth and professional development. For details on all of these initiatives, visit www.hpnonline.com/ inside/2016-05/1605-SF-Sidebar2.html.

SPD’s transformation from the inside out convinced its OR customers to extend their support.

“As with any culture change, it happened with small wins adding up over many months,” Balch said. “Although there were many drivers to this increase in OR account- ability, the biggest breakthrough came when the OR team started to see a change in our department’s commitment to professional- ism. As we began owning our own service challenges and offering creative solutions to better serve the OR, their teams began responding in kind. The mentality of ‘us vs. them’ that is so often present between SPD and OR departments began to take a back seat to a philosophy of ‘better together.’

“When nurses and scrub techs began to realize how much quicker our teams could turn around sets, they began to take the initiative of restringing upon themselves,” he continued. “When they understood how safe scope transport drastically reduced the number of scopes taken out of service for repair, service line coordinators began owning this care and handling compliance with their own staff. From there, it just snowballed.” HPN
OPERATING ROOM

Efficient, effective patient monitoring is vital

by Kara Nadeau

As the healthcare industry works to become more efficient and effective in its delivery of care, patient monitoring has grown in importance. The ability to intervene more quickly to patients in distress — with greater knowledge of their conditions — helps minimize the risk for dangerous and costly complications and adverse events.

In this article, HPN examines the latest technological developments in patient monitoring devices for the surgical suite and the patient’s bedside. We explore trends including wearable sensors, data collection and transmission, electronic health record (EHR) integration, alarm management, solutions for non-acute care environments, patient tracking, multiple monitor management and remote monitoring. The article features insights from manufacturers of monitors, sensors and related equipment, as well as some of the latest products to hit the marketplace.

Patients carry superbugs on their hands, study finds

Hospitals may be cracking down on handwashing for doctors, nurses and other staffs, but they’re missing a big source of superbug spread, a new study finds: Patients.

Researchers at the University of Michigan found close to a quarter of the patients they tested had some sort of drug-resistant germ on their hands when they were discharged from the hospital to a post-acute care facility such as a nursing home, rehabilitation center or hospice.

The finding, publishing in JAMA Internal Medicine, supports what many healthcare experts have argued for years: that patients are a major source of antibiotic-resistant germs. These “superbugs” have been spreading to doctors, nurses and other healthcare providers, and to patients and visitors in the hospital environment.

According to Veffa Devers RN, BSN, MS, the healthcare industry works to become more efficient and effective in its delivery of care, patient monitoring has grown in importance. The ability to intervene more quickly to patients in distress — with greater knowledge of their conditions — helps minimize the risk for dangerous and costly complications and adverse events.

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Identifying issues sooner and smarter

According to Carla Kriwet, CEO, Patient Care and Monitoring Solutions for Philips, another way monitors have evolved to meet changing needs is by allowing patients to be monitored unobtrusively, continuously, and in a way that provides valuable data and actionable insights to clinicians and caregivers.

“Technologies are evolving in such a way that they can help caregivers detect early signs of patient deterioration for early intervention, which in turn helps to reduce costly adverse events, complications, unplanned transfers back to the ICU and longer lengths of hospitalization,” said Kriwet. “Additionally, alarms are becoming smarter and more meaningful to clinicians by only alerting them to clinically significant issues through easy-to-use interfaces and dashboards that highlight the most at-risk patients and provide clinicians with smart, actionable information and communication tools to support enhanced workflows.”

Philips’ next-generation, medical grade wearable biosensor automatically and continuously measures clinically relevant

PATIENT CONNECTION

FDA proposes ban on most powdered medical gloves

The U.S. Food and Drug Administration has announced a proposal to ban most powdered gloves in the United States. While use of these gloves is decreasing, they pose an unreasonable and substantial risk of illness or injury to healthcare providers, patients and other individuals who are exposed to them, which cannot be corrected through new or updated labeling.

The proposed ban applies to powdered surgeon’s gloves, powdered patient examination gloves and absorbent powder for lubricating a surgeon’s glove.

Powder is sometimes added to gloves to help make it easier to put them on and take them off; however, powdered gloves are dangerous for a variety of reasons. In particular, aerosolized glove powder on natural rubber latex gloves, but not on synthetic powdered gloves, can carry proteins that may cause respiratory allergic reactions.

Although powdered synthetic gloves do not present the risk of allergic reactions, these devices are associated with an extensive list of potentially serious adverse events, including severe airway inflammation, wound inflammation, and post-surgical adhesions, which are bands of fibrous scar tissue that form between internal organs and tissues. These side effects have been attributed to the use of glove powder with all types of gloves.

As these risks cannot be corrected through new or updated labeling, the FDA is moving forward with the proposal to ban these products, which — if finalized — would ultimately remove them from the marketplace completely. The proposed rule is available online at www.regulations.gov for public comment for 90 days.

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They tested for a number of bugs, including methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant Enterococcus (VRE), and resistant gram-negative bacilli.
vital signs including heart rate, respiratory rate, skin temperature and more. The biosensor then transmits the data it collects to a connected clinical decision support software application, where the software can be configured to promptly notify the appropriate caregiver or clinician when preset limits are exceeded. The wearable biosensor is designed to help patients in low-acuity areas of the hospital, such as the general ward, helping to reduce readmissions and costs.

Improved alarm management
An estimated 72 percent to 99 percent of clinical alarms are false\(^2\), which can interfere with patient care and compromise safety. When clinical staff members are bombarded by numerous alarms, it can be difficult to discern which device is sounding or which patient’s condition is deteriorating. Clinicians often become desensitized to the alerts, ignore them or even disable the monitors’ alarm functions.

The Joint Commission created the National Patient Safety Goal (NPSG) NPSG.06.01.01 to improve the safety of clinical alarm systems by requiring hospitals to prioritize alarm system management, better identify the most important alarm signals, establish policies and procedures and educate staff about the systems for which they are responsible. As of January 2016, all U.S. hospitals accredited by the Joint Commission must have established systems for which they are responsible. As of January 2016, all U.S. hospitals accredited by the Joint Commission must have established policies and procedures for managing clinical alarms.

“The high volume of alarms generated by patient monitors and devices presents significant challenges for hospitals,” said Anne Crammond, Director of Marketing, Monitoring Systems & IT, North America, Dräger. “When critical-care professionals are consistently exposed to the alarms of every patient within a unit, they spend time and effort assessing their need to respond. This strain, which is dubbed ‘alarm fatigue,’ drains resources and adds stress to an already demanding environment.”

She added: “Hospitals are creating new alarm-management plans and workflows and adopting new technologies and strategies to not only meet NPSG mandates, but to also ensure the wellbeing of their workers and patients.”

Designed to help hospitals meet NPSG mandates and improve workflow and patient safety, the Dräger Alarm Management Solution provides contextual knowledge needed to develop an alarm management plan. It is a source for alarm auditing and reporting, workflow consulting and alarm management plan development and implementation.

Using advanced analytics and alarm-audit- ing software, Dräger provides hospitals with detailed reports on alarms and responses to critical events and helps evaluate the effectiveness of current alarm policies and procedures. Dräger’s team of experts use those findings to work with hospital alarm committees to ensure they make evidence-based decisions to meet NPSG mandates and reduce adverse events related to alarms.

In March 2016, Nihon Kohden America launched its new Aware Alarm Management and Reporting system. The system allows hospitals to quickly aggregate alarm data by time, date and care setting, helping them to identify alarms with the highest frequency. Hospitals can then use the Aware data to educate staff on the importance of alarm management while also developing and executing protocols for alarm reporting and data management policies.

As part of the Aware offering, Nihon Kohden’s Nurse Executives are available to assist nursing leadership and other key stakeholders identify ways to reduce nuisance alarms, perform patient touch-point assessments and review alarm settings for goal-based optimization.

Solutions to fit your environment
Tim O’Malley, President of EarlySense, explains how many of the monitoring products on the market today were developed for use in acute care areas, such as the intensive care unit (ICU), operating room (OR) and post-anesthesia care environments, where there are low clinician-to-patient ratios. With these products, patients are typically tethered to the monitor with a lead. According to O’Malley, when healthcare facilities attempt to use these monitors in non-acute patient care areas where clinician-to-patient ratios are much higher, clinical staff members are often burdened by false alarms due to poor patient-to-lead/sensor interfaces, or sensors/leads detaching from the patients.

“Hospitals are looking for ways to increase safety for their patients, by continuously monitoring all patients and obtaining actionable information which will support the caregivers in detecting early signs of patient deterioration, act quickly and ultimately save lives,” said O’Malley. “However, an environment in which low acuity-level patients reside requires much different technology than the post-operative or ICU units of a hospital. An effective technology for monitoring these lower-risk patients must be easy to use by the staff, place few limitations on patients and their family, have low alarm rates in an effort to avoid alarm fatigue and be cost effective.”

The EarlySense All-in-One System is a contact-free, continuous patient monitoring solution to assist in early detection of adverse events, including code blues, preventable ICU transfers, patient falls and pressure ulcers. It is comprised on a sensor placed under the patient’s bed mattress that measures heart rate, respiration rate and movement without touching the patient; a bedside monitor that displays the patient’s

Operating Room

The Dräger Alarm Management Solution

Nihon Kohden’s Aware Alarm Management and Reporting

Philips’ next-generation, medical grade wearable biosensor

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Tracking your most important asset

“Patients, while being the most important hospital asset, are notoriously the most difficult to track,” said Ari Naim, CEO of CenTrak. “The technology exists today to help monitor where a patient is at all times, how long they have been there, and where they are moving. This can help increase response times, optimize patient flow and enhance patient safety if they wander into restricted areas.”

According to Naim, use of Real-Time Locating Systems (RTLS) for monitoring patients, via active-RFID, Wi-Fi, Bluetooth Low Energy (BLE) and other technologies, is increasingly recognized as a pivotal component to improving patient satisfaction and maximizing reimbursement. A RTLS solution can provide a hospital visibility into which patients have checked-in, how long they have been waiting, as well as their current status and location. He points out how greater visibility in this area helps hospitals meet patient needs in a timely manner, improving the patient experience and, in turn, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.

Centrak’s RTLS solution integrates with a hospital’s EHR so that the movements of each patient — from entry/hospital admittance, to their progress and treatments administered within ancillary departments, up until their departure — are automatically updated in the EHR and time-stamped for hands-free documentation. Hospitals can also use this integrated solution to record patient-provider interactions, as well as associated equipment to provide hospital administrators with contact-tracing information should there be an infectious outbreak.

Managing multiple monitoring solutions

As patient monitoring technology evolves and expands, healthcare facilities must find ways to manage all of the various solutions they use at a patient’s bedside. Numerous monitors and their associated stands and cables can cause clutter if not well managed, and potentially interfere with the delivery of care. GCX Vice President of Sales and Product Development Cris Daugbjerg points out how patient monitors are becoming even more critical to data and decision support as they are integrated with EHRs and other technology systems. Healthcare facilities must carefully consider where and how monitoring solutions are positioned in a room so that clinicians can more easily access and interact with them.

“A patient monitor is no longer just a static device placed on a wall for viewing,” said Daugbjerg. “Today, caregivers must have greater physical interaction with monitors. As a result, ergonomics is a higher priority.”

GCX, which develops medical device mounting solutions, recently introduced two new adjustable arms, the VHM-P and VHM-PL, to make it easier for hospitals to manage the myriad medical equipment cables in patient rooms. The medical-grade arms feature seamless, unibody construction, can accommodate up to eight cables, conceal approximately 80 percent of cabling, facilitate one-handed positioning and provide swivel/tilt and pivot-tension adjustments and parallel linkage for consistent viewing angle. The VHM-P and VHM-PL also offer durability and ease of cleaning to fight the spread of infection, and are designed to allow easy removal/replacement of covers. Additionally, the VHM-PL locking version provides quick and safe vertical repositioning of the mounted device without interrupting workflow.

“As monitoring and electronic health records converge, there is a variety of possible bedside workstation configurations that combine monitoring and IT hardware such as additional screens and keyboards,” added Daugbjerg. “Such a workstation may also need to be reconfigured as the hospital’s approach evolves. GCX’s modular design and flexibility accommodate this variety of needs and facilitates technology updates. The mounting hardware can often be upgraded or reconfigured down the road rather than replaced.”

Accessing patients remotely

As the healthcare industry seeks out ways to care for more patients in an effective and affordable manner, the use of telemedicine has rapidly expanded. According to the American Telemedicine Association (ATA), nearly 1 million Americans are currently using remote cardiac monitors, and over half of all U.S. hospitals now use some form of telemedicine.

During late November and December 2015, REACH Health conducted its 2016 U.S. Telemedicine Industry Benchmark Survey among 390 healthcare executives, physicians, nurses and other professionals throughout the United States. Roughly two-thirds of respondents indicated that telemedicine was the top priority or one of the highest priorities for their healthcare organization—a 10 percent increase from the 2015 survey results.1

“Telemedicine decision-making is rapidly moving from individual departments and specialties to an enterprise initiative,” said Steve McGraw, President and CEO of REACH Health. “Both hospitals and health systems reported significant increases in the average number of telemedicine service lines which are active or being implemented in concert.”

McGraw further noted that the top three telemedicine program objectives identified by survey participants all related to patient benefits: improving patient outcomes, improving patient convenience, and increasing patient engagement and satisfaction. The fourth most common objective was providing rural or remote patients access to specialists.

References:
Our Genesis™ container lineup now features a new entry

New Genesis™ low temperature containers

The V. Mueller™ brand Genesis container system—the name you trust in the OR—now offers low temperature containers to help protect and organize your heat- and moisture-sensitive surgical instrumentation during low temperature, hydrogen-peroxide sterilization. They are also compatible with pre-vacuum steam and 100% ethylene-oxide sterilization cycles.

