Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003183	39802, 19843	6/11/19

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Diversey Surgical Center	2744 N. Western Ave., Chicago, IL 60647

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A licensure survey was conducted on 6/11/19. The Facility was not in compliance with Title 77: Public Health, Chapter 1: Department of Public Health, Subchapter b: Hospital and Ambulatory Care Facility, Part 205: Ambulatory Surgical Treatment Center Licensing requirements, as evidenced by:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE	TITLE	DATE
[redacted] Julie Swanson 7/2/19	Administrator	

Illinois Department of Public Health

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000	A licensure survey was conducted on 6/11/19. The Facility was not in compliance with Title 77: Public Health, Chapter 1: Department of Public Health, Subchapter b: Hospital and Ambulatory Care Facility, Part 205: Ambulatory Surgical Treatment Center Licensing requirements, as evidenced by:	205.230	On June 26, 2019, 9:00AM - an emergency Consulting Committee meeting was conducted to formally document vote and elect for CEO and members of a Consulting Committee. see attachement A. (Quarterly Consulting Committee Minutes) On the minutes, responsibilities of the consulting committee are discussed and delineated. The minutes of the meeting format are also ammended which more in detail represents the entirity of the organization agenda covering aspects such as credentialing, aprroval of new and changes in policies and procedures, tissue review report, QA/PI report, Infection prevention and control, environment of care, and other organizational activities. The Consulting Committee will be responsible in the documentation and record keeping of the minutes of the meeting. The Consulting Committee will meet on a regular basis (quarterly) at a minimum. A quorum may be called upon 50% or more of the memebers are present. Attached: Consulting Committee Minutes, ByLaws of the Medical Staff, AHCC Organizational Structure	6/27/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE [redacted] Julie Swanson

TITLE Administrator

DATE 7/2/19

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205.230 a) 2	Section 205.230 a) 2) Standards of Professional Work a) A qualified consulting committee shall be appointed in writing by the management or owner of the ambulatory surgical treatment center and shall establish and enforce standards for professional work in the facility and standards of competency for physicians. The qualified consulting committee shall meet not less than quarterly and shall document all meetings with written minutes. The minutes shall be maintained at the facility and shall be available for Department inspection. 2) The qualified consulting committee shall review the development and content of the facility's written policies and procedures, including the details of the quality assessment and performance improvement program, the infection control program, the patient rights plan, the disaster preparedness plan, the procedures for granting privileges, and the quality of the surgical procedures performed. The reviews shall be documented in the minutes. This Regulation is not met as evidence by: Based on document review and interview, it was determined that the Facility failed to ensure that detailed reviews of the quality assessment and performance program, the infection control program, the patient rights plan, the disaster preparedness plan, granting of privileges, and the quality of the surgical procedures performed were documented in the governing body meeting minutes. This could potentially affect the average 65 procedures performed at the Facility every month.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE	TITLE	DATE
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205.230 a) 2	Section 205.230 a) 2 (continued) Findings include: 1. The Facility's bylaws regarding responsibilities of the Consulting Committee were requested from the Administrator (E#1) on 6/10/19, at approximately 2:00 PM. On 6/11/19, at approximately 10:20 AM, E#1 stated that there were no written bylaws regarding oversight by the Consulting Committee. E#1 stated that the Consulting Committee is the Governing Body and is responsible for oversight of all facility operations including quality assurance and performance improvement (QAPI), medical staff credentialing, infection control, patient rights, and disaster planning. 2. The quarterly Consulting Committee meeting minutes from January 2017 to April 2019 were reviewed on 6/10/19. The minutes failed to include documentation of any discussions regarding QAPI, credentialing, infection control program, patient rights plan, and the disaster preparedness plan. 3. An interview was conducted with the Administrator (E#1) on 6/10/19, at approximately 3:30 PM. E#1 reviewed the meeting minutes from January 2017 to April 2019 and could not find documentation of discussions, actions and/or activities made by the Governing Body during the quarterly meetings. E#1 stated that the meeting minutes used to be written on a more detailed template that included sections about credentialing, policies and procedures, QAPI, and infection control; however, the Medical Director (MD#1) and Office Manager (E#4) "thought it was okay" to not have the details for each section written out.			

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205.550 b)	Section 205.550 b) Infection Control b) Each ASTC shall maintain a written, active and effective facility-wide infection control program. A system designed for the identification, surveillance, investigation, control, and prevention of infectious and communicable diseases in patients and health care workers shall be included in this program. This Regulation is not met as evidence by: A. Based on document review, observation, and interview, it was determined that for 1 of 2 Physicians (MD#1) observed, the Facility failed to ensure that personal clothing was not exposed in the restricted perioperative area (OR). Findings include: 1. On 6/10/19 at approximately 8:45 AM, the Facility's "Surgical Attire" policy was requested. The policy was not found. 2. On 6/11/19, at 12:15 PM, the "Association of periOperative Registered Nurses [AORN] 2018 Edition Guidelines for Perioperative Practice," was reviewed. The Guidelines included, "Guidelines for Surgical Attire... Recommendation I: Clean surgical attire should be worn in the semi-restricted and restricted areas of the perioperative setting... 1.b.5. Personal clothing that cannot be contained within the scrub attire either should not be worn or should be laundered in a health care accredited laundry facility..." 3. On 6/10/19 at 9:00 AM, an observational tour was conducted in the perioperative area (OR). The Surgeon (MD#1), who performed a pain procedure in OR suite #1, wore a tee shirt under his scrub shirt that was exposed at the neck level.	205.550 b)	On June 24, 2019, A Policy for Infection Control was drafted. Policy # 07.04.20 Titled Surgical Attire. The policy provides for guidance to perioperative personnel for surgical attire, including scrub attire, shoes, jewelry, head coverings, and surgical masks worn in the semi-restricted and restricted areas, which has an expected outcome that the patient will be free from signs and symptoms of infection. The drafted policy was cross referenced from OSHA, and AORN. (see attached Policy#07.04.20 Surgical Attire) The aforementioned Policy was presented and discussed in an emergency Consulting Committee meeting on June 26, 2019 was approved and inserviced to the staff on and other perioperative personnel for immediate implementation 6/27/19. (see attched Policy#07.04.20 Surgical Attire); Surgical Attire In-service Log.) see also attached tool used for Competency verification on Surgical Attire.	6/27/2019

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205.550 b)	Section 205.550 b) (continued) 4. On 6/10/19 at 3:55 PM, an interview was conducted with the Infection Control Officer (E #2). E #2 stated that the Facility follows AORN Guidelines and that MD #1's tee shirt should have been covered by the scrubs. B. Based on document review and interview, it was determined that for 1 of 1 sterilizer log reviewed, the Facility failed to ensure that daily biological indicator test (a process used to test the effectiveness of sterilization). This could potentially affect the average 65 procedures performed at the Facility every month. Findings included: 1. The Facility's Policy titled, "Sterilizer Monitoring" (revised 4/2/18), was reviewed on 6/10/19 and required, "...Spore [biological indicator] testing will be conducted daily when sterilizer is in use and on every load for implantable. (See accompanying inserts for manufacturers instructions for use).." 2. The manufacturer's guidelines for the biological indicator, were reviewed on 6/10/19 and required, "...Record the processed and control biological indicator results..."	205.550 b)	On June 21, 2019, Policy # 07.04.07 Titled: Sterilizer Monitoring was reviewed with the staff as part of an in-service under Infection Control Plan. see attached sign in log for in-service, Policy on Sterilizer Monitoring, 3M attest Biological IFU. To guarantee the success of Performance Improvement of such activities, the Sterilizer Monitoring activities will be included in the performance improvement activities which will be collected daily and evalauated monthly for improvement for the next 6 months. The Performance Improvement actities will also be reported to the consulting committee on a quarterly basis. (see attached Performance Activities Indicator)	6/21/2019

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	Section 205.550 b) (continued)			
205.550 b)	3. The sterilization logs from 3/1/19 to 5/1/19, were reviewed on 6/10/19 and indicated: - On 3/22/19, two loads of surgical instruments were sterilized. Load #1 contained 2 video cases (camera equipment inserted in the body during surgery), a hand tray (surgical instruments used to repair the hand), and a laryngoscope blade (used to open the airway when viewing the throat). Load #2 contained an Arthrex Power Tray (instruments used to saw or drill bone) and an Arthrex hand instrument (surgical instrument used to repair the hand). The log lacked documentation of the results of the biological indicator tests for both loads. - On 3/27/19, one load of surgical instruments was sterilized. The load contained dilators (surgical instrument used to expand an opening or passage), forceps (a pair of pincers or tweezers used in surgery), curettes (surgical instrument used to remove material by a scraping action), and speculums (instrument used to dilate an opening or canal in the body to allow inspection). The log lacked documentation of the result of the biological indicator test. 4. An interview was conducted with a Surgical Technician (E#5) on 6/10/19, at approximately 1:15 PM. E#5 stated that biological indicator testing is required daily. E#5 verified that no results were marked for loads performed on 3/22/19 and 3/27/19 and stated, "It should have been documented, we have no record of the results for those days."			

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205.550 j)	Section 205.550 j) Infection Control - Hand Hygiene j) Thorough hand hygiene shall be required after touching any contaminated or infected material. This Regulation is not met as evidence by. Based on document review, observation, and interview, it was determined that for 1 of 1 Housekeeper (E#3) observed, the Facility failed to ensure that hand hygiene was performed after removing gloves. Findings include: 1. On 6/11/19, the Facility's "Infection Prevention Program and Plan," (undated), was reviewed. The Plan included, "...Hand Hygiene will be performed for... After removing gloves..." 2. On 6/10/19 at 9:00 AM, an observational tour was conducted in the operating area (OR). At 10:00 AM, a Housekeeper (E#3), in the Holding/ Post Operative Area, disposed of a cleaning cloth, removed gloves, did not disinfect hands, and left the room. 3. On 6/10/19 at 3:55 PM, an interview was conducted with the Infection Control Officer (E#2). E#2 stated that hand hygiene should be performed after gloves are removed.	205.550 (j)	On June 20, 2019, A facility wide in-service was conducted to all personnel. Title: Guideline Implementation: Hand Hygiene (see attached brochure) A post evaluation was also conducted at this time and Competency Verification was also conducted on June 24, 25, and 27 following the in-service. (see attached sample of tool used in comptency verification) (see also log of attendance on Hand Hygiene in-service)	6/27/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE [redacted] Julie Swanson

TITLE Administrator

DATE 7/2/19

American Health Care Center

3412 W. Fullerton Ave., Chicago, IL 60647
773-235-8000

Quarterly Consulting Committee Minutes

Date: June 26, 2019

Emergency Meeting

Time: 9:00 am

Location: Fullerton-Kimball Medical and Surgical Center (conference room)

No of Pages: *(2)*

I **Approval of the previous minutes of meeting**

The minutes of the previous meeting (1st Quarter 2019) has been approved. A new format of agendas on the meeting is discussed which will be included in the subsequent meetings. The Medical Staff Bylaws has been amended, the Consulting Committee members and Chief Executive Officers has been voted on and listed hereinafter.

CEO- Dr. R. Xia
Members:
D. Ur – Medical Director
J. Swanson – Administrator
A. Sabater, RN – Clinical Nurse Manager
Sophia Demas – Office Manager
Andriy Khlopas – Nurse Practitioner

The meeting also delineates the other committees that reports to the Consulting Committee, namely Credentialing, Quality Improvement and Infection Control. (see attached ByLaws of the Medical Staff)

II **Credentialing**

The Credentials Committee has reported no new medical staff or LIPs under renewal and all members are up to date with their credentials. A review and discussion of the Medical Staff Bylaws and the steps to credentialing and re-credentialing were reviewed. Dr. R. Malcom has filed a leave of absence for the year commencing May 2019. Dr. H. Brown has resigned from the medical staff as of April 2019. Dr. T. Huang has been re-appointed as of June 01, 2019.

III **Approval/review of Policies and Procedures**

A new policy has been created and presented to the committee for approval: Policy #7.04.20 Title: Surgical Attire, the policy was approved for in-service and implementation.
Policy #7.04.17 STERILIZER MONITORING has been reviewed and in-service will be conducted for the staff on June 26, 2019.

IV **Tissue Review Report**

Tissue review reports for the 1st quarter 2019. No discrepancies were reported from the pre-operative and post-operative diagnosis basing on the tissue reports, all tissue reports are also received on a timely manner.

V QA/PI Report

Performance Improvement and Quality Assurance such as Medication monitoring (i.e., Look-Alike – Sound-Alike Medication and High Risk Medication List; Medication Cabinet Checklist; Outdated Supplies – has been assigned to S. Garcia to monitor on a weekly basis for the next two months and tapering off to monthly. The Sterilizers Biological Testing has been added to the Quality/Performance Improvement indicator daily monitoring for the next 6 months tapering to 3 months and eventually to monthly.

VI Infection Prevention and Control

A new policy was drafted and approved: Policy # 07.04.20 Surgical Attire
Hand Hygiene In-service and competency evaluation was conducted for the staff.
Sterilization Monitoring policy has been reviewed and in-serviced to the staff.

VII Environment of Care

The quarterly Fire Drill has been conducted on June. 19, 2019 at 2:30 PM, report has been filed to the Safety Coordinator. The Disaster Plan was also discussed and revision of the Plan is being looked into and details will further be discussed in the upcoming 2nd Quarterly Meeting.

VI Census Report

The census report for the quarter has been reported. (see attached report).

VII Employee Related Agenda

Nothing discussed.

VIII Other Agendas and Announcements

Aflac renewal is up-coming this July 2019, new enrollees will be welcomed.

Adjournment

Attendees: *(list of people in attendance, must have a sign in sheet)*

Attendees:

R. Xia, MD

D. Ur, MD

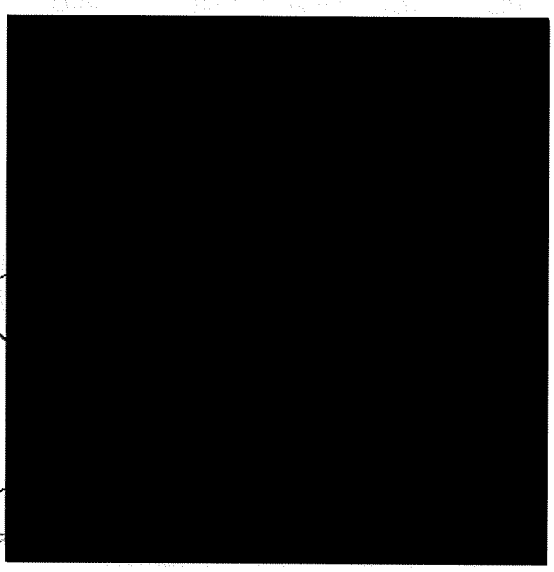
A. Sabater, RN

J. Swanson

K. Mazurek

S. Demas

A. Khlopas, NP



AMERICAN HEALTH CARE CENTER
MEDICAL STAFF BYLAWS

American Health Care Center is an organization under the state of Illinois whose purpose is to serve as a medical and ambulatory surgical center providing quality care for patients having outpatient procedures performed.

The Medical Staff of the American Health Care Center (AHCC) is responsible for the quality of medical care in all of its centers, and must accept and discharge this responsibility subject to the ultimate authority of the Consulting Committee (the "Board"). The physician, dentist and podiatrists