HEALTHCARE PURCHASING NEWS

June 2022
The self-study lesson on this central service topic was developed by 3M Health Care. The lessons are administered by Endeavor Healthcare Media.

Earn CEUs

After careful study of the lesson, complete the examination at the end of this section. Mail the completed test and scoring fee to *Healthcare Purchasing News* for grading. We will notify you if you have a passing score of 70% or higher, and you will receive a certificate of completion within 30 days. Previous lessons are available at www.hpnonline.com.

Certification

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 recertification 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.cbspd.net.

HSPA (Healthcare Sterile Processing Association, https://myhspa.org)) has pre-approved this in-service for 1.0 Continuing Education Credits for a period of three years, until May 5, 2025. The approval number for this lesson is **3M-HPN 220605**.

For more information, direct any questions to *Healthcare Purchasing News* (941) 259-0832.

LEARNING OBJECTIVES

1. *Identify the "fantastic four."*
2. *Review the process of building a "fantastic four" team.*
3. *Recognize the importance of bringing awareness to broken processes.*

Sponsored by:
3M Health Care

SELF-STUDY SERIES

The fantastic four

Sterile processing, operating room, quality and education

by Anna Castillo-Gutierrez

It is safe to say that Sterile Processing departments around the world have quickly evolved to one of the most complex departments in our healthcare arena. Technicians are expected to know and understand critical processes in each Sterile Processing area while maintaining basic infection control standards set by regulatory agencies, all while complying with individual hospital policies and procedures. All of this, not counting the multitude of IFU's that need to be followed daily for individual instruments, devices and equipment found within our department. It can be daunting and almost impossible without purposefully laying out a path to achieve quality results for each device we deliver to the operating room. So, how do we achieve this? How do we get to a point of awareness and be able to recognize flawed processes instead of individual errors? And finally, what resources are needed to get the ball moving in the right direction?

Call to action

The first step is to simply realize that every single process and staff member should be constantly reviewed, from the time of hire to the individual processes that are taken. Again, it may seem daunting, but you may have all the resources at your disposal already within your facility. You simply need to reach out and lay out a plan of action to bring awareness to issues that need to be addressed within your department and the four amazing groups that will help you achieve this are Sterile Processing leadership, Operating Room leadership, your Quality team and Education team. They all play a vital role in patient safety and therefore are responsible for ensuring processes are reviewed and updated as needed throughout all of the perioperative setting. So, let us talk about these roles and how you could bring your departments together to form a super-crew of experts ready to rectify and prevent errors one process at a time.

Sterile Processing leaders have a large burden to carry and depending on the hospital, may have multiple responsibilities they need to carry out daily; from setting schedules and ordering supplies to ensuring staff are following procedures and processes, they must inspect what they expect. One of the biggest tasks they are accountable for is coordinating the day-to-day tasks and assignments in the department that allow the operating room to complete surgeries and procedures without eventful instrument delays, errors, and issues. This coordination does not happen alone, there is often input from Operating Room leaders who provide needed information such as required loaners, special needs from surgeons and supply requests for each case. Perioperative navigation is definitely a team effort, each group responsible for a certain aspect and each aware of the major roles they play but there are two other groups who are often not used to their full potential.

The Quality and Education teams within the perioperative department are valuable resources you should never be without. Most of us know of the constant finger-pointing that can occur within periop, this is often due to having a telescopic view of an issue that is often one sided. We have all fallen prey to this and honestly, it's normal. Our Operating Room team may not be aware of the complex processes Sterile Processing must adhere to and vice versa, our Sterile Processing team may not know of the constant battle to beat time and care for the patient effectively. Experienced Quality and Educational staff who are knowledgeable of both processes and areas can offer an unbiased view of the issue at hand and offer solutions that benefit patient outcomes. These four teams, along with effective coordination and planning, can truly make a difference that keeps processes on the right path. So, how do you assemble this awesome team of genius minds and get everyone to participate?

Factual, collected data from errors derived from all areas can provide the

most compelling story of why this team should be assembled. Your Quality or Infection Control team may be able to pull information to paint a picture showing broken processes or gaps that could be easily prevented. At a minimum, this team should collaborate on a monthly basis and discuss issues openly in a safe environment. Each of the four teams should consist of at least one leader or staff member who is able to make knowledgeable decisions and communicate effectively. Issues, reoccurring problems and procedures with gaps or opportunities should be identified and written down to create a priority list. As a rule, the team should focus on one issue or project at a time and errors identified from a single person should be addressed by that staff member's direct supervisor. One way to identify gaps within periop, whether in the Operating Room or Sterile Processing department, is to perform audits that identify compliance issues related to a facility's policies, procedures and agency standards and regulations. Once you have a narrowed down priority list, identify which issue impacts patient safety directly and begin there. One thing to keep in mind; your priority list may seem long at first, but if you focus the team's attention to resolving one issue at a time you may find that other issues start to resolve themselves as a result.

