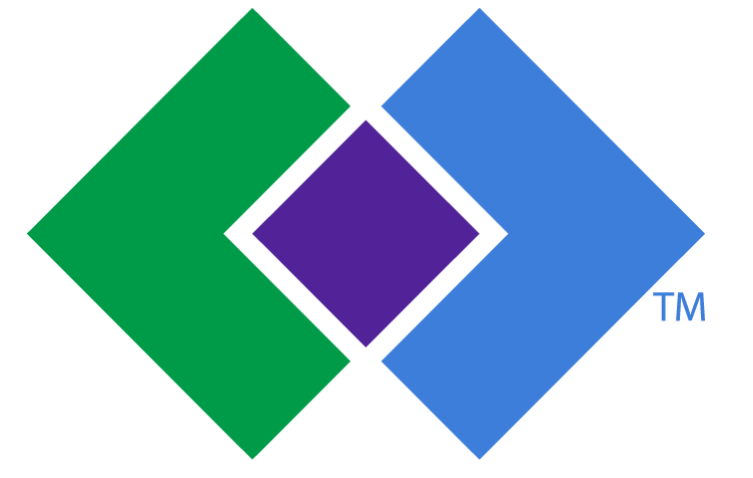


# Investigation of a Reprocessing Breach in an Ambulatory Care Clinic

HealthPartners Clinics

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## Background

- Reprocessing breaches can result in patient exposure to bloodborne pathogens.
- Infection Prevention was notified of a reprocessing breach that occurred during a four-week period after a workflow change in reprocessing practices at a suburban clinic.
- Initial assessment revealed that instruments were cleaned manually with enzymatic detergent, ultrasonically washed, dried and packaged for sterilization. Prior to steam sterilization, some unprocessed items were mistakenly restocked in exam rooms for use. Instruments included speculums and one ring forceps.
- Chemical indicators were inconsistently checked at the point of use, so it was possible that unprocessed instruments were used on patients.

## Methods

### Corrective Actions

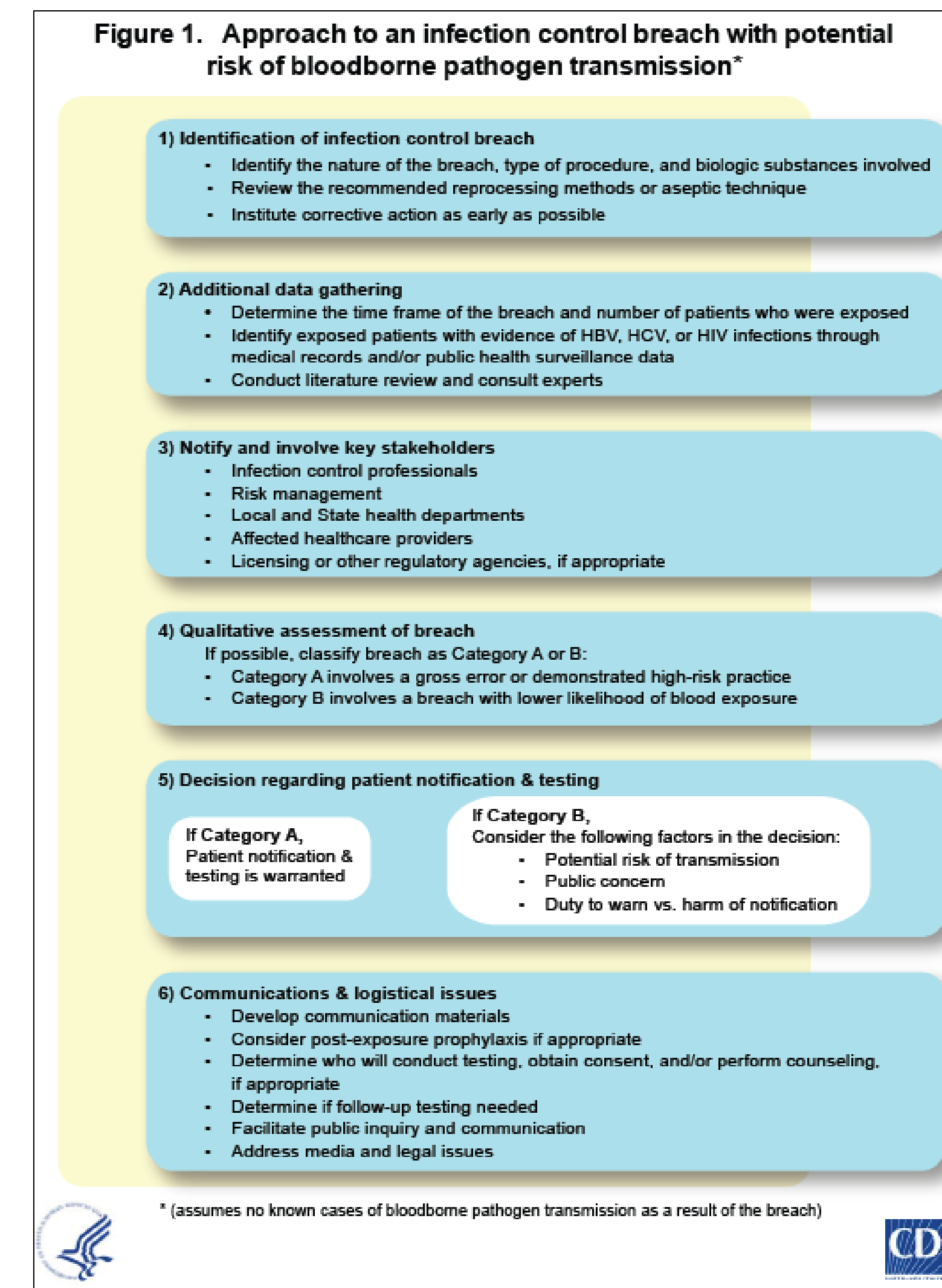
- Checked all sterile storage for unprocessed items and removed them
- Limited entry to the reprocessing room to trained personnel only
- Provided education to all staff on the importance of checking chemical indicators prior to use
- Placed reference posters for reading indicators where instruments are stored