The Genesis container system consistently provides a return on your investment and is a green alternative to sterilization wrap. Look for the distinctive orange gaskets, handles and ID tags.
INFECTION PREVENTION

Steady numbers, significant trends

2016 infection prevention salary survey

by Susan Cantrell, ELS

The 2016 Healthcare Purchasing News Infection Prevention Salary Survey results are in. This year, infection-prevention (IP) professionals from various healthcare facilities around the country responded to a range of questions.

To answer the big money question: The average overall reported salary for an IP professional this year, according to our respondents, is $77,629. That figure is down $1,600 from last year. However, 59 percent of all respondents told HPN that they did receive an increase in base salary.

What follows is a snapshot of some of the finer details related to compensation, along with a look at some of the changing job responsibilities and other trends that infection preventionists are facing in today’s healthcare environment (please refer to the surrounding charts for a complete breakdown of the survey results).

Today’s IP professional and “her” earnings profile

Most IP professionals are female (88 percent vs. 8 percent who are male and 4 percent who did not identify their gender). They’re also in their early to mid 50s. Registered nurses dominate the IP field at 83 percent but their job titles vary.

The top three most common titles are infection preventionist, IP or infection-control (IC) coordinator, and IP or IC director.

Infection preventionists are also a well-educated bunch:

• Postgraduates (25 percent of respondents) earn an average $91,764.
• Undergraduates (50 percent of respondents) earn an average salary of $76,540.
• The remaining 25 percent have earned a master’s or other degree.

Infection preventionists are a diverse bunch:

• ED: 8 percent
• Medical/surgical: 24 percent
• Obstetrics: 13 percent
• Pediatrics: 12 percent
• Long-term care: 16 percent
• Other: 22 percent

Infection preventionists work in a variety of hospital sizes and types:

• Avg. # of employees per department:
  - 206

There is a lot of job satisfaction among today’s infection preventionists: 98 percent of respondents said their job is fun and challenging.

To answer the big question, what is the salary of an infection preventionist these days? The answer is: about $77,629, on average. This is down $1,600 from last year, but 59 percent of respondents said they received a base salary increase in 2016.

Thanks to all those who participated in the 2016 IP Salary Survey. You helped us get a clear picture of the current state of the profession. Early bird gets the worm—get your 2017 salary survey results before anyone else! Fill out the survey before June 1, 2017, by visiting www.HPN.com/IPsurvey.

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• Associate’s degree graduates (24 percent of respondents) earn an average salary of $66,907.
• High school graduates (1 percent of respondents) earn an average salary of $40,000.

IP professionals have experience, having worked, on average, 11 years in the field and eight years at their current facility. About 16 percent of respondents said they have worked less than two years as an IP professional. The Certification Board of Infection Control and Epidemiology certified 46 percent of our respondents with fewer IP professionals saying that they hold certifications from various other certifying societies and organizations.

Job security also appears to remain stable this year with 46 percent of IP professionals saying they feel very secure; 47 percent feel somewhat secure; and only 7 percent feel somewhat insecure.

Thirty-five percent received salary increases between 2 percent and 2.99 percent with 26 percent of respondents reporting a raise between 1 percent and 1.99 percent. However, 79 percent said they do not expect to see a bonus this year. Of those who do, 50 percent (versus 65 percent in 2015) of respondents said they expect to receive a 1 percent to 2 percent increase.

Job environment
The majority of our respondents, 43 percent, work in a rural facility followed by 30 percent working in urban facilities and 27 percent in suburban facilities. IPs from 45 states responded to the survey with those from nonprofit facilities topping the list at 60 percent; 30 percent from profit-facilities; and 9 percent from government-owned facilities. The majority work at either a standalone hospital (59 percent) or at an IDN, alliance, or multi-group health system (23 percent).

The average number of beds is 206, which is down slightly from last year. We also saw a rise in the number of smaller facilities reported in this year’s survey. Salaries, not surprisingly, are highest at the largest facilities. Most IP professionals who responded —79 percent — also have small departments with one to two employees; only 1 percent reported having 16 to 20 employees in their department. Studies show inadequate staffing ratios have been linked to higher rates of infection. Fortunately, in many hospitals, the ratio of infection preventionists to beds is improving, but many more still need to come on board. The current recommendation is one IP to 100 beds. That may need to be adjusted, based on type of healthcare facility. When IP professionals were asked if their facilities IP-per-patient ratio was aligned with current CDC recommendations, 41 percent answered...
Infection Prevention

affirmatively; 25 percent answered negatively; and 35 percent said they do not know.

IP professionals wear many hats

The American Journal of Infection Control published a study that showed IP professionals today are wrestling with a lot of added responsibilities. Moreover, some do not. When survey respondents were asked if they felt the C-suite in their facilities appreciates and understands the IP’s role in providing good patient care while managing costs, 46 percent answered yes. A disappointing 37 percent said no, and 18 percent said they did not know.

Furthermore, only 33 percent of respondents said they spend 100 percent of their time working on IP activities exclusively. Many said when they’re not doing work specific to IP they are taking on a wide variety of other responsibilities, including:

- employee or occupational health (43 percent of respondents)
- National Healthcare Safety Network reporting (35 percent)
- education/compliance (29 percent)
- disaster/bioterrorism preparedness (20 percent)

### Salary by type of facility

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital, standalone</td>
<td>$74,004</td>
</tr>
<tr>
<td>IDN/Alliance/Multi-group health system</td>
<td>$87,078</td>
</tr>
<tr>
<td>Long term acute care facility (LTAC)</td>
<td>$80,441</td>
</tr>
<tr>
<td>Behavioral/Psychiatric health facility</td>
<td>$75,500</td>
</tr>
<tr>
<td>Rehabilitation facility</td>
<td>$72,083</td>
</tr>
<tr>
<td>Surgi-center/Ambulatory center</td>
<td>$80,833</td>
</tr>
<tr>
<td>HMO/PPD/IPO/Insurance</td>
<td>$76,500</td>
</tr>
<tr>
<td>Clinic</td>
<td>$67,500</td>
</tr>
<tr>
<td>Other</td>
<td>$87,500</td>
</tr>
</tbody>
</table>

### Salary by number of beds

<table>
<thead>
<tr>
<th>Bed Range</th>
<th>Survey Average Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% - Over 1000 beds</td>
<td>$107,667</td>
</tr>
<tr>
<td>2% - 750-999 beds</td>
<td>$95,100</td>
</tr>
<tr>
<td>5% - 500-749 beds</td>
<td>$89,227</td>
</tr>
<tr>
<td>4% - 400-499 beds</td>
<td>$85,800</td>
</tr>
<tr>
<td>10% - 300-399 beds</td>
<td>$79,457</td>
</tr>
<tr>
<td>12% - 200-299 beds</td>
<td>$87,962</td>
</tr>
<tr>
<td>24% - 100-199 beds</td>
<td>$81,849</td>
</tr>
<tr>
<td>17% - 50-99 beds</td>
<td>$73,603</td>
</tr>
<tr>
<td>7% - 26-49 beds</td>
<td>$65,500</td>
</tr>
<tr>
<td>17% - 0-25 beds</td>
<td>$62,705</td>
</tr>
</tbody>
</table>

### Salary by education

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Graduate</td>
<td>$91,764</td>
</tr>
<tr>
<td>Gender not specified</td>
<td>$111,500</td>
</tr>
<tr>
<td>Female</td>
<td>$89,289</td>
</tr>
<tr>
<td>Male</td>
<td>$97,167</td>
</tr>
<tr>
<td>Bachelor's degree</td>
<td>$76,540</td>
</tr>
<tr>
<td>Gender not specified</td>
<td>$75,500</td>
</tr>
<tr>
<td>Female</td>
<td>$76,401</td>
</tr>
<tr>
<td>Male</td>
<td>$79,286</td>
</tr>
<tr>
<td>Associate's degree</td>
<td>$66,907</td>
</tr>
<tr>
<td>Female</td>
<td>$66,582</td>
</tr>
<tr>
<td>Male</td>
<td>$70,100</td>
</tr>
<tr>
<td>High School</td>
<td>$40,000</td>
</tr>
<tr>
<td>Female</td>
<td>$40,000</td>
</tr>
</tbody>
</table>

*Any disparity in percentage totals is due to rounding.

Tracking the trends

Antimicrobial stewardship programs are growing in importance with 72 percent reporting that their facility has one in place – a positive 10 percent jump up from last year – and 19 percent are considering the possibility of implementing a program compared to 23 percent in 2015.

Hand-washing surveillance systems are capturing the attention of more facilities with 60 percent reporting that they have one in place compared to 57 percent in 2015; 17 percent are considering it.

Room-disinfection systems are on the rise slightly with 22 percent using them versus 20 percent in 2015. More than half of our respondents, 51 percent, said they do not use a room disinfection system, which is up slightly from 48 percent last year. Few respondents, 17 percent, also said they are considering purchasing one versus 21 percent in 2015.

Disinfection of electronic devices is another important measure to consider due to the increased use of tablets, smart phones, laptops and other devices during patient care. However, the trend is slow to catch on with 54 percent stating they do not have a system in place for disinfecting electronic items versus 47 percent last year. Only 12 percent (14 percent

### Is your facility using a data mining software program to track, report and analyze infection trends?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Considering</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>38%</td>
<td>54%</td>
<td>7%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Has your facility established an antimicrobial stewardship program?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Considering</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>72%</td>
<td>8%</td>
<td>19%</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Is your facility utilizing or planning to utilize a program to disinfect electronics (tablets, smartphones, laptops) used by clinicians during the course of patient care?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Considering</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>12%</td>
<td>54%</td>
<td>24%</td>
<td>11%</td>
</tr>
</tbody>
</table>

### Has your facility instituted or planned to adopt a hand washing surveillance program?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Considering</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>18%</td>
<td>17%</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Is your facility utilizing or planning to utilize a room disinfection system?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Considering</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>22%</td>
<td>51%</td>
<td>17%</td>
<td>10%</td>
</tr>
</tbody>
</table>

### Salary by years in IP & years at facility

<table>
<thead>
<tr>
<th>Years in IP</th>
<th>IP - AVG: 10.6 yrs</th>
<th>Facility - AVG: 8 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>200-299 beds</td>
<td>$90,342</td>
<td>$87,278</td>
</tr>
<tr>
<td>26-49 beds</td>
<td>$89,289</td>
<td>$86,550</td>
</tr>
<tr>
<td>10-19 beds</td>
<td>$83,574</td>
<td>$81,500</td>
</tr>
<tr>
<td>5-9 beds</td>
<td>$84,459</td>
<td>$81,121</td>
</tr>
<tr>
<td>2-4 beds</td>
<td>$86,508</td>
<td>$79,457</td>
</tr>
<tr>
<td>1-4 beds</td>
<td>$87,667</td>
<td>$79,286</td>
</tr>
</tbody>
</table>
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in 2015) reported using one; 24 percent are considering a plan and 11 percent aren’t sure.

Data-mining software programs that are designed to track, report, and analyze infection trends was a new topic included in this year’s survey and for good reason. IP professionals said they are spending too much time on manual data collecting and reporting which takes them away from other important tasks.

According to the survey results, we found that 38 percent of respondents are now using data-mining software programs while a greater number, 54 percent are not. Another 7 percent said their facility is considering adopting one.

A case study presented at the Association for Professionals in Infection Control and Prevention in June 2015 nailed down just how much time infection preventionists spend on reporting required by the Centers for Medicare and Medicaid Services. Those in the trenches will not be surprised to hear that five hours and eight minutes a day of an infection preventionist’s time, based on a five-day work week, are eaten up by data collection. This leaves IPs with little time left over to observe practices, go on rounds, lead safety drills, or educate staff. And, of note, during the time this study was performed, the featured 355-bed acute-care community hospital was only at 60 percent capacity.

Many respondents are responsible for evaluating and/or purchasing a multitude of supplies, including but not limited to:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand sanitizers</td>
<td>77%</td>
</tr>
<tr>
<td>Disinfectants/sterilants</td>
<td>69%</td>
</tr>
<tr>
<td>Handwashing systems and hand-hygiene monitoring systems</td>
<td>66%</td>
</tr>
<tr>
<td>Cleaning equipment and supplies</td>
<td>64%</td>
</tr>
<tr>
<td>Needlestick and sharps safety devices</td>
<td>57%</td>
</tr>
<tr>
<td>Masks/respirators</td>
<td>56%</td>
</tr>
</tbody>
</table>

This study did not include time needed for performing state and local healthcare-acquired infection reporting, as many facilities must do, so it appears that IPs are burdened, particularly in the smaller community hospitals that may only have one IP, with reporting of data. No doubt the documentation serves useful purposes, but it leaves IPs with little time for other activities designed to protect patients.

A case study noted that previous studies have shown that infection data collection, analysis, and reporting are one of IPs’ most time-consuming activities at a time when their role is expanding to encompass even more responsibilities. The study suggested that automated surveillance systems could provide some relief from too much time spent at a desk and too little time on infection prevention, and observed that staffing and resources need to be taken into consideration as well to ensure a safe environment for patients and staff.

Looking ahead

HPN also asked IP professionals, as it does every year, to tell us what they want to learn more about. Here are the top 10 requests:

- antibiotic/antimicrobial stewardship (59 percent)
- disinfection/sterilization (57 percent)
- multidrug-resistant organisms (54 percent)
- hand-hygiene surveillance (53 percent)
- healthcare-associated infections/prevention (52 percent)
- infection tracking/reporting systems (48 percent)
- environmental services (42 percent)
- cleaning verification testing (39 percent)
- personal protective equipment (39 percent)
- needlestick/sharps safety (36 percent)

We look forward to hearing from you when the HPN Salary Survey goes out again next year. Please respond and spread the word. This is a chance for your voice and concerns to be heard. Make some noise. HPN

References:
May 2016
The self-study lesson on this central service topic was developed by STERIS. The lessons are administered by KSR Publishing Inc.

Earn CEUs
The series can assist readers in maintaining their CS certification. After careful study of the lesson, complete the examination at the end of this section. Mail the complete examination and scoring fee to Healthcare Purchasing News for grading. We will notify you if you have a passing score of 70 percent or higher, and you will receive a certificate of completion within 30 days. Previous lessons are available on the Internet at www.hponline.com.

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The CBSPD (Certification Board for Sterile Processing and Distribution) has pre-approved this in-service for one (1) contact hour for a period of five (5) years from the date of original publication. Successful completion of the lesson and post test must be documented by facility management and those records maintained by the individual until re-certification is required. DO NOT SEND LESSON OR TEST TO CBSPD. For additional information regarding certification contact CBSPD - 148 Main Street, Suite C-1, Lebanon, NJ 08833 • www.sterileprocessing.org.

IACHSMM (International Association of Healthcare Central Service Materiel Management) has pre-approved this in-service for 1.0 Continuing Education Credits for a period of three years, until April 1, 2019. The approval number for this lesson is HPN 160404.


LEARNING OBJECTIVES

1. Explain the uses for water in instrument reprocessing cycles

2. Discuss how poor water quality can affect processes, instruments and patients

3. Understand how to use AAMI TIR 34 as a resource for managing water quality

Water quality for device reprocessing

What you don’t know can hurt patients, instruments and equipment

by Richard Schule, BS, MBA, FCS, FAST

Water, which can exist as a solid, liquid and vapor, is made up of one atom of oxygen and two atoms of hydrogen bonded together by shared electrons. Amazingly, only about three percent of the world’s water is fresh (not salty), and only 11.5 percent of that three percent of fresh water is available to sustain the life of every person, animal and plant on earth.

Water can contain contaminants that are organic (carbon-based, such as proteins and lipids) and inorganic (such as iron, copper, lead and calcium). In addition, microorganisms can survive and even multiply in water.

Local public water systems treat water to make it potable (safe to drink); this includes reducing the levels of harmful chemicals and various types of bacteria, viruses and other microorganisms. Despite this treatment, water can become re-contaminated with chemicals and microorganisms as it is distributed for use.

Water use in healthcare facilities

Water is essential for numerous healthcare functions, such as patient skin hygiene, hand hygiene for staff and visitors, and food preparation and cleanup. The quality of the water becomes more important when it is being used for higher risk healthcare purposes, such as preparing injectable drugs and fluids, and irrigating surgical sites during patient procedures. Among the most complex water quality requirements are those for reusable medical device reprocessing. This includes water for:

- Maintaining moisture during transport of used devices from operating rooms to pre-cleaning areas
- Rinsing organic soils from instruments during pre-cleaning
- Diluting cleaning chemistries
- Preparing liquid chemical disinfection/sterilization solutions
- Rinsing during manual and automated disinfection and liquid chemical sterilization processes
- Thermal (hot water) disinfection
- Steam sterilization
- Humidification in low-temperature sterilization methods (ethylene oxide, e.g.)

Once the water reaches healthcare facilities’ pipework, it can become re-contaminated with a variety of substances before being used for device reprocessing. Water treatment methods can be applied, but as they fix one issue they may cause other problems. For example, many hospitals will add chlorine or other antimicrobial chemicals to water to control microbes (e.g., for Legionella, a type of bacterium); this may reduce microbe levels but can cause other concerns, such as damage to medical devices that can lead to weakening and breakage, potentially during a procedure. In addition, contaminants in water can impact patient safety by contributing to infections and toxic reactions. Poor quality water can also reduce the efficiency and useful life of equipment, increase maintenance costs, impede cleaning efficacy, and interfere with disinfection and/or sterilization. For these important reasons, facility maintenance and sterile processing managers must determine the required water quality needed for each of the facility’s uses, and implement controls to reduce these risks.

Water quality issues to watch for: treatment vs. consequences

There are many factors to be aware of when balancing water purity, functional needs, and potential consequences for a hospital’s reprocessing needs. For example, figure 1 shows the indirect relationship between corrosivity and contamination in water. When it comes to purity, for every “good” there is a potential “bad;” the purer the water, the more corrosive it can be.

There can also be unintended consequences from some kinds of water treatment. For example, one of the impurities in tap water is the chemical used to inactivate microorganisms and make it potable. In the US, either chlorine gas or chloramines are used – sometimes both. These compounds are harmful to purification resins and membranes...
used in water softeners and deionization (DI) and reverse osmosis (RO) systems, so they are usually removed with charcoal filters before they reach these systems. Unfortunately, once the disinfectant is removed, the water becomes a perfect breeding ground for microorganisms. Resin beds in softeners and DI systems are notorious for growing bioburden, which then may cause issues downstream depending on what the purified water is for.

Microbial contamination in water can also be a concern especially if it is used as the final rinse water (e.g., following chemical disinfection or for use in thermal disinfection processes).

Microorganisms can survive and develop as communities called biofilms, in water or moist environments. Biofilms usually start as a single type of microorganism (commonly bacteria) that associate with a surface (such as a water pipe). They can become very strongly attached to the surface, begin to develop a protective matrix, and then allow other types of microorganisms to live on or associate with them. Biofilms are found everywhere: on teeth, on rocks, in water systems, and on medical devices. Once established on surfaces, biofilms provide a particular challenge to cleaning, disinfection, and sterilization, and can cause damage to device surfaces over time. They have been associated with a number of healthcare-associated infections, particularly related to flexible endoscopes that have been reprocessed with biofilm-contaminated water or have developed a biofilm on their surfaces that compromises the effectiveness of reprocessing.

Biofilm can also develop in water lines and storage tanks. Typically, RO or DI treated water is stored in a tank, since more water may be treated than is immediately used.

In addition to the dangers of waterborne microorganisms themselves, there is risk from their by-products. Many types of microorganisms produce substances that are toxic to humans. If present in sufficient quantity, they can have effects on compromised patients. For example, endotoxins are present in certain types of microorganisms. They are released by these organisms over time, or when the microbe is damaged or killed. High levels of endotoxin can lead to toxic reactions in patients (e.g., fever and more serious complications).

Metals and other contaminants, including chemicals such as chloride, silicates or phosphates, can lead to different problems. Chloride concentrations are a particular concern, since a concentration greater than 10 milligrams per liter, particularly when heated, can cause damage such as pitting (formation of small holes) on some stainless steel and plastic components.

Hardness is determined by the concentration of calcium and magnesium ions in the water. Hard water deposits are commonly referred to as ‘scale’ and are most often seen as a white spotting on surfaces, or sometimes brown or black staining. Scale cannot be removed by water and can lead to clogging of equipment, decreased heating capability, spotting on instruments, and eventual device damage.

Rusting is another common problem. On devices this is typically seen as brown deposits on surfaces. Close inspection of these devices will show that the rust is developing over time on parts of the device that are already damaged. There are many causes, but the most common are normal wear-and-tear, exposure to saline and blood, and water quality (mainly chlorine and other chemical contaminants that, when heated, cause damage).

A high (alkaline) or low (acidic) pH in water can also lead to instrument damage. Ideally, water should not be lower than pH 6 or higher than pH 9. The neutral range for potable water is between pH 6.5 to 7.5.

One factor that is often unrecognized is ineffective cleaning, disinfection and sterilization, which carries obvious risks for patients. There are many reasons for it, but poor water quality is a contributing factor. The use of well-formulated cleaning and disinfection chemistries can help mitigate the effect of poor water quality, but formulations vary in capability. Many product labels list specific limitations for the quality of water they require for effectiveness.

Avoidance is good

Poor water quality for reprocessing is a concern because of its potentially pathogenic consequences to susceptible populations, and because of the many issues it engenders for healthcare providers. When water quality is properly managed, however, many of these consequences can be avoided. In this case, preventing bad outcomes is a good thing.

References
Water quality for device reprocessing

Circle the one correct answer:

1. Water requirements for instrument reprocessing include:
   a. Maintaining moisture during transport of used devices from operating rooms to pre-cleaning areas.
   b. Rinsing during manual and automated disinfection and liquid chemical sterilant processes.
   c. Water system treatments to make water potable.
   d. All of the above.
   e. a and b.

2. Steam sterilization is not affected by the quality of water.
   a. True.
   b. False.

3. Poor quality water can reduce the efficiency and useful life of equipment, increase maintenance costs, impede cleaning efficacy and disinfection and/or sterilization.
   a. Enhance.
   b. Contribute to.
   c. Interfere with.
   d. None of the above.
   e. a and b.

4. The purer water is, the less corrosive it will be.
   a. True.
   b. False.

5. Resin beds in softeners and deionization systems are notorious for growing bioburden. This is because:
   a. Charcoal filters remove chlorine gas and chloramines before water enters these systems to avoid damage to the purification resins and membranes.
   b. Chlorine gas or chloramines are used to reduce the number of microorganisms in the water.
   c. Potable water is used when sterile water should be used.
   d. Deionization and reverse osmosis systems filter out the microbes as part of the purification process.
   e. All of the above.

6. Which of these statements is true?
   a. Biofilms have been associated with HAI.
   b. Biofilms develop a protective matrix and allow other types of microorganisms to live on or associate with them.
   c. Established biofilms are typically easy to remove from device surfaces.
   d. All of the above.
   e. a and b.

7. Hard water deposits, or scale, can be removed by rinsing with potable water.
   a. True.
   b. False.

8. Which statements are true?
   a. All disinfection chemistries are capable of mitigating the effects of poor quality water.
   b. Some disinfectant labels list specific water quality limitations for effective cleaning.
   c. Poor water quality can contribute to ineffective cleaning, disinfection and sterilization.
   d. b and c.
   e. All of the above.

9. AAMI TIR 34 is a valuable water quality resource because:
   a. It is thoroughly researched and comprehensive, and can be updated to be responsive to the most current information.
   b. It can help facility staff understand, assess, generate, monitor and maintain the appropriate quality of water for reprocessing functions.
   c. It provides guidance for water maintenance personnel and reprocessing department staff.
   d. All of the above.
   e. b only.

10. AAMI TIR 34: 2014 includes:
    a. Discussions of the categories, selection, treatment, monitoring, and control of water quality for reprocessing.
    b. Categorization of water quality by process (potable, softened, deionized or high-purity).
    c. Personnel considerations, a glossary of important terms, and continuous improvement guidance.
    d. All of the above.
    e. a and c.
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BeliMed Infection Control
When to reprocess stored scopes; CS department practice assessment

by Ray Taurasi

Q My organization is currently debating the definition of “reprocess” in the context of recommendations regarding how long flexible endoscopes can be stored without being reprocessed before use. Regardless of how many days our multidisciplinary team decides to set as the limit, the question of which steps, exactly, should be performed to reprocess the scope after reaching the limit is one where I have not been able to find a clear recommendation. My understanding is that the scope should be fully reprocessed, including all of the normal steps. Others argue that this approach is overkill, and not only causes needless wear to such infrequently used endoscopes, but also wastes resources. These folks claim that a cycle through the automated endoscope reprocessor (AER) is all that is required to get the scope ready again for patient use. We need expert advice.

A To answer your question let’s consider why the scope is being reprocessed in the first place. The answer of course is that the scope may have become contaminated while in storage. The nature and degree of that potential contamination is uncertain. The area or parts of the scope that are contaminated are unknown. Is the contamination organic, bacterial, or some other soil source?

The general rule and practice in sterile processing is that when a surgical instrument or medical device, such as an endoscope, becomes contaminated or is potentially contaminated the entire device including all its parts are to be reprocessed. This means that all steps in the cleaning, decontamination and disinfection process are to be followed in accordance with the device manufacturer’s IFUs. Many AERs do not have a cleaning phase, they only provide a disinfection cycle, thus the scopes must be thoroughly cleaned via a manual cleaning process prior to being placed in the AER for disinfection. In order for the disinfection process to be effective a device must first be cleaned. Residual soils can act as a barrier to the required intimate contact between all surfaces and parts of the medical device and disinfectant. There can be no short cuts to reprocessing protocols.

I am the director of nursing for perioperative services. I was at a recent conference which discussed the alert issued by the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) relative to epidemic failures in reprocessing, sterilization and disinfection procedures in hospital CS departments. The alert requires that hospitals should immediately have a professional assess the performance of their central sterile processing department to ensure they are doing things correctly. Would it be acceptable for me to assign one of my OR nurses to conduct this assessment or do I have to hire a professional consultant to do this?

A In September 2015, the FDA and the CDC did release an alert titled “Immediate Need For Healthcare Facilities to Review Procedures for Cleaning, Disinfecting and Sterilizing Reusable Medical Devices.” This was in response to the high number of well documented breaches and failures in compliance to reprocessing protocols which have led to several adverse patient care outcomes including deaths. This alert was not directed toward any one hospital department. The alert included all healthcare facilities, hospitals, ambulatory surgical centers, clinics and offices. The alert did state that healthcare facilities should arrange for a healthcare professional with expertise in device reprocessing to immediately assess their reprocessing procedures.

The assessment should ensure that reprocessing procedures are done correctly to allow the required time for reprocessing personnel to follow all steps in the device and equipment manufacturer’s IFUs precisely. The alert also stated:

• Staff should be retrained with competencies documented.
• Manufacturer’s instructions for use should be obtained and followed.
• Sufficient time should be allowed to comply with all IFUs (this would include processing equipment, medical device, chemistries, cleaning devices, testing tools, etc.).
• Ensure that availability of the appropriate number and types of processing equipment is available (e.g., sonic washers, accessories, flushing devices, manual wash stations and sinks).
• Perform regular audits of the cleaning, disinfection, sterilization and storage processes.

It should be noted that this alert is not solely directed to the Sterile Processing Department—it includes any area in a facility or organization that performs any cleaning, disinfection or sterilization of medical devices. I have found that most hospitals have some degree or portion of reprocessing being conducted outside of the sterile processing area (e.g., OR, Clinic, Physician office, L&D, Endoscopy, GI Lab, etc.). Thus any and all areas that perform any aspect of reprocessing of medical devices should be included in the assessment.

You asked if it would be acceptable to have one of your OR nurses conduct this assessment. If the nurse was a “healthcare professional with expertise in device reprocessing” and had the professional sterile processing credentials then it might be acceptable to have them conduct the assessment. I am sure as a perioperative director you are aware there is nothing in the nursing curriculum which provides the necessary education in the special skills and knowledge required to be proficient in sterile processing technology. It would be unfair and inappropriate to place one of your staff nurses in the position of having to conduct such an assessment, without the required education and expertise. There is no need or requirement for you to hire an outside consultant to do this assessment provided you have a qualified, credentialed Sterile Processing professional on staff with the expertise. In accordance with the Association for the Advancement of Medical Instrumentation (AAMI) standards the sterile processing manager and supervisory personnel should be qualified by way of proper education, certification and continued education. I believe that any sterile reprocessing done throughout the healthcare facility should come under the direction and management the Sterile Processing Director. This would ensure the standardization of proper reprocessing protocols throughout the organization. HPN

Ray Taurasi is Eastern Regional Director of Clinical Sales and Services for Healthmark Industries. His healthcare career spans over three decades as an Administrator, Educator, Technologist and Consultant. He is a member of AORN, AHA, SGNA, AAMI and a past president of IAHCSSMM. Taurasi has been a faculty member of numerous colleges teaching in the divisions of business administration and health sciences.
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The International Association of Healthcare Central Service Materiel Management (IAHCSMM) is actively working to get Central Service (CS) technician certification bills passed in Massachusetts and Pennsylvania, and progress is being made in both states.

The Massachusetts bill passed out of the Joint Public Health Committee on November 25, 2015. The bill was sent to the Joint Health Care Financing Committee; however, when the Public Health committee passed the bill out of its committee, it changed some of the language in our bill and gave us a new bill number, S.2070. We are working with the chairs of the Health Care Financing committee to change our language back to what was introduced. Our deadline to have our bill pass out of the Health Care Financing committee is April 27, 2016. The week of March 14, 2016, we met with legislators to discuss passing our legislation out of this committee. We met with 10 different legislators and two of them, Rep. Jeff Sanchez and Sen. James Welch, are the co-chairs of the Joint Health Care Financing Committee.

Also, we received a letter of support from UMass Memorial Medical Center. For two years, we worked to attain a letter of support from this hospital and, fortunately, their letter arrived while we were meeting with legislators. We now have four different hospitals in the state supporting our legislation.

Our members in Massachusetts have been reaching out to their legislators, asking them to encourage legislators on the Joint Health Care Financing Committee to vote favorably to pass the bill. As of the date of this publication, 109 members have sent emails, which equates to 123 different legislators being contacted (there are 200 total in the legislature) and 318 emails sent. I make follow-up phone calls to the legislators’ offices, asking if they received the emails and whether or not they will support our legislation. Most of the time, the office staff will not commit a legislator to a yes or no regarding our issue; however, the important thing is to keep the issue in front of them.

If we are successful in passing the bill out of Health Care Financing committee, the bill will be sent to the Ways and Means Committee. Our bill must finish its committee assignments and pass out of the House and Senate, and be signed by the Governor prior to December 31, 2016.

The Massachusetts Chapter for Central Service Professionals held its spring program on March 19, 2016. At the program, State Sen. Michael Rush, a co-sponsor of our legislation, spoke to attendees and explained that if we want our legislation to pass, everyone must contact their state elected officials. He described how easy it is for individuals to contact their elected officials and also reminded that elected officials want to hear from their constituents.

Progress in Pennsylvania
Our lobbyist in Pennsylvania arranged for us to meet with legislators the week of February 8. Two IAHCSMM members attended the meetings with me—Dawn Olsen, RN, and Amanda Masters, RN. We met with legislators who serve on the House Health Committee and asked them to bring our bill up for a committee hearing by this spring.

During one of our meetings, a legislator explained that the reason he signed onto our bill as a co-sponsor was because his father developed a hospital-acquired infection. We are hopeful that we will get a committee hearing this spring. I will be traveling back to Harrisburg to meet with more legislators the week of April 11.

This summer, the IAHCSMM Advocacy Committee and I will be looking at several different states for legislation in 2017. The number of new states will depend on what happens with our Massachusetts and Pennsylvania bills. It will also depend on what the state of Tennessee decides to do with its CS study bill.

The states leading our list at this time are Vermont, New Hampshire and Rhode Island. We are considering these three because we have had success in neighboring states and would like to keep up the momentum in this geographic region. Currently, three states in the nation require certification of CS technicians: New Jersey, New York and Connecticut.

Josephine Colacci, JD, serves as IAHCSMM’s Government Affairs Director.
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2016 SPD EQUIPMENT & TECHNOLOGY GUIDE

The evolution solution

For best outcomes, utilize, standardize, recognize your SPD

by Valerie J. Dimond

Despite diligent efforts made by Central Services / Sterile Processing Departments (CS/SPDs) to get it right, infection outbreaks and deaths linked to poorly cleaned and/or sterilized, decontaminated medical devices continue. Why do certain reprocessing errors persist and what will it finally take to stop them once and for all?

David Jagrosse, President of the International Association of Healthcare Central Service Materiel Management (IAHCSMM), believes stronger laws and more accountability is a good place to start.

“There is a lack of oversight and regulation within the CS field in the United States,” he asserted. “Standards in the U.S. are ‘guidelines,’ with the exception of New Jersey where AAMI ST:79 was adopted into the health code along with required certification. In Europe and Canada, the standards read ‘shall’ and must be followed, whereas in the U.S., the strongest language is ‘should.’

Opinions vary on why sterile processing “never events” happen but one that seems universal, among industry experts, educators, and those working firsthand in the SPD, involves issues around manufacturer’s instructions for use (IFU). As more complex medical devices flood the market, the IFUs that accompany them are also increasingly complicated which can make them difficult to learn and follow properly. On top of that, some of them require a lot more time to complete than most technicians have.

The AAMI Foundation recently called for the creation of a national coalition that would work to improve education and training among clinicians who use healthcare technology during patient care. Part of that effort, they said, would include new “recommendations and/or guidelines to assist in the purchase of complex healthcare technology” as well as “recommendations and/or guidelines for ways to assess competency in the use of complex technology.” Although the language doesn’t mention a specific role sterile processing might play in the effort, it does lead to some important questions.

Shouldn’t SPD professionals be included in the purchasing decisions? Are committees looking closely enough at an instrument’s reprocessing requirements before buying it? Are the IFUs easy to understand and execute? Are they “validated” and reliable? Industry experts say device manufacturers should be able to answer these and other important questions long before purchase agreements are signed.

“CS departments within most hospitals in the U.S. are not equipped to ‘validate’ IFUs; we ‘verify’ the IFU by trying to best replicate the testing conditions outlined in the IFU by the manufacturer and the test lab that the manufacturer used,” Jagrosse explained. “We need to build stronger relationships with industry and these test labs so that the cleaning and sterilization conditions used best replicate those in a real hospital setting.”

And when it comes to evaluating products, facilities must include CS/SPD in the conversation more often. “I can’t speak to specific numbers or percentages of facilities that include CS/SPD staff on product evaluation committees but I certainly think it would add value to the product selection process for reusable medical devices,” said Natalie Lind, IAHCSMM’s Education Director. “It is important to review the IFU before purchasing a reusable device. The CS/SPD member of the committee can share information about the capability of their department to reprocess a specific device.

“It is unfortunate, but many times the first that a CS/SPD department is aware of a new reusable device is when it appears in the decontamination area and is needed shortly for a procedure,” Lind continued. “Participating in the product evaluation process helps make the introduction of new devices go more smoothly and it enables the CS/SPD department to have more time to prepare for handling those new devices.”

Jagrosse says facilities that don’t heed her advice could face some pretty serious setbacks. “There have been instances where $40,000 devices have been purchased by hospitals, only to discover upon receiving the item that the department had no compatible sterilization mode [such as a device that requires ethylene oxide (ETO) sterilization and they do not have that modality],” Jagrosse said. “I not only encourage CS to have representation on the committees, but I also encourage hospitals to change the capital equipment request form so that it asks the question ‘Does this device require high-level disinfection or sterilization?’ If the answer to that question is yes, then this request must be reviewed by the CS manager.”

Outside of product selection, Lind says SPD managers also need to remain watchful of staff skill and performance, making certain that shortcuts are avoided and IFUs are followed precisely at every turn. “Are we brushing lumens vigorously in an effort to get them clean, or are we running the brush through a channel once and thinking that is good enough?” said Lind. “Competencies should be developed at every healthcare worker touch point to help ensure that reusable technologies/devices are reprocessed correctly and the clinician receives a safe device or device component. Failure in that initial step may impact patient outcomes. Every device, from the simplest instrument to the most complex, requires attention to detail during every step of its reprocessing.”

What’s working

Despite the struggle to end reprocessing errors — some of which fall squarely on the shoulders of manufacturers whose devices seem nearly impossible to clean sufficiently — SPDs across the nation are demonstrating higher levels of awareness and a stronger motivation for seeking out and following evidence-based processes.

“The days of using generalities and opinion to reprocess medical devices are fading to the past and the focus is on the science of cleaning, decontamination and sterilization,” Lind said. “That is evidenced by the number of facilities that are placing more emphasis on training and education. Emphasis on best practices is greater than ever before and increasing numbers of CS/SPD professionals are seeking to enhance their knowledge by reaching out to other facilities, as well as professional associations and vendors to help ensure that their processes are appropriate.”
Todd Campbell, President, TBJ Inc., says of recent outbreaks linked to dirty scopes. “An unfortunate reality evidenced by the spate when that happens, patient health is at risk — if an instrument isn’t cleaned thoroughly — then it’s not going to be sterilized thoroughly. If an instrument isn’t cleaned thoroughly, it might be time to upgrade cleaning equipment with newer products that will better assist technicians in the pre-cleaning of instruments so they are safe for the next case.”

“Our hydro-force option automatically re-circulates water creating a gentle turbulence that helps reduced bio burden from instruments automatically which frees technicians to do other tasks during the hydro-force cycle,” said Campbell. “Our automatic sink-filling system enables technicians to push a button and automatically fill a sink bowl to a pre-determined level and inject detergent simultaneously. This also frees them up to walk away and do other tasks instead of manually filling a large sink basin. Our dual purpose ultrasonic sink gives technicians the option of using a sink basin as a standard sink or an ultrasonic cleaning sink with the same 1000-watt cleaning capacity as a console style ultrasonic without an increased foot print that consumes valuable floor space. We oftentimes receive feedback from technicians that the new, customized equipment has made a dramatic improvement in their daily pre-cleaning routines.”

When it comes to flushing scopes, Dan Gusanders, President, Pure Processing LLC, says SPD technicians who have to bend over deep basins all day to perform cleaning activities can feel stressed, are prone to repetitive motion and strain injuries and are less efficient overall due to longer turnaround times. “Following OSHA guidance, we developed a power height-adjusted sink that brings the sink to the perfect back-protecting ergonomic height for each user without exertion,” Gusanders said. “The sink also has an attachable perforated back wall that allows all pre-cleaning tools, brush soaking functions and tubing accessories to be organized below the shoulder-height of virtually any user, for quick access and injury-free use. Our company has received anecdotal reports from sterile processing technicians and managers about significant improvements in productivity, consistency and user comfort after they replaced their manual syringe flushing of scope lumens and channels with our automated FlexiPump Independent Flushing System. Those who also placed PureStation Sink Inserts in their existing too-deep sinks have reported achieving better ergonomics and more efficient pre-cleaning functions without having to replace their existing sinks.”

Brown adds that reprocessing technicians need a variety of tools at their fingertips to complete manual cleaning effectively — there is no one size fits all. “It is vital to have the right instrument cleaning brushes and by ‘right’ I mean the right style, length, diameter and material. Key Surgical offers a wide range of cleaning brushes. A variety of bristle material options are combined with over 60 different diameters and lengths to provide options. Our double-ended toothbrush style brush is perfect for cleaning box locks and serrations and our newest brushes feature rigid stainless steel handles and stiff, nylon bristles to clean challenging instrumentation such as flexible bone reamers.”

Healthmark Industries, also well-known for offering a wide variety of innovative brushes and other accessories, recently introduced the Distal Soak to its Instrument Retrieval product line. This device helps prevent the drying of gross contaminants on the soiled device before cleaning procedures begin. “The Distal Soak is designed to protect the delicate tips, and keep the distal end of surgical instruments moist after clinical use to facilitate cleaning,” explained Healthmark Marketing Manager Matt Smith. “They are available in two styles: closed-hole cap which is filled with solution prior to inserting the device or the open-hole cap design which is used when flushing the solution through the internal channel of the device in compliance with the device manufacturer’s IFU.”

Healthmark’s single-use Small Bore Endoscope Channel Brushes were also added to the ProSys instrument care line to help technician’s clean flexible endoscopes. “Created for the same purpose as expensive reusable brushes, this single-use 1mm diameter brush is a suitable alternative designed for flexible endoscopes that have a balloon suction channel or an instrument channel diameter between 1.0 and 1.5mm,” Smith said. “Fastened to white nylon bristles that have a balloon suction channel or an instrument channel diameter between 1.0 and 1.5mm,” Smith said. “Fastened to white nylon bristles this brush provides a dramatic improvement in cleaning efficiency and is perfect for cleaning box locks and serrations.”

People are the greatest assets. I have seen brand new departments with the latest equipment — and that is wonderful; however, the greatest value can be seen in developing the knowledge and skill sets of technicians. The newest, shiniest technical machine in the world is only as good as the technician who runs it. Machines have no critical thinking skills. Certification and ongoing training and education of CS professionals will bring the greatest benefits to facilities and, most importantly, the patients they serve.”

Getting the job done
Here’s a small sampling of what Central Service/Sterile Processing Departments (CS/SPDs) are using to make surgical instruments safe for use:

**CLEAN ROUTINE**

If an instrument isn’t cleaned thoroughly then it’s not going to be sterilized thoroughly. When that happens, patient health is at risk — an unfortunate reality evidenced by the spate of recent outbreaks linked to dirty scopes. Todd Campbell, President, TBJ Inc., says facilities should pay greater attention to when

David Anbari, Vice President, General Manager, National Sales and Operations, Mobile Instrument Service & Repair Inc., says the SPD is also stepping up its efficiency initiatives after a period of cutbacks and inertia. “Facilities that cut back staffing, replacement of end-of-life items, and routine maintenance services have now reinvested in these programs and the result is better care and outcomes for patients,” he said. “Why the change? It is anyone’s guess, but we think the combined impact of improving financial performance and reimbursement penalties related to hospital-acquired conditions were the impetus for change.”

Lindsay Brown, CCSVP, Senior Sales Representative, Clinical Educator, Key Surgical, also stressed the importance of getting departments to work as a unit, not in silos, to solve problems. “Many healthcare facilities are experiencing financial repercussions and an even greater number of patients are experiencing the physical repercussions of improper reprocessing,” said Brown. “Instead of pointing fingers, SPD staff, OR staff and vendors need to accept responsibilities and work together to find solutions.”

As the call for certification legislation gets louder and more facilities begin to realize the important impact that sterile processing has on outcomes, Jagrosse says at the end of the day it really is the technicians, and not necessarily the products they use, which make a CS/SPD successful.

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and connects to a stainless-steel wire core. The agile and maneuverable design allows the shaft to be pulled entirely through the endoscope channel, reducing the chance of re-depositing loosened debris.”

**TESTING**

Tom Overbey, Director of Marketing, Ultra Clean Systems, says when inspecting instruments, if protein on a surgical instrument isn’t identified and removed then the device can’t be sterilized properly. Overbey says facilities could improve its understanding of the dangers of prions, which are actually proteins and the root cause of Mad Cow Disease (CJD). “Prions serve no biological function and if a patient is subjected to instruments with this type of protein, it becomes fatal in patients and all the surgical instruments used in the case must be destroyed,” he said.

“Residual protein can go virtually undetected and has the potential for creating infection or worse in patients.” Unfortunately, Overbey says it’s a common problem as many technicians lack the knowledge and/or effective tools for detecting it. “With any protein, especially hydrophobic protein where protein is well attached to an instrument, swabbing test methods are guesswork; you can never really tell where the protein is located on the instrument. If you do manage to swab where protein is located, you may not actually transfer protein to the swab thus giving you a false result. Additionally, some use an ATP test to check for protein when in fact ATP is a purine not a protein. With ProReveal fluorescence protein detection test, an instrument is selected after being processed in a washer disinfector and is placed in the system. A special reagent is then applied to the instrument. The ProReveal shows you exactly where the protein is and how much is present on the instrument. You can literally see what your results are without swabbing and without the guesswork.”

Paul A. McDermott, Director, New Product/Market Development, McGan Technology, a company that makes products that test the integrity of the insulation on electrosurgical devices after decontamination, says many hospitals still do not test instruments on a routine basis even though AORN and IAHCSMM recommend it. “We have listened carefully to SPD staff and management concerns; many techs complained about the time [it takes] to test instruments,” McDermott said. “This past year we introduced the new McGan MM513 test kit which eliminated the need to use both hands and reduced the testing time in half. It’s now considered the safest, most efficient insulation testing system in use today. We have non disposable electrodes that if taken care of properly, can last years versus disposable electrodes which can cost the hospital thousands of dollars over a short period of time. If a hospital uses 10 instrument sets a day the savings of finding faulty instruments with reusable electrodes would pay for a McGan unit within 22 days.”
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If your facility doesn’t sterilize according to Manufacturers’ validated Instructions for Use (IFU) and Preventive Maintenance (PM) Documents, then there’s risk for higher infection rates, costly citations and damaging publicity. oneSOURCE makes it affordable and easy for your entire facility to follow IFU and PM Documents, including Biomedical Equipment and Biological Tissue, as required by CMS, Joint Commission & AAAHC Accreditation. Our online database puts thousands of current documents at your fingertips, improving processing efficiency, patient safety and making reimbursements more reliable.

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Anbari (Mobile Instrument Service & Repair Inc.) says patient safety is still the top priority but operational efficiencies in the SPD are equally concerning—and for good reason, according to what he encounters at some facilities. “In extreme situations, staffing models are still random and variable, training programs are infrequent and lacking,” Anbari said. “Disruptions from missing instruments or quick-turn items happen daily. Facility designs do not support workflow. There is mixed success in OR and SPD staff communications. Equipment flow is still in silos in the OR and SPD. What these issues have in common is a lack of data to inform managers as they run their SPD operations. For the facilities that have tracking systems, they are incomplete or fail to supply key management data; and many facilities still lack basic systems to track workflow and throughput. Without the data, it is hard to identify bottlenecks and drive efficiency.”

Anbari says partnering with a company that can help to keep instruments in excellent working condition at all times is key to achieving greater efficiencies, especially when paired with a good tracking system. “We worked with a five-hospital health system on a new proactive approach to maintaining their surgical equipment. Using data from their tracking systems and our proprietary algorithms on maintenance frequency requirements for surgical equipment types, we were able to increase maintenance frequencies on their highest usage items and fund the increase by reducing unnecessary maintenance on items that had lower usage or lower maintenance requirements,” he said. “Simultaneously, we performed a comprehensive assessment of their equipment care and handling practices by looking at staff competencies, tools, and facility design. We designed tailored educational and coaching programs to address deficiencies that were damaging equipment. After one year, the net reduction in spend was over 30 percent compared to the prior year and there were double-digit improvements in all key clinical performance indicators we defined prior to our service launch.”

Joe Smith, Director of Marketing, Belimed, says facilities are also facing more frequent visits by The Joint Commission than ever before and will need to take added measures to ensure compliance. Smith describes how Belimed can help: “Clean Steam is a unique Belimed sterilization process that utilizes contaminant-free steam for terminal sterilization. There have been cases where SPD’s would see contamination (spotting) in the instrument tray when opened in the OR. Once Clean Steam was implemented all issues related to spotting were resolved,” he said. “Simultaneously, we performed a comprehensive assessment of their equipment care and handling practices by looking at staff competencies, tools, and facility design. We designed tailored educational and coaching programs to address deficiencies that were damaging equipment. After one year, the net reduction in spend was over 30 percent compared to the prior year and there were double-digit improvements in all key clinical performance indicators we defined prior to our service launch.”

The truth is that microfiber really works best the first time it’s used. After that, it’s just a magnet for nasties—Hair, lint, fungi, mold, even spores—recirculating through the laundry. Microfiber, while great at grabbing up bioburden from hospital floors or surfaces, is terrible at letting go even when washed. So why take that risk with tonight’s OR terminal cleaning? PREMIRA® Microfiber Pads are revolutionary. New microfiber every time because our products are disposable. Superior bioburden removal and liquid sorption every time because PREMIRA products are single use. And white in color because they can be, unlike those fuzzy, graying mops that hide dirt and microbes in your laundry bins.

So simplify your cleaning life, EVS and OR Techs! Eliminate logistical headaches, Purchasing Managers! Get cleaner environmental surfaces, Infection Preventionists! And rest easier nursing staff and patients, because the Single Use Revolution is coming.


PREMIRA® Microfiber Pads
• Eliminate Cross-Contamination
• Doesn’t Neutralize Disinfectants
• Consistently Better Cleaning
• Optimize Staff Efficiency
• Smaller Storage Footprint
• Clinically Superior

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INDEPENDENT

SURGICAL AND ENDOSCOPIC Equipment Repair Authority

Mobile Instrument is the single source for all your instrument/equipment repair and maintenance needs.

- OnSite Services
- General Instruments
- Laparoscopic Instruments
- Rigid & Flexible Scopes
- Power Equipment
- Video Equipment

For more information call 800-722-3675 or visit www.mobileinstrument.com

Visit www.ksrleads.com/7605hp-014
PC or instrument tracking system. The software is unique in that it is adaptable to any instrument tracking system on the market. Provided the instrument tracking system can communicate to the hospital’s Electronic Medical Records software, the data from ICS can be assigned to the patient level.”

**IMPRESS products**, a division of BD, also offers “scalable, real-time and integrated instrument management systems with extensive support,” according to Marketing Manager Jodi Rummelhart. “Using these solutions, you can manage your inventory, people and processes throughout the continuum of instrument management,” she said. “Our dedicated IMPRESS Managers work with customers to understand their individual goals prior to implementation. This allows for ‘customized’ system setup and use and ultimately helps aid in department and facility improvements. One example of system functionality is ORIS integration with the IMPRESS system. This integration supports having patient needs drive SPD processing. SPD staff can view items that have assigned case times within the system and prioritize work accordingly.”

**STORAGE AND PROTECTION**

For those seeking wrap alternatives, Chris Toth, Product/Market Manager, V. Mueller Products and Services, a division of BD, says his company’s Genesis containers protect instruments during sterilization, transport and storage. “Designed to achieve and maintain sterility, Genesis containers provide a return on your investment and a green alternative to sterilization wrap,” Toth said. “Following a one-time capital purchase of Genesis containers, one hospital began to see an accumulated return on investment from not having to buy as much disposable sterilization wrap. In the first year, the facility saw a savings of $21,069.08 and a reduction of 7,424.12 pounds of wrap. By the second year, the facility saved over $48,000 and decreased 11,876.6 pounds of wrap.”

Scott Cohen, CEO, Innovative Sterilization Technologies LLC, talks about ONE TRAY, a rigid container solution introduced about two years ago that is gaining considerable attention from CS/SPD professionals. “With a total 20 minute, door-close-to-door-open sterilization cycle, hospitals now have the terminal sterilization efficiency to reach internal improvement goals,” said Cohen. ONE TRAY eliminates the need for IUSS and provides a valid solution for processing OEM spine and orthopaedic instrumentation and implants without having to deal with wet packs/torn sterilization wrap and workflow disruptions.

“ONE TRAY decreases overall costs of sterilization and elevates the quality of processing,” Cohen asserted. “Having this technology available in ‘emergency’ situations is greatly needed. From turning a whole contaminated back table to processing a surgeon’s special ‘one-of-a-kind’ instrument for the next case. ONE TRAY provides the solution to most issues relating to performance, efficiency, and productivity. Handling these types of situations quickly results in cost savings and a proven ROI on ONE TRAY investment many times over.”

Also a Product/Market Manager with V. Mueller Products and Services, Alicia Diaz discussed the value of using the company’s instrument tip protectors to guard against damage from breaking or chipping during sterilization and handling. “The tip protectors can help eliminate reprocessing costs caused by torn pouches or wrap, and also protect staff from sharps injuries during handling,” she said. V. Mueller instrument tape, designed to securely adhere to surgical instruments, also helps identify, organize and track instruments. “The number of and differing types of instrument sets that SPDs are required to process continues to increase. This heightened volume and corresponding complexity, especially of non-hospital owned instrumentation, puts a tremendous strain on Sterile Processing Department resources.”

Sonia Leonard, Marketing Communications Manager, Medivators, shared some
FRAIL. BENT INSTRUMENT BASKETS. BOWED. LESS DURABLE PLASTIC TRAYS. DELICATE. FLIMSY. NO LONG EVITY. BAD VENTILATION. TRAYS THAT AREN’T LASTING A YEAR. RUST. BRITTLE CRACKING TRAYS. BROKEN LATCHES. WARPing FROM REPEATED STERILIZATION. RUST. DROPPED TRAYS IN SPD. WET PACKS. UNACCEPTABLE TO THE OR. CRACKED COVERS. EXPENSIVE AND FREQUENT REPLACEMENT LONG WAIT TO GET YOUR REPAIRED TRAYS BACK.

THE SOLUTION.

Customizable Instrument Protection Trays

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Visit us at IAHCSMM Booth #1200 - 1202
information about the company’s ENDODRY Cabinet, a storage solution that maximizes patient protection by ensuring that endoscopes are “100 percent bone-dry.”

“With the Mediator’s ENDODRY Drying and Storage Cabinet, HEPA filtered air is continuously circulated through each endoscope channel and around its exterior for complete drying prior to use,” Leonard explained. “Capable of managing eight endoscopes per cabinet, the integrated cassette system protects the endoscope by minimizing operator handling which reduces endoscope damage and subsequent repairs.”

Sharon Hadley, BSN, RN, CNOR, CSPDM, CHL, Vice President, Clinical Training, IMS, says her company assists OR and SPD with workflow efficiencies using its multiple tray sterilization units, including a new technology called the “The Cube.” She explained how the product “allows for up to 12 orthopedics and neurology vendor trays to be reprocessed without wrapping within one convenient container. Use of these units may result in a significant reduction in wrap waste and lost containers and a decrease in turn time in the OR, which can lead to an increase in staff and surgeon satisfaction.”

In 2015, says IMS SPD services also helped a 581-bed hospital in Georgia save a significant amount of money by identifying over 20 case carts in disrepair that had been left and forgotten for many years. Fortunately, Hadley says they were able to repair those carts for a fraction of the cost and they also cut its IUSS rate from 17 percent under 4 percent by creating a Missing Item Tracking Form. “Using the form helps detect missing items and then alerts the department to what specific instrumentation is missing. This assists the SPD to find and provide instrumentation to the correct location in less than 24 hours," Hadley said. The SPD team also benefited from IMS in-services which helped them prepare for an upcoming TJC visit of which no discrepancies were noted. HPN

Reference:

Please refer to HPN’s Annual Buyer’s Guide below for a complete listing of sterile processing products and services, including capital equipment.
The Right Choices In The Fight Against Infection

The O.R. Choice
- Rapid, efficient sterilization of surgical instruments
- Compact footprint, easily fitting into existing space
- Integral generator when building steam is unavailable
- Offered in vertical sliding and manual hinged door types
- Single and double door configurations

The SPD Choice
- Large chamber size, capable of sterilizing heavy loads
- Convenient, hands-free door sealing mechanism
- Stainless steel cladded insulation helps prevent wet packs
- Offered in horizontal sliding and automatic hinged door types
- Single and double door configurations

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Visit www.ksrleads.com/?605hp-016
2016 SPD Equipment & Technology Vendors

- Metrex
- Ruhof Healthcare
- Steris Corporation
- Ultra Clean Systems, Inc.
- United Biotech

Rust and Stain Removers
- BD
- Carefusion
- Case Medical Inc
- www.casemed.com

2016 SPD Equipment & Technology Vendors

Packaging/Containment/Storage

Basket/Bins
- Aesculap
- www.aesculapusa.com
- AirClean Systems
- www.aircleansystems.com
- Integra Miltex
- www.integramiltex.com
- Miele
- www.miele-pro.com
- Potomac Labs
- www.potomaclabs.com
- Ruhof Healthcare
- www.ruhoftm.com
- Steris Corporation
- www.steris.com

Sterilants
- 3M Health Care
- www.3m.com/infectionprevention
- ASP (Advanced Sterilization Products)
- www.aspjj.com
- Metrex
- www.metrex.com
- Spericidin by Contec
- www.spericidin.com
- Steris Corporation
- www.steris.com

2016 SPD Equipment & Technology Vendors

Instrument Holders/Protectors
- 3M Health Care
- www.3m.com/infectionprevention
- ASP (Advanced Sterilization Products)
- www.aspjj.com

Instrument Holders/Protectors
- Aesculap
- www.aesculapusa.com
- AirClean Systems
- www.aircleansystems.com
- Case Medical Inc
- www.casemed.com
- Getting USA Inc
- www.getingeusa.com
- Healthmark Industries Company Inc
- www.healthmark.com
- IMS
- www.imsteris.com
- Innovative Sterilization Technologies
- www.iststerilization.com
- Key Surgical
- www.keyfern.org
- Logi-D
- www.logi-d.net
- Logiqip
- www.logiqip.com
- Medisafe America
- www.medisafeamerica.com
- Mediators
- www.mediators.com
- Millennium Surgical
- www.millenniumsurgical.com
- Richard Wolf
- www.richardwolfusa.com
- Rousseau Metal
- www.rousseaumetal.com
- Ruhof Healthcare
- www.ruhoftm.com
- Steelco USA
- www.steelco-usa.com
- Ultra Clean Systems, Inc.
- www.ultracleansystems.com

Containers/Container Systems
- ASP (Advanced Sterilization Products)
- www.aspjj.com
- Aesculap
- www.aesculapusa.com
- BD
- www.carefusion.com
- Case Medical Inc
- www.casemed.com
- CS Medical
- www.csmedicalllc.com
- Ecolab Inc
- www.ecolab.com
- Healthmark Industries Company Inc
- www.healthmark.com
- IMS
- www.imsteris.com
- Innovative Sterilization Technologies
- www.iststerilization.com
- Medline
- www.medline.com
- Millennium Surgical
- www.millenniumsurgical.com
- Resto Medical Solutions
- www.restore-med.com
- Rousseau Metal
- www.rousseaumetal.com
- Ruhof Healthcare
- www.ruhoftm.com

Instruments/Containers
- Aesculap
- www.aesculapusa.com
- BD
- www.carefusion.com
- Case Medical Inc
- www.casemed.com
- Cygnus Medical
- www.cygnusmedical.com
- Innovative Sterilization Technologies
- www.iststerilization.com
- Key Surgical
- www.keyfern.org
- Logi-D
- www.logi-d.net
- Logiqip
- www.logiqip.com
- Medisafe America
- www.medisafeamerica.com
- Mediators
- www.mediators.com
- Millennium Surgical
- www.millenniumsurgical.com
- Richard Wolf
- www.richardwolfusa.com
- Rousseau Metal
- www.rousseaumetal.com
- Ruhof Healthcare
- www.ruhoftm.com

Sterilization Equipment
- Case Medical Inc
- www.casemed.com
- Cygnus Medical
- www.cygnusmedical.com
- Innovative Sterilization Technologies
- www.iststerilization.com
- Key Surgical
- www.keyfern.org
- Logi-D
- www.logi-d.net
- Logiqip
- www.logiqip.com
- Medisafe America
- www.medisafeamerica.com
- Mediators
- www.mediators.com
- Millennium Surgical
- www.millenniumsurgical.com
- Richard Wolf
- www.richardwolfusa.com
- Rousseau Metal
- www.rousseaumetal.com
- Ruhof Healthcare
- www.ruhoftm.com

Disposable Instrument Tray

Made from 100% renewable resource.
Biodegradable.

Solve Central Sterile bottlenecks.
You needed an instrument set, but Central Sterile was short on trays! A problem that could have been avoided with Cygnus Medical’s SingleCycle Instrument Tray. Disposable and steam sterilization compatible, SingleCycle is a cost-effective option for instruments traveling to different floors or off-site for reprocessing. It’s designed to protect even the most delicate instruments from damage and provides secure, tamper-proof protection of used surgical instruments. Keep them nearby to avoid shortage problems during even the busiest times.
THINK INSIDE THE CUBE.
Take the Pain out of Ortho and Neuro Trays with the MTS300 The Cube

- No wrapping/unwrapping necessary
- Sterilize up to 12 trays per load
- Enables easy transit to the OR
2016 SPD EQUIPMENT & TECHNOLOGY VENDORS

IMS
www.imsteris.com
Innovative Sterilization Technologies
www.innovativestere.com
Instrument Specialists Inc.
www.isisurgery.com
LogiQuip
www.logiquip.com
Medisafe America
www.medisafeamerica.com
Medivators
www.medivators.com
Mobile Instrument Service
www.mobileinstrument.com
PCI Medical
www.pcimedical.com
Rousseau Metal
www.rousseaumetal.com
Ruhof Healthcare
www.ruhof.com
Stanley InnerSpace
www.stanleyinnerSpace.com
Steelco USA
www.steelco-usa.com
STERIS Corporation
www.steris.com
Symmetry Surgical
www.specurg.com
Velmed Inc.
www.velmedinc.com
INSTRUMENT STRINGERS
Healthmark Industries Company Inc.
www.hmark.com
Healthmark Industries
www.hmark.com
IMS
www.imsteris.com
Restore Medical Solutions
www.restore-med.com
MEDICAL GRADE PAPER BAGS
Healthmark Industries Company Inc.
www.hmark.com
IMS
www.imsteris.com
Restore Medical Solutions
www.restore-med.com
MEDICAL GRADE PAPER BAGS
Healthmark Industries Company Inc.
www.hmark.com
IMS
www.imsteris.com
Restore Medical Solutions
www.restore-med.com
STERILIZATION WRAPS/POUCHES/SEALERS
3M Health Care
3m.com/infectionprevention
ASP (Advanced Sterilization Products)
www.aspjj.com
Innovative Sterilization Technologies
www.innovativestere.com
Instrument Specialists Inc.
www.isisurgery.com
LogiQuip
www.logiquip.com
Medisafe America
www.medisafeamerica.com
Medivators
www.medivators.com
Mobile Instrument Service
www.mobileinstrument.com
PCI Medical
www.pcimedical.com
Rousseau Metal
www.rousseaumetal.com
Ruhof Healthcare
www.ruhof.com
Stanley InnerSpace
www.stanleyinnerSpace.com
Steelco USA
www.steelco-usa.com
STERIS Corporation
www.steris.com
Symmetry Surgical
www.specurg.com
Velmed Inc.
www.velmedinc.com
VENDOR SPOTLIGHTS
RUHOF
Rapid Detection of Contamination
The Ruhof ATP Complete System is a quick, easy to use and reliable method to check for microbiological contamination, helping to lower the risk of HAIs to patients and staff. ATP Complete can be used throughout your healthcare facility where rapid detection of contamination is crucial. In just 15 seconds ATP Complete verifies the efficacy of cleaning protocols for surgical instruments, endoscopes, and all non-critical surfaces and also monitors the effectiveness of hand washing methods.

See Ruhof at IAHCSMM booth #1100
Visit www.ksrleads.com/7605hp-020

HEALTHMARK INDUSTRIES
Cool Aid Single-use Vests are designed to manage the core body temperature. Worn under surgical attire, they are ideal for use by staff during surgery because cooling is achieved with the reusable cooling packs rather than with a system of hoses and an external source. This innovative design allows for greater freedom of movement without worrying how to launder them.

See Healthmark at IAHCSMM booth #600
Visit www.ksrleads.com/7605hp-017

April 24-27
San Antonio, TX
VENDOR SPOTLIGHTS

**RUHOF**
Premixslip, Ruhof’s instrument lubricant and rust inhibitor, is now available in a new spray can with applicator tip to enable deep penetration into hard-to-reach cannulas and sticky box-locks and joints. Premixslip is the only instrument lubricant and rust inhibitor clinically tested to be thoroughly steam penetrable and steam sterilizable. Used routinely as part of the Ruhof Instrument Care System, Premixslip will greatly reduce repair and replacement costs.

See Ruhof at IAHCSMM booth #1100
Visit www.ksrleads.com/?605hp-040

**CYGNUS MEDICAL**
Tray Belts • Sterile Wrap Protection
Protect wrapped trays from the external damage that can occur during sterilization, storage and transport. Tray Belts provide a cushioned barrier from the many sharp edges that can easily rip and tear sterile wrapping. The Belts also prevent abrasion marks and damage caused by dragging the wrapped tray. Contact Cygnus Medical today to learn more.

See Cygnus Medical at IAHCSMM booth #328
Visit www.ksrleads.com/?605hp-044

**SUMMIT MEDICAL**
InstruSafe Trays by Summit Medical are designed to protect and organize surgical instruments during sterilization, transportation and storage. Our perforated aluminum trays are made with medical grade silicone parts and have been FDA 510(k) cleared for a variety of sterilization cycles. Each tray is engineered for customization, creating endless solutions for your instrument set needs.

See Summit Medical at IAHCSMM booth #1200
Visit www.ksrleads.com/?605hp-034

**ONESOURCE**
Your manufacturers’ instruction for use (IFU) documents are just one click away at oneSOURCedocs.com. Your entire facility will be compliance-ready with online access to thousands of up-to-date manufacturer and Tech-Ready documents for cleaning reusable surgical instruments and devices. For more information, call 1-800-701-3560 or visit our website, www.onesourceds.com.

See OneSource at IAHCSMM booth #516
Visit www.ksrleads.com/?605hp-025

**MOBILE INSTRUMENT SERVICE & REPAIR**
Mobile Instrument is the nation’s largest, full-service equipment repair and maintenance company serving hospitals and surgery centers since 1978. Mobile provides rigid and flexible endoscope repair for all manufacturers’ makes and models, even those deemed obsolete. Mobile is a contracted supplier for all major GPOs providing quality repairs which feature fast turnaround and full warranty at the best possible pricing. Extensive loaner inventories with loaners provided at no charge. Contact Mobile Instrument Repair at 800-722-3675.

See Mobile Instrument at IAHCSMM booth #301
Visit www.ksrleads.com/?605hp-019

**KEM MEDICAL PRODUCTS CORP.**
KemSure premium sterilization barcode labels have been developed specifically for sterilization processing. Designed to withstand the rigors of sterilization processing, they provide durability and print reliability. KemSure labels are an ideal component for all instrument tracking systems. Available in eight sizes, seven colors and 3” and 1” cores.

See Kem Medical at IAHCSMM booth #912
Visit www.ksrleads.com/?605hp-018

**BELIMED**
At Belimed, we are different! We provide innovative technology, clinical expertise and world-class CSSD layout and workflow designs. Visit us at IAHCSMM Booth #510 to learn why Belimed is the fastest growing sterile processing equipment and solutions provider in the US since 1997 and get a sneak peek of our new Belimed Protect Cleaning Solutions portfolio.

See Belimed at IAHCSMM booth #510
Visit www.ksrleads.com/?605hp-023
**DALE MEDICAL**

Dale’s IV-ARMOR is the ideal way to maximize IV patency while protecting the site from patient tampering. The flexible protective overlay minimizes line occlusions caused by kinking while allowing for a full range of motion. IV-ARMOR reduces the risk of infection associated with IV reinsertion.

Visit www.sterilestorage.com to learn more.

See Dale Medical at AACN booth #2247
Visit www.ksrleads.com/7605hp-033

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**HÄNEL STORAGE SYSTEMS**

The Rotomat Vertical Carousel from Hänel can save up to 70% of the existing floor space within a central sterile storage department while improving accuracy, enhancing security and boosting productivity. The Rotomat is ideal for wraps and trays as well as implants, consumables and soft goods. Visit www.sterilestorage.com to learn more.

See Hänel at IAHCSMM booth #322
Visit www.ksrleads.com/7605hp-030

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**DALE MEDICAL**

Dale’s IV-ARMOR is the ideal way to maximize IV patency while protecting the site from patient tampering. The flexible protective overlay minimizes line occlusions caused by kinking while allowing for a full range of motion. IV-ARMOR reduces the risk of infection associated with IV reinsertion.

Visit www.sterilestorage.com to learn more.

See Dale Medical at AACN booth #2247
Visit www.ksrleads.com/7605hp-033

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**AESCULAP**

CONFIDENCE IN OUR PRODUCTS.
TRUST IN OUR EXPERTISE.
Aesculap gives you the confidence to optimize sets with its validated and proven SterilContainer System and quality surgical instruments. Trust in Aesculap to help lower expenses through its quality repair and process consulting services.

See Aesculap at IAHCSMM booth #1000
Visit www.ksrleads.com/7605hp-046

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**INNOVATIVE STERILIZATION**

ONE TRAY is the ONE Standard of Care. The ONE TRAY system achieves a Sterility Assurance Level (SAL) of 10 to the -6 and has a 180-day shelf life, with no dry/cool time required, and comes with a LIFETIME WARRANTY! It is what you DON’T SEE that matters most. Invest in the best!

See Innovative Sterilization at IAHCSMM booth #642
Visit www.ksrleads.com/7605hp-036

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**BD**

See how V. Mueller products can make your life easier at BD booth 620. We feature the IMPRESS instrument tracking system, V. Mueller detergents and instrument-processing supplies and Genesis sterilization containers.

See BD at IAHCSMM booth #620
Visit www.ksrleads.com/7605hp-038

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**MEDIVATORS**

A Higher Standard for Endoscope Drying and Storage
MEDIVATORS Storage and Drying Cabinet continuously forces HEPA filtered air through all endoscope channels, ensuring a completely dry endoscope.
- Permanent ventilation of channels eliminates residual moisture within the cabinet.
- Circulation of dry HEPA filtered compressed air through each channel and around the outer sheath ensures a fully dried endoscope.
- Short drying cycle improves scope turn-around time.

See Medivators at IAHCSMM booth # 1001
Visit www.ksrleads.com/7605hp-042

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**PURE PROCESSING**

PureSteel Instrument Flushing Sink XI
This NEW compact flushing sink has a small footprint ideal for cramped spaces. It can be dedicated to pre-cleaning robotics, MIS and/or endoscopy devices. Includes: 3 flushing pumps, to simultaneously flush up to 9 channels (3 robotic instruments); a two-gallon tank for cleaning detergent; and a digital thermometer to monitor enzyme temperature. www.PureProcessing.com.

See Pure Processing at IAHCSMM booth #428
Visit www.ksrleads.com/7605hp-032

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**ULTRA CLEAN SYSTEMS**

The Triton 72 by Ultra Clean Systems Inc. has more throughput than any other ultrasonic cleaning system. It can clean up to 40 da Vinci robotics in a 15-minute cycle. Other features include an industry-best 72 lumen instrument capacity, exclusive Titanium Rod Transducer (TRT) technology, variable cleaning cycle time, and a 10" touchscreen display.

See Ultra Clean Systems at IAHCSMM booth #210
Visit www.UltraCleanSystems.com

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**DALE MEDICAL**

Dale’s IV-ARMOR is the ideal way to maximize IV patency while protecting the site from patient tampering. The flexible protective overlay minimizes line occlusions caused by kinking while allowing for a full range of motion. IV-ARMOR reduces the risk of infection associated with IV reinsertion.

Visit www.sterilestorage.com to learn more.

See Dale Medical at AACN booth #2247
Visit www.ksrleads.com/7605hp-033

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- Circulation of dry HEPA filtered compressed air through each channel and around the outer sheath ensures a fully dried endoscope.
- Short drying cycle improves scope turn-around time.

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Visit www.ksrleads.com/7605hp-042

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See Pure Processing at IAHCSMM booth #428
Visit www.ksrleads.com/7605hp-032
NEW TECHNOLOGY

Sterile Box mobile container can sterilize surgical instruments in low-resource settings

Rice University students and their mentors have created a sterilization station for surgical instruments that can help minimize risk of infections to patients anywhere in the world.

The station built into a standard 20-foot steel shipping container houses all the equipment necessary to prepare surgical instruments for safe reuse, including a water system for decontamination and a solar-powered autoclave for steam sterilization. Autoclaves are standard in modern hospitals but badly needed in low-resource settings.

After months of design and construction, Douglas Schuler, an associate professor of business and public policy in Rice’s Jones Graduate School of Business, and his team published an article in the open-access journal PLoS ONE detailing trials to validate what they call the Sterile Box.

They reported the system’s performance was nearly perfect over 61 trials in 2015 to sterilize and prepare a set of instruments for return to the operating room.

The researchers cited studies that show about a third of patients in low-resource settings suffer surgical-site infections, a number nine times higher than in developed countries. These infections are frequently the result of care providers using medical instruments that carry traces of microorganisms or biological material from previous patients.

Schuler and his students have been working to sterilize instruments with sunlight for years. Their first design used a mobile A-frame solar-thermal device, the Capteur Soleil, that focused sunlight to heat a stand-alone autoclave. But the team decided to design a more comprehensive platform in which instruments could be processed day and night.

Rice Professor Maria Oden, director of the university’s Oshman Engineering Design Kitchen and a co-author of the article, said rural areas and small cities in developing countries often have medical facilities with improperly maintained or malfunctioning sterilization equipment or no equipment at all. Unreliable power and inadequate quality control over sterilization are also issues, the fact that the Sterile Box is a complete drop-in system is significant, she said.

The Rice team added solar panels and electrical storage to the container, as well as water distribution from two tanks, one on the ground and a co-author of the article, said rural areas and small cities in developing countries often have medical facilities with improperly maintained or malfunctioning sterilization equipment or no equipment at all. Unreliable power and inadequate quality control over sterilization are also issues, the fact that the Sterile Box is a complete drop-in system is significant, she said.

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PRODUCTS & SERVICES

Critical juncture needed for stocking CCUs, ICUs

by Rick Dana Barlow

Clinicians and administrators tend to treat critical care performance with kid gloves and all the sensitivity the operations and processes deserve based on the patients being treated.

Supply chain performance for this key clinical area should be no exception. Without the gear and tools at their fingertips at a moment’s notice, Critical Care Nurses find it a bit of a challenge to do their jobs in caring for their fragile patients.

Historically, communication between the two departments — Critical Care and Supply Chain — by and large, has been brittle and spotty at many facilities. Healthcare Purchasing News has learned and reported since 2003. This motivated HPN to hold panel discussions exploring how the two departments can work together at the yearly American Association of Critical-Care Nurses National Teaching Institute in May. This year, HPN hosts its 13th annual panel discussion on Critical Care and Supply Chain at the AACN-NTI conference in New Orleans on Tuesday, May 17, and Wednesday, May 18, at 1:45-2:30 p.m.

While communication breakdowns may be typical at many facilities, some have developed a form of détente, bordering on cooperation and collaboration, while others figured out successful ways to click and have thrived.

Either way, it remains clear that both must work together hand-in-hand, shelf-to-shelf, as quickly as possible, navigating through performance demands, supply usage patterns, a mutual understanding and respect of each other’s responsibilities.

Along those lines, HPN Senior Editor Rick Dana Barlow reached out to two healthcare executives who will participate in this year’s panel discussion in a few weeks for their perceptions on the professional relationship between Critical Care and Supply Chain. Meghan Pishnery, RN, CCRN, serves as Assistant Nurse Manager, ICU/CCU, Cleveland Clinic. Kathy Chauvin, RN, serves as Director of Resource Utilization and Value Analysis, Franciscan Missionaries of Our Lady (FMOL) Health System in Baton Rouge, LA. Both nurses with critical care and supply chain experience, Pishnery and Chauvin highlighted their observations and expectations about roles and responsibilities.

HPN: As a Critical Care Nursing professional, how do you measure success when it comes to Supply Chain support?

PISHNERY: The success of supply chain support can be measured by the stock and availability of the necessary supplies needed by the critical care nurse on a daily basis. Having the understanding by supply chain of restocking the supplies in a timely manner and anticipating the needs of supplies the unit will need is important.

CHAUVIN: When I worked as a Critical Care Nurse in years past, the main measure of supply chain support was having the right products to care for the patient available at the right time in the right location. As a nurse, the main focus is on the care of the patient and being as close to the bedside as possible at all times. Nurses should not have to hunt for supplies or have to call down to Materials Management to bring up needed supplies. Nor should they need to order supplies themselves. Supply Chain should be engaged with management and staff to assess the supply needs and have those available when needed. If supplies are running low, they should be replenished and assessments made on increasing the PAR levels to the current demand.

Do you feel that Supply Chain really understands Critical Care’s product and service needs not only within your organization but also across the industry? Why?

PISHNERY: I do feel that my own organization’s Supply Chain understands Critical Care service needs. At my organization we meet with Supply Chain sometimes on a monthly basis to discuss the needs and any issues that may have come up. The Supply Chain representatives at my organization are always willing to assist and adjust our supply needs to cater to the needs of the unit. As for across the industry, I think there has been an improved relationship with the Critical Care unit and Supply Chain partnership. There is more of an
understanding of what supplies and why sometimes they are needed more frequently.

CHAUVIN: I think it is getting better with the incorporation of Value Analysis teams and new product introduction policies. This has allowed an avenue for open discussion between Supply Chain and Nursing. Open communication between the groups fosters relationship building. The nurse’s reliance on Supply Chain team members to understand the clinical needs and be able to provide supply and services is critical to the success of the organization.

How might successes be communicated and shared with the industry at large?

PISHNERY: Communication and sharing the success can be done by publishing best practices to share with others across our profession. This could be submitted to a professional magazine/journal, website or blog.

CHAUVIN: Networking, sharing best practices among leadership groups, inviting the supplier community to the table to discuss best practice and outcomes. Suppliers conduct extensive research on their products’ efficacy and efficiency. Suppliers and end users should collaborate to achieve common goals.

As a Critical Care Nursing professional, what are some things you thought you knew about Supply Chain Management that were off-base?

PISHNERY: When I was a newer nurse, I did not understand the process that is needed to maintain the supplies in the unit; that Supply Chain only brought up supplies on their time. That they did not understand that when we needed supplies immediately. That they just added it to their list as not an emergent item.

CHAUVIN: When I was a practicing nurse, my thoughts were whatever products were on the shelf was what you used, like it or leave it. If you ran out of something, it was your responsibility in most cases to order, pick up from Central Supply, and make sure charges were complete. This resulted in time away from the bedside. If you felt the product was less than optimal in performance or quality, there was no clear path to communicate to the people that could find an alternative product or find another recourse of action. There may have been an avenue for end-user input, but most caregivers were not aware of this. As a critical care nurse I was not aware of the inner workings of Supply Chain and all the complex operations required to get goods and services into the organization.

In your mind, what makes for a “Supply Chain superhero” for Critical Care Nurses?

PISHNERY: The “supply chain superhero” would be someone who truly understands the needs of the Critical Care Nurse and nursing unit providing the supplies necessary to care for their patients. Anticipating the number of supplies needed based on the patient census and acuity of the intensive care unit. The superhero would have a working relationship with the nurse manager and meet to address concerns and make improvements.

CHAUVIN: Quality products in the right place, at the right time, and in the right quantity to take care of the needs of the patient.

Let’s explore a real-life scenario. A Critical Care Nurse notices a supply he or she needs RIGHT AWAY is missing. What’s the first thing he or she does? Call “down” to Supply Chain Management? What is that conversation like? How might it go south? How might it be improved?

PISHNERY: I have personally seen this happen many times. The first thing the nurse usually does is call Supply Chain Management and state that the supply the nurse needs be “red tagged” immediately. Sometimes the conversation can be heated as the nurse is frustrated that the supplies they need to care for their patient are not available. Both sides of the conversation can become intense. The nurse may vent their frustrations with not having the supplies they need to person just answering the phone. Most times, the nurse then comes to one of the managers in the unit and states the issue [like this], “As always we are out of ....”

This situation could be improved by having a meeting with Supply Chain and a group of staff from the Critical Care unit to share what supplies are usually short and discuss how there could be improvement. With the conversation the nurse needs to understand that the person answering the phone is not the reason why the supply is out. They should not escalate the situation with an attitude on the phone. Supply Chain can make sure that when the staff is calling down for a supply that is needed immediately, the particular supply is brought to the unit in a timely manner.

CHAUVIN: The nurse says, “I need a widget right away.”

Supply Chain responds, “Do you have a Lawson number?”

The nurse replies, “Who is Lawson and what department does he work in?”

One way to improve this situation is to have an “assigned” Supply Chain technician to each department who takes care of the supply needs in real time, makes changes based on need and anticipates future needs.

Will you briefly describe a supply problem in the Critical Care area you experienced, and then explain how you worked — or tried to work — with Supply Chain Management to resolve it?

PISHNERY: In my area we use Omnicell to stock supplies for the unit. When a particular...
“Our vision for integration is divided into the three tiers of ‘People, Processes, and Surgical Assets.’ A successful integration will be a campus where every SPD employee is competent at each facility, all processes are standardized, and surgical assets are utilized to their full potential.”

Weston “Hank” Balch, CRCST, CIS, CHL, System Director, Sterile Processing Operations for KentuckyOne’s Louisville campus.

“The high volume of alarms generated by patient monitors and devices presents significant challenges for hospitals. When critical-care professionals are consistently exposed to the alarms of every patient within a unit, they spend time and effort assessing their need to respond. This strain, which is dubbed ‘alarm fatigue,’ drains resources and adds stress to an already demanding environment.”

Anne Crammond, Director of Marketing, Monitoring Systems & IT, North America, Dräger.

“The ‘supply chain superhero’ would be someone who truly understands the needs of the Critical Care Nurse and nursing unit providing the supplies necessary to care for their patients. Anticipating the number of supplies needed based on the patient census and acuity of the intensive care unit. The superhero would have a working relationship with the nurse manager and meet to address concerns and make improvements.”

Meghan Pishny, RN, CCRN, Assistant Nurse Manager, ICU/CCU, Cleveland Clinic, Franciscan Missionaries of Our Lady (FMOL) Health System, Baton Rouge, LA.

“Facilities that cut back staffing, replacement of end-of-life items, and routine maintenance services have now reinvested in these programs and the result is better care and outcomes for patients. Why the change? It is anyone’s guess, but we think the combined impact of improving financial performance and reimbursement penalties related to hospital-acquired conditions were the impetus for change.”

David Anbari, Vice President, General Manager, National Sales and Operations, Mobile Instrument Service & Repair Inc.

ONE OF THE HOTTEST OPPORTUNITY PATHS for cost savings in healthcare today is in Purchased Services. No matter who you talk to, folks will agree that Purchased Services — things that healthcare organizations pay outside firms to do for them — represent a great opportunity to deliver savings to the bottom line. While that idea may be true, it is also extremely naive.

Let’s remember, first of all, that the reasons most organizations choose to “purchase a service” is because they believe it will be more cost-effective than doing it themselves.

Still, Purchased Services is one of this year’s buzzwords, and many organizations find themselves poised to rush into the fray, go out there and save some money. So they purchase a “solution” (really a tool) from one of the many purveyors of savings in the marketplace, or they engage a high-priced consultant, or even call-in support from their group purchasing organization (GPO) to help them discover savings that they have heard are out there.

Often the savings discovered fall far short of initial expectations, and leadership at the healthcare organizations find themselves sitting around the conference table with egg on their faces, asking, “What went wrong?”

The answer is simple: They failed to take a holistic approach to the problems they were trying to solve.

Opening doors
Just what is meant by the term “holistic”? Merriam Webster defines it as: “1: of or relating to holism; 2: relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts <holistic medicine attempts to treat both the mind and the body>.”

A holistic approach to managing Purchased Services, therefore, would necessarily require an intimate and discrete knowledge of the “whole” problem as opposed to managing costs related to one or more of its parts. Interestingly enough, this brings us to why, after all these years, Supply Chain Leaders are finding their way into participating in contracting in spaces where heretofore they were never allowed to enter.

Throughout history, healthcare has seen in its operational structure the existence of two types of domains — the domain of the Subject Matter Expert (SME) and the domain of the Physician (all knowing, all powerful and ready to jump to a competing organization on a moment’s notice). A virtual “gender neutral ‘Gentlemen’s Agreement’” has often existed keeping Supply Chain away from areas like Food Services, Environmental Services, IT, Laboratory Services, etc. Consequently, people who know about the ins and outs of contracting were kept separate from people who know the ins and outs of various important operational disciplines.

Not necessarily the best use of resources, but the peace was maintained and many local fiefdoms were built.

Enter the Affordable Care Act. Suddenly, healthcare organizations were going to be held accountable and rewarded or penalized because of outcomes, customer satisfaction and operational effectiveness. The C-suite was under siege, and no one was safe.

Traditional responses at such a time of crisis (generally a year or years of negative operating margins) would see the advent of one of the major consultancies that would come in, slash the figure identified by senior leadership, go away and wait for the next call. This time, however, things were different. Now every organization was going to be compared to its peers all the time, and rewards or penalties were going to be meted out depending on where the organization fit into the distribution.

Almost immediately a spate of suppliers began to shower the marketplace with “solutions” for the Purchased Services arena, claiming that these products would deliver various percentages of savings to the bottom lines of the organizations that purchased and used them. While many of these offerings were strong and viable, none was in and of itself a — or — the “solution.” It is rather
PEOPLE & OPINIONS

like saying that a hammer and nail are the “solution” to getting two boards to stick together.

They are merely a tool and a coupling device. It still takes human intervention to accomplish the desired result, and while a $500 drill with an LED bulb that lights up the spot you’re aiming at is significantly advanced over the hand-turned auger an Amish craftsman uses, I can guarantee without doubt that any work the Amish craftsman does would far exceed anything I could do with the most expensive tool.

So what does a “Holistic Approach” look like? Here are 11 steps I suggest:

1. Define the problem you want to solve.
2. Identify the team you need to solve it.
3. Develop a single, measurable benchmark to measure against.
4. Get the tools and resources you need to address the problem optimally.
5. Assemble the team.
7. Work the plan.
8. Identify a solution(s).
9. Implement.
10. Measure against the benchmark.
11. Review and revise as needed.

Define the problem you want to solve. Often, people fall into the trap of looking at a current approach to an issue and thinking that the current approach is the best and simply try to re-negotiate a better price for their current solution. Or they choose a completely different approach to what they think is the problem and try to find a way to financially justify that approach (this is known as the “jeopardy” approach to problem-solving, where you start with the answer and ask questions that will produce that answer just like in the television game show).

What is really required in order to approach purchased services opportunities is an intimate understanding of the total environment associated with an issue. Failure to accurately identify the totality of an issue can produce a solution that is “penny wise and pound foolish.”

Let’s take a look at Food Services as an example.

You are a Supply Chain Leader and your CFO has asked you to help bring home savings related to Purchased Services. He has even given you the place he wants you to start: Food Services.

Currently, your organization has outsourced the management of the Food and Nutrition Services (FNS) operation to a third party. You have a managed services agreement that covers what the outsourced party will do and how much you will pay. Such an agreement is generally fair game for all the folks who want to help you save money on Purchased Services.

You are currently paying the vendor $1.5 million per year to manage operations across your multi-entity integrated delivery network (IDN). You have heard individual suppliers, your GPO and, of course, the big box consultancies say their products can slash 15 percent to 35 percent from your costs. You pick up your smartphone, engage its calculator, and quickly identify an opportunity range of $225,000 to $525,000. Your eyes pop out of your head.

You have a representative from Supply Chain meet on the unit to take the lead on this from the feedback from the nurses in the unit. Having meetings and email communication should reinforce the needs of the support needed by Supply Chain. Also having a representative from Supply Chain meet on the unit with the staff and see how the supplies are stored and used. If an item is unavailable from the supplier due to a shortage or it no longer being made, the Supply Chain team needs to communicate this to the nursing unit, so that proper arrangements can be made to bring in new items.

Critical care from page 51 •

How might Critical Care and Supply Chain Work together to promote patient-centered care?

PISSHNERY: Both sides need to communicate openly with each other. If there are issues with supplies not being delivered, then the nurse manager needs to communicate to Supply Chain. If an item is unavailable from the supplier due to a shortage or it no longer being made, the Supply Chain team needs to communicate this to the nursing unit, so that proper arrangements can be made to bring in new items.

CHAUVIN: Develop a common mission between Supply Chain and nursing of patient-centered care and best outcomes. This can be supported by appropriate utilization of supplies and continual communication and feedback to supply chain.

How might Critical Care demonstrate to Supply Chain that its management of product utilization reinforces the need for more effective supply chain support?

PISSHNERY: Communication is the keyword again. There needs to be a relationship with both sides. The Nurse Manager needs to take the lead on this from the feedback from the nurses in the unit. Having meetings and email communication should reinforce the needs of the support needed by Supply Chain. Also having a representative from Supply Chain meet on the unit with the staff and see how the supplies are stored and used.

CHAUVIN: Supply Chain should be able to make adjustments of product PAR levels based on the acuity level of the patient population. This can only be achieved by communication of needs to Supply Chain by nursing staff.

How will the working relationship between Critical Care and Supply Chain have to change to meet the demands for patient-centered care, precision medicine and population health?

PISSHNERY: Healthcare is ever-changing. With the increased need of certain supplies the levels may need to be adjusted frequently. Sometimes we use a certain item for a short time until our staff or physician team finds an item that may improve patient outcomes. This item will need to be adjusted or added by Supply Chain to the unit. Other items that are not used at all can be removed. The nurse manager can communicate these issues to supply chain.

CHAUVIN: This has to be a symbiotic relationship between the two groups. Open communication, mutual goals and measuring/celebrating success.

Stay tuned for part two.

Fred W. Crans is a veteran supply chain consultant at Cincinnati-based TriHealth and a frequent contributor to Healthcare Purchasing News. He can be reached via email at fred_crans@trihealth.com

PRODUCTS & SERVICES
I read a great article today on improving healthcare quality — not in a clinical journal, but rather in *The Journal of Healthcare Finance*. The article, entitled “The Economics of Healthcare Quality and Medical Errors,” provides compelling evidence of what quality experts across industries have known for years: Quality lowers costs. That goes against what many have come to believe: that you get what you pay for, and if it costs more, it must be better quality. The data tells a different story and may be the impetus we need to reduce variation in healthcare.

First, consider this: The article says the cost of medical errors in the U.S. in 2008 approached $20 billion. The majority of those costs were associated with additional medical expenditures needed to treat the consequences of medical errors. The authors believe the total economic impact may be as high as $1 trillion annually — when you consider the costs associated with the loss of quality-adjusted life years (QALYs), a measure economists use to put a dollar value on one year of life lived in perfect health.

Dr. Makary and a number of other physician executives who participated believe the problem is that many physicians do not view variation as a bad thing. One of the biggest technical and cultural challenges in healthcare is recognizing when variation is in the best interest of the patient, and when variation is unnecessary, and even lethal.

According to Dr. Makary, the chances of a patient experiencing the first or second scenario is just that — chance. Medicine is based on science, but decisions are often a matter of preference or opinion.

That’s not to say that there is not an art to medicine. One of the surgeons participating in the ASU event explained that he makes decisions every day based on the best studies he can find, but that he rarely treats a patient that matches the exact profile of the patients featured in the studies. He must base his decisions on both science and experience. That’s the value of training. But Dr. Makary and the other physicians contend that’s very different than personal preference.

As the Executive Director of GHX, Karen Conway works with industry associations, standards bodies, government agencies, analyst firms, academic institutions and the media to identify opportunities for hospitals and suppliers to optimize supply chain operations and improve business and clinical performance. Conway is chair-elect of the board of directors of AHRMM, the supply chain organization for the American Hospital Association. Conway is currently writing a book on the Accountable Healthcare Leader, drawing upon the concepts developed in her 2013 global leadership book, *Leading from the Edge*, which she co-authored with the former chief talent officer of Cisco. Conway serves on the board of Healthcare Purchasing News.
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Value Analysis requires adopting a system approach

A repeatable, scientific, trainable and auditable system drives long-term success

by Robert T. Yokl

I have observed, trained or facilitated hundreds of value analysis teams over the last three decades and have come to the conclusion that the most successful value analysis teams that I have witnessed have had a repeatable, scientific, trainable and auditable system to ensure their long-term value analysis success. These are the VA teams that are cohesive, cooperative, fun to watch, and have double-digit savings to report to their management each and every year.

Exception
Unfortunately, these highly systematized value analysis programs I just described were the exception to the general rule. My usual value analysis team meeting experience was to see a group of hospital, system or integrated delivery network department heads and managers passing around a new product offering and then asking their team leader what were the features, benefits and price of the new product.

To my consternation, what I was observing wasn’t value analysis at all, but what I like to call price or comparison shopping. If you aren’t aware of it, the classic definition of value analysis coined by the father of value analysis, Larry Miles, is “Value analysis is the study of function and the search for lower cost alternatives.” Now that you know the definition of value analysis, do the VA meetings that I just described seem like value analysis to you?

Repeatable
More importantly, each value analysis study I observed was handled differently from project to project. Meaning, there was no consistent or repeatable system for these healthcare organizations’ value analysis project managers to follow.

Remember, to be successful in value analysis you need to have a reliable and repeatable VA system, or your value analysis team members will design their own value analysis system that I promise you won’t be scientific and will not provide you with the outcomes your healthcare organization is depending on. For instance, I once observed a value analysis project manager, who was assigned a lab product study, spend a whole month visiting other hospitals’ labs to collect data on her project. The only problem with the VA system that she devised was that no hospital visits where required to complete her study. This is how out of control a VA project can get if you let your VA project managers design their own VA systems. Don’t let this happen to your VA team.

Scientific
The “scientific method” devised in the 17th century starts by defining a problem, then observing, measuring and gathering relevant data to solve the problem at hand. With this fact in mind, much too often, value analysis teams list on their agendas new products, services or technologies for evaluation in which there is no existing problem (e.g., cost, quality or safety) identified. So why are these “problem-free” products, services or technologies on your VA agendas? Henceforth, if there isn’t an existing cost, quality or safety problem with an existing product, service or technology it shouldn’t be on your VA agenda. This new VA technique will save you time and money.

Trainable
If you, for instance, have a six-step value analysis system as my firm does, you can train your value analysis team members in your own VA system. They then should be required to employ it every time they are evaluating a new product, service or technology. This then enables all of your team members to speak the same language and be on the same page with every value analysis study. Sometimes, value analysis training is negated or denied because it costs a few hundred dollars. Just think, however, what the cost of not training your value analysis team members is costing you when these people approve or disapprove millions of dollars of products, services or technologies for your healthcare organization annually.

Auditable
It is mission-critical that you audit your value analysis studies after they are completed by your project managers to ensure that your project manager followed your value analysis system to the letter. This is because we have seen hundreds of thousands of dollars left on the table due to VA project managers taking short cuts. Also, if you find that your VA project manager didn’t follow your VA system exactly, you can retrain them in any area you found deficient. You can’t do this if your VA project manager is “winging it” with their own VA system.

Authentic
Value analysis can look easy at first glance, but it really needs to be a repeatable, scientific, trainable and auditable system to truly be efficient, effective and have long-lasting success. So if your value analysis program doesn’t have these winning attributes I just talked about it’s never too late to refine, redesign or reinvent your VA program to be more than just checking off a box that you have a value analysis program at your healthcare organization.
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