Staff compliance

Focus on the processes and returning staff to a compliant state. It is reasonable to be concerned about whether staff will find a process easy to achieve or if staff will like a new process, but this group should ensure decisions are made based on best practices, compliance, and practicality. As the issue is discussed, bring awareness of what can be done to correct the issue immediately but ensure that all the gaps are filled in, so the issue does not return. For example, let us say that the Operating Room staff are not performing point-of-use treatment before transporting to the decontamination area. Specifically, staff are not spraying enzymatic detergent; a few questions that should arise are:

- Is the Operating Room supplied with the enzymatic spray?
- Who is responsible for restocking the supply when it is out?
- Who is responsible for treating the instruments during and after the procedure?
- Does your facility have a policy, procedure or guideline describing the care and handling of instruments at point of use? Is it easy to understand or has it been recently updated?
- Has Education addressed this issue?
- Is treatment skipped in certain services or rooms? Is there a pattern to this issue?
- If education has already occurred, is this an accountability issue or a process issue?

Having these kinds of questions answered together with the four teams present can bring awareness of the true reason staff may be uncompliant, if it is found to be an accountability issue the correct leader will be present to make corrections. I would like to add that most often I have found staff to be unaware of their facility's policies and procedures or the regulations concerning the issue, or they may have known of the policy, but roles were not clearly stated. Your Quality team can be the team who investigates the details of how and when errors occurred and deliver results back to the team so everyone can then bring ideas to the table. Once there is a clear action plan for correction, the Education team can begin to prepare the delivery of information or in-service.

It can be easy to get carried away by the presumptions that staff should be knowledgeable about the roles and responsibilities in their own job descriptions and the fact is that we all should hold ourselves accountable for our individual learning and progress in our careers. With that, there are always gaps, educational needs and updates in the healthcare arena. A single person or team alone cannot keep up with the ever-evolving changes in our industry, so as this heroic team of professionals dive deep into evaluating their departments, keep a few things in mind.

Keep ideas simple to understand and plan out how all staff and stakeholders will receive the information. A simple blanket statement or email from an Educator or Manager may work for a few staff but should never be considered absolute. Educators, fill in gaps and deliver information in a well-rounded and well thought out manner with the help of the Quality and Leadership teams. Sterile Processing and Operating Room leaders, be explicit about the actions you want staff to take, the outcome, goals and the expectations of what will happen if the expressed actions are not followed. In other words, level set the playing field for all and be sure everyone is aware of the roles and responsibilities each one of them have.

Education and training

Educators should present ideas in a manner that will capture the audience. Everyone learns differently, and some even require visual aids to capture concepts. The Sterile Processing Team leaders and Operating Room leaders should be present when these concepts, in-services and information are being presented. Nothing says, "this is important to me," more than a leader being present and voicing their concern on the topic.

Going back to the example where point-of-use treatment is not being performed, let us provide an example that shows how a program can be developed. We have already supplied the questions to investigate what can be impeding staff from spraying and wiping down instrumentation at the end of the case. I will propose that in this case, the facility has a policy that suggests the "scrub person" is responsible for point-of-use treatment. As the Quality and Education team start to investigate, it is noted that some staff understand that the scrub technician, not the scrub person, is responsible for spraying the instruments at the end of the surgical procedure. When asked what the process is when a scrub/surgical technician is not present in the case, and no one is able to identify who should be responsible, someone may suggest the PCT helping in these situations. It is observed that although there is a policy in place there needs to be education to describe the roles within it because we can all interpret policies in unique ways.

When putting together an in-service or training, plan around how the staff learn and how their processes actually work. Review processes to see if they are in fact achievable or easy to produce and try to eliminate obstacles that can impede staff from being compliant. For example, if the enzymatic solution is found only in certain areas of periop, why not suggest having them closer to surgical suites so staff do not have to waste time retrieving it? Some hospitals may not have sterile water listed on preference cards. How can staff stay compliant in flushing cannulated instruments during cases if the proper tools are not being supplied to them? It is more common to see that processes are broken rather than staff wanting to stay uncompliant.

Self-Study Test Answers: 1.B 2. A 3. A 4. A 5.B 6. B 7. A 8. B 9. A 10. B

One way to get staff onboard with an idea is elaborating on findings and results. If you can offer insight, share with staff. I often find divulging a bit of information can give staff a sense of importance or urgency for why a new concept or process needs to be developed. The more staff know and are a part of the process for change, the more staff are likely to remain compliant. You may even find new insightful information that may not have been known during initial investigations. Ultimately, you want staff to have skin in the game, so they feel they took part in the process early on and have a say in workflow processes.