### Organize a Team

- Organized a team including risk management, medical director, site leaders, system leaders, patient safety, lab, communications, state public health and infection prevention
- Reviewed CDC framework for evaluating an infection control breach
- Focused on process failures over personnel mistakes

### Patient Notification

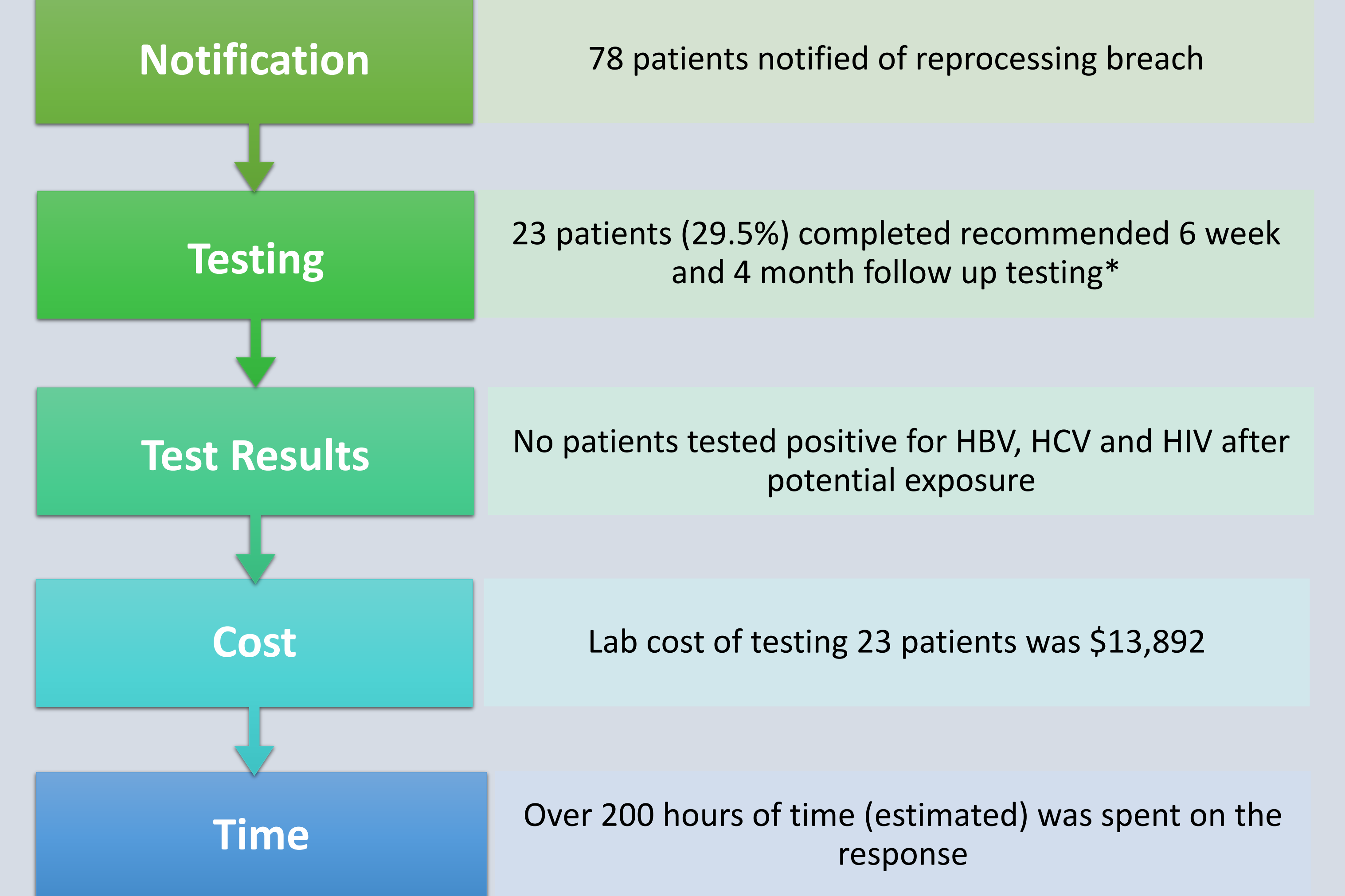
- Determined risk for bloodborne pathogen exposure
- Developed order set to mistake-proof lab ordering process
- Created Standard Work and script for nurse patient communication
- Used Plan, Do, Study, Act framework to determine and evaluate steps in notification process
- Sent patient notifications via the Electronic Medical Record and mail
- Testing recommended for Hepatitis B, Hepatitis C and Human Immunodeficiency virus (HIV)



“The intent of an evaluation should be to discover the factor(s) that led to the potential exposure and to protect patients from adverse events, as appropriate, and not to assign blame to a particular person or persons.” (Rutala, 2007)

Internal & External Indicator Guide			
Indicator Type	NOT Processed	Processed	
Steam	Internal Steam Indicator		
	Internal Steam Indicator		
	External Steam Indicator Tape		
	External Steam Indicator Arrows		
Sterrad	Internal Sterrad (gas plasma) Indicator		
	External Sterrad (gas plasma) Indicator Tape		
	External Gas (Ethylene Oxide) Indicator		
Gas	Internal Gas (Ethylene Oxide) Indicator		
	External Gas (Ethylene Oxide) Indicator Tape		

## Results



\*Response rate aligned with similar investigations per public health partners

## Lessons Learned

- Investigating a reprocessing breach is time and resource intensive.
- Engaging a multidisciplinary team that included public health experts and using CDC resources supported a patient-centered disclosure process.
- Standard Work, scripting, and FAQ's helped staff feel prepared and confident in responding to patient inquiries.
- This investigation was stressful for the clinical team. While maintaining transparency builds trust, the possibility of bloodborne pathogen exposure was difficult news to share with patients. Supportive resources should be shared with staff and a focus on process improvements should be emphasized over mistakes.
- This investigation underscores the importance of infection prevention programs in ambulatory care to support best practices, including:
  - All staff play a role in providing safe patient care.
  - Onboarding and annual training should include information about checking chemical indicators and proper storage and handling of sterile instruments.

References:  
 Center for Disease Prevention and Control (2012, February 27) *Steps for evaluating an infection control breach.*  
[https://www.cdc.gov/hai/outbreaks/steps\\_for\\_eval\\_ic\\_breach.html#:~:text=Decision%20regarding%20patient%20notification%20and%20testing%20for%20category%20A%20breaches,of%20patient%20notification%20and%20testing.](https://www.cdc.gov/hai/outbreaks/steps_for_eval_ic_breach.html#:~:text=Decision%20regarding%20patient%20notification%20and%20testing%20for%20category%20A%20breaches,of%20patient%20notification%20and%20testing.)

Rutala, W.; & Weber, D. (2007) How to Assess Risk of Disease Transmission to Patients When There is a Failure to Follow Recommended Disinfection and Sterilization Guidelines. *Infection Control and Hospital Epidemiology*, 28 (2), 146-155.

No Disclosures