

Infection prevention

Onus on OR managers to scope out competency of endoscopy staff

Recent highly publicized outbreaks of infections linked to improper reprocessing of flexible endoscopes have raised concerns about infection prevention in gastrointestinal endoscopy procedures.

Because of the headlines, legislatures are hearing from their constituents that they are fearful of being exposed to infections, and legislatures are getting involved.

The Society of Gastroenterology Nurses and Associates (SGNA) is hearing the concerns as well and focusing on root causes to build prevention, Leslie Stewart, BA, RN, CGRN, told OR Manager.

Legislatures want to know what kind of infection prevention programs are being followed in endoscopy units and if qualified people are doing the appropriate jobs. Their constituents want validation that it is safe to have a screening diagnostic or therapeutic procedure performed in an endoscopy unit, says Stewart, past president of SGNA and former (retired) manager of endoscopy at Jersey Shore University Medical Center, Neptune, New Jersey.

The endoscopy community is looking for answers, says Stewart—not just the reprocessing steps defined in SGNA’s “Standards of infection control in reprocessing of flexible gastrointestinal endoscopes” and the “Multisociety guideline on reprocessing flexible gastrointestinal endoscopes,” but how to build a true quality program focused on infection prevention.

“A good part of that is knowing who your personnel are and the proper training of your personnel to fulfill their roles,” says Stewart. In endoscopy, that can get complicated, she says, because staff members have many different levels of education, including RNs, licensed practical nurses (LPNs), and licensed and unlicensed endoscopy technicians. Validating the preparedness and continued competency of unlicensed endoscopy technicians has proved to be a bigger challenge than knowing what the steps are for reprocessing an endoscope, Stewart notes.

SGNA member surveys also have shown personnel competency to be an important issue in addressing infection prevention (sidebar).

Standards, guidelines not enforced

Unlike operating room staff, unlicensed and uncertified personnel can work in an endoscopy procedure room or in the decontamination area without any validation of competency requirements.

SGNA provides a guideline addressing entry-level recommendations for unlicensed personnel (sidebar, p 18). SGNA also recommends that facilities validate that their staff members are competent to work in endoscopy, and offer standards and guidelines to assist in that process. However, no national or state legal requirements mandate that facilities comply with the recommendations as they apply to unlicensed personnel.

As a result, “unlicensed endoscopy technicians are only as good as the person who teaches them their skills,” says Stewart, “and therein lies the pitfall. If endoscopy technicians aren’t correctly instructed in an orientation program, their skills and knowledge maintained with education, and their competencies validated with testing, errors can and do occur.”

Certification programs growing

In the 1990s, SGNA had a program that prepared endoscopy technicians for the certification exam offered by the Certifying Board of Gastroenterology Nurses and Associates—which was the certifying board for gastroenterology nurses at the time. Participation was encouraged but was not legally required.

This program was eliminated in 1998 because of low utilization, and the low number of test takers did not provide test validation.

SGNA continues to offer multilevel education programs online and onsite to prepare endoscopy technicians, but they remain voluntary. The Certification Board for Sterile Processing and Distribution (CBSPD) and the International Association of Healthcare Central Service Materiel Management (IAHCSMM) offer certifying processes for sterile processing technicians, but the decision of whether to require certification is left to each individual institution. These certifications only validate that technicians can reprocess endoscopes and equipment. They do not certify their competence to assist during a procedure.

CBSPD's Certified Flexible Endoscope Re-processor exam focuses exclusively on flexible endoscopes, whereas the sterile processing technician examinations do not, says Nancy Chobin, RN, CSPDM, CRER, assistant vice president of sterile processing, Barnabas Health System, West Orange, New Jersey. CBSPD also has separate exams for technicians who work in surgery centers, says Chobin, a member of the CBSPD committee that develops questions for certification exams.

Chobin says she believes so strongly about the need for a national standard for flexible endoscopes that she submitted a request to the Association for the Advancement of Medical Instrumentation (AAMI) to develop a document specifically for flexible endoscope reprocessing. AAMI approved the request, and Chobin co-chairs a committee that has been working on the document since 2012.

Chobin anticipates that the document, which covers all aspects of reprocessing including quality assurance, will be available in early 2015.

"This is an important document because it is a consensus document developed by all of the regulatory and standard-setting organizations," says Chobin.

Legislation pending

Quality-focused legislation, such as Senate Bill 313 in the US Senate, would establish requirements for Board of Medicine licensure of surgical assistants and certification of surgical technologists. As the bill was rolled out through several states for review, sterile processing technicians were added, and endoscopy assistants and technicians may be added in the future, says Stewart.

State hospital associations are fighting this bill because of the costs involved. "They are saying, 'we are overeducated and oversurveyed now, and we really don't want to put in more money to educate endoscopy technicians,'" Stewart explains.

SGNA infection prevention survey findings

Infection prevention remains the key patient safety issue in the practice of gastrointestinal endoscopy. A survey of members of the Society of Gastroenterology Nurses and Associates found the following infection prevention concerns:

- staying current on latest infection prevention information
- adequate orientation, training, and consistent manufacturer instructions
- time and cost required for infection prevention education
- diversity in sense of urgency and importance—from "very concerned" to "why all this concern"
- diversity in preparedness—from "very prepared" to "overwhelmed"
- financial pressure on resources
- inconsistent infection prevention quality measures
- lack of standardization—mixed signals between regulatory agencies, organizational documents, and manufacturer instructions
- site/setting not always ready to embrace infection prevention principles
- inadequate training and lack of knowledge by everyone on the team as well as inconsistent monitoring
- diversity of roles among team members involved in infection prevention
- lack of evidence-based knowledge to defend principles.

Some states are using Senate Bill 313 as a template for their own programs and regulations. They are adding requirements, or they are shifting over existing requirements for surgical and sterile processing technician licensing to endoscopy technicians.

Along with this, the Department of Veterans Affairs and New York State have been pushing since January 2013 to have endoscopes reprocessed in the sterile processing department (SPD) instead of in the endoscopy unit by unlicensed technicians. What's happening, says Stewart, is that hospitals are either bringing SPD personnel into endoscopy to do the reprocessing or they are sending endoscopy personnel to SPD to reprocess the equipment and then bring it back to the endoscopy unit.

"In order to send their scopes to SPD and then have them returned, the endoscopy unit would have to have a huge inventory of endoscopes," she says, "or the turnaround would drastically slow down the schedule or bring it to a halt."

It is very unrealistic, says Stewart, but that is exactly what some Veterans Affairs hospitals around the country are doing because they could not control the barrier breaches that were occurring.

Chobin adds that she does not allow flexible endoscopes to be reprocessed in SPD because most SPDs don't have sufficient equipment, space, or dedicated personnel. Also, transporting the endoscopes back and forth between units can damage them.

"Flexible endoscopes are highly technical equipment, and reprocessing should be done by technicians who do it over and over again and have developed an expertise," she says. "It is not something anyone should do once a week or once every 2 weeks or when someone is on vacation—that's how we get into trouble."

Education programs a priority

OR directors who have endoscopy personnel under their supervisory umbrellas are setting up their own educational programs for technicians because surveyors are asking them how they validate their endoscopy staffs' competency. Others are replacing endoscopy technicians with SPD personnel or with OR technicians who carry a license or certification.

Stewart and Phyllis Russo, BSN, RN, CGRN, have authored and present the Endoscopy Assistant/Technician Orientation and Competency Program, which is presented in 15 sessions for new and experienced endoscopy technicians learning their roles and preparing for certification. They also present a 1-day update session that assists skilled technicians in validating competency and preparing for the certification exam.

They teach these programs at community colleges in New Jersey and in ambulatory surgery centers throughout the country. OR directors and endoscopy managers can send their technicians to these programs instead of building one of their own,

SGNA recommendations for unlicensed personnel in GI endoscopy

The Society of Gastroenterology Nurses and Associates recommends the following requirements, knowledge, and skills for unlicensed assistive personnel in gastrointestinal (GI) endoscopy.

Entry-level recommendations:

- high school graduate or equivalency
- previous patient care experience with healthcare training
- basic life support
- strong intrapersonal skills
- communication skills.

Clinical knowledge and competency recommendations:

- knowledge of anatomy, physiology, and pathology of the organs of the GI tract
- basic knowledge of the respiratory, cardiac, and neurological systems and their impact on the endoscopy patient
- knowledge of medical terminology
- knowledge of medications frequently used in GI procedures and patient responses to those medications
- knowledge of GI endoscopy procedures and related equipment
- knowledge of infection prevention principles
- knowledge and understanding of reprocessing standards of endoscopy and accessory equipment
- knowledge of patient safety in all areas of endoscopy.

says Stewart. (For more information on these programs, contact Stewart at lestew710@aol.com.)

SGNA has an associates and an advanced associates program that is similar in content, but it is web based. "Though it lacks the hands-on ability offered in our program," says Stewart, "it can be very useful to the technicians with RN support and observation." (<http://www.sgna.org/Education/AssociatesandTechnicians.aspx>)

"Education is a priority. Managers know that their unit is only as good as their weakest tech," says Nancy Schlossberg, BSN, RN, CGRN, nurse manager, Bon Secours Health Center at Harbor View Endoscopy Center, Suffolk, Virginia. "A facility can have the best nurses and techs in the world, but one incorrectly reprocessed endoscope can generate far-reaching, uninvited negative front page news. Anyone who touches an endoscope must understand and competently demonstrate the required reprocessing steps," says Schlossberg.

This also includes managers and charge personnel, notes Stewart, because surveyors are beginning to take a different look at endoscope reprocessing.

In the past, surveyors would talk only with managers about their process. Then during a certain period, surveyors wanted to talk only with the technicians doing the reprocessing and to see a demonstration of their process. Now surveyors are asking technicians the hows and whys of what they are doing, and they are asking the managers to demonstrate the skill. Their theory, says Stewart, is that if managers can't demonstrate the skill, they can't teach the technician to do it properly.

"In addition to making sure your personnel can competently demonstrate all the reprocessing steps, you need to have an individual who can 'ride herd' on everyone who handles the scopes and related equipment to ensure compliance with current infection prevention guidelines and endoscope instructions for use," says Schlossberg. In her unit, that person is a technician. "If she sees a staff member not handling a scope properly or failing to wear appropriate personal protective equipment," for example, "she immediately brings it to their attention," she says.

"This technician also serves as our infection prevention champion," says Schlossberg, referring to the SGNA Infection Prevention Champions Program. The goal of the program is for each endoscopy facility in the country to have a team member enroll as a champion. This person acts as the link to the most current infection prevention news and ensures the most current and safest practices are followed (<http://www.sgna.org/InfectionPrevention.aspx>). The champion can be an RN, LPN, or endoscopy technician.

Use of unlicensed personnel growing

In response to a 2010 change in Medicare regulations placing deep sedation under hospital anesthesia services, endoscopy suites began having anesthesiologists and certified registered nurse anesthetists (CRNAs) administer sedation rather than RNs.

"As a result, we are seeing the declining use of RNs and the greater use of unlicensed personnel in the procedure room, especially in surgicenters," says Stewart.

SGNA guidelines state that an RN should be in each endoscopy procedure room, but SGNA holds no regulatory ability to enforce these guidelines, she says. In surgicenters, it is not uncommon to have an RN in charge of several endoscopy rooms staffed with endoscopy technicians who assist the physicians with the procedures.

The Joint Commission requires that an RN supervise the patient's care, and Medicare guidelines stipulate that an RN must be available onsite. In limited compliance, endoscopy units define these regulations by having an RN in the admitting area, an RN floating between several procedure rooms, and an RN in the postanesthesia care

unit. "By the letter of the law, they are complying with these requirements, but in the middle of this is the RN's responsibility to delegate procedure responsibilities to the endoscopy technician and the opportunity for much confusion," says Stewart.

The 2014 American Society for Gastrointestinal Endoscopy's "Guidelines for safety in the gastrointestinal endoscopy unit" recommend having an RN in a room where moderate sedation is given and an RN, LPN, or unlicensed assistant in a room where either no sedation or deep sedation is given.

"As much as I believe the technician plays a significant role in the procedure, I believe an RN needs to be in the room to support the technician and assist the physician to ensure patient safety," says Stewart. "I do not believe we can replace the value of the RN in the endoscopy procedure setting, but if this is becoming an increasing trend, we must take a serious look at endoscopy technician education to meet these challenges," she says.

State guidelines define what licensed and unlicensed personnel are permitted to do during a procedure, such as inject a polyp with saline or snare a polyp, but people are ignoring state regulations, says Stewart.

Physicians will say the unlicensed personnel are working under their licenses, and, therefore, they can complete these tasks under their supervision. But that is not correct, says Stewart. Legally, technicians can do only what the state practice act permits. Many endoscopy technicians bring a high level of education and experience to their role, but many have limited educational and medical backgrounds and don't understand the legal limitations, she says.

The problems crop up when complications or a breach in technique occurs, and unlicensed personnel don't understand what is actually happening. In a survey of endoscopy technicians in New Jersey in 2001, Stewart says, many responded that they didn't fully understand what was going on in the procedures for at least 2 to 2 1/2 years. They had to learn the language and just the basics of anatomy, physiology, and pathology that most nursing students learn in the first semester.

"The technicians are not the guilty parties," Stewart adds. "They want education, they want certification, and they want licensure. They want a system that recognizes their value. They want our trust and respect. But the system is not building in the opportunity for them to get that education, and if it's not required and enforced by the State, it's not going to happen."

In the meantime

What OR and endoscopy managers need to do when hiring technicians is validate their level of education and their ability to maintain competency. They also need to observe the technicians first hand and do biannual or annual tests of competency to make sure they are following recommended guidelines for infection prevention practices.

"It is a lot of responsibility for managers," says Stewart, "but until the state requires either licensure or certification, it falls to the managers to ensure their competency, which also ensures quality of care and patient safety." ❖

—Judith M. Mathias, MA, RN

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