Once the Quality team has investigated, the Sterile Processing and Operating Room leaders have planned the correction action and the Education team has delivered the information; it is now time to follow the most crucial step, maintaining compliance. The maintenance process in any quality program is often overlooked and is the reason some projects fall apart after all the hard work has been done. All four teams must be dedicated to supporting and sustaining the quality improvement project for it to reach its goal. If one team does not follow-up with staff to ensure progress is going in the correct direction, the results could lead to staff becoming overwhelmed with constant changes in processes, staff not being held accountable and low morale from another unsuccessful attempt to correct an issue. Staff should be provided with an opportunity to know how they are progressing, good or bad. A project can start to dwindle and disappear until there is no recollection of the change if a plan is put into place without supervision. The management of a project within this team should be shared and expressed cohesively, the staff should be aware that the final decision was made together to better the perioperative department as a whole.

Conclusion

From beginning to end, the process of building your Fantastic Four Team will take time, energy and focus to put together and start completing tasks. The goal is to get started and make progress for the entire perioperative department instead of simply addressing issues on a one-sided scale and truly use resources that are already available to you. I am more than certain that your Quality and Education team are ready to collaborate to reduce their workload and find solutions that actually work for everyone. As you start to reach out to your Operating Room leaders, Educators and Quality teams, keep in mind and make everyone on the team aware that these processes and projects may take time to assess, design, plan, implement and review for compliance. As you progress, take time to celebrate wins. Keeping patients safe in our hospitals is a big deal and feedback should be provided to staff to make them aware of the current progress they have contributed to.

Our roles as individual leaders in the perioperative setting have evolved throughout the years. Specifically in Sterile Processing, the department that was often discounted and left alone in the basement has now been known to be at the forefront of leading effective initiatives that impact patient safety. Continuing this trend, I believe and look forward to seeing innovative ideas come from the Sterile Processing department, but we absolutely cannot do it alone. Building effective and collaborative teams that bring awareness of broken processes and issues helps in resolving antiquated procedures that no longer work in our day-to-day workflows. All you need to do is reach out and build your own team of superheroes! HPN

Anna Castillo-Gutierrez, AA, CRCST, CSPDT, CIS, CFER, Certified CPR Instructor is a System Sterile Processing Educator at Texas Children's Hospital. She is a Sterile Processing technician certified with HSPA and CBSPD with knowledge of Sterile Processing standards and guidelines according to AAMI, ANSI, SGNA, AORN, OSHA and CDC. She is Procurement, Scheduling and Tracking Systems knowledgeable. Experienced in purchasing, contract acquisition, project planning and management.

CONTINUING EDUCATION TEST • JUNE 2022

The fantastic four

Sterile processing, operating room, quality and education

Circle the one correct answer:

1. **Policies are the same in every hospital and staff should be aware of all of them.**
   A. True
   B. False
2. **Every single process and staff member should be constantly reviewed, from the time of hire to the individual processes that are taken.**
   A. True
   B. False
3. **The perioperative Quality Team can help in obtaining data related to known issues and errors within the operating room and Sterile Processing department.**
   A. True
   B. False
4. **The team of Sterile Processing and Operating Room leaders, Quality and Education should discuss issues openly in a safe environment.**
   A. True
   B. False
5. **Errors identified from a single person should be addressed and corrected by the team of Sterile Processing and Operating Room leaders, Quality and Education teams.**
   A. True
   B. False
6. **The Quality team is responsible for keeping staff accountable during projects.**
   A. True
   B. False
7. **Educators should present ideas in a manner that will capture the audience, in an easy-to-understand format.**
   A. True
   B. False
8. **Staff should be held accountable for following processes and leadership should not have to ensure processes are easily achievable.**
   A. True
   B. False
9. **The maintenance phase of a project is the most important part of the process.**
   A. True
   B. False
10. **You should never provide staff with feedback on the progress that has been made during a project. You should wait until the end of a project.**
    a. True
    b. False

CONTINUING EDUCATION TEST SCORING

HEALTHCARE PURCHASING NEWS EDUCATION HUB

HSPA HEALTHCARE STERILE PROCESSING ASSOCIATION

CBSPD

The approval number for this lesson is **3M-HPN 220605.**

HPN is thrilled to now offer all CEU quizzes online by scanning the QR code on the right or visiting: https://educationhub.hpnonline.com. **The cost to take the quiz online remains at $10.**

Due to rising costs if you would like to mail in your completed quiz using the method below the price is now $50 for each test taken.

Request for Scoring

❑ I have enclosed the scoring fee of **$50 for EACH test taken** — payable to **Endeavor Business Media**. We regret that no refunds can be given. (It is not neccessary to submit multiple tests separately.)

Detach exam and return to:
Continuing Education Division
Healthcare Purchasing News
2477 Stickney Point Road, Suite 221B
Sarasota, FL 34231

FLOWCODE PRIVACY.FLOWCODE.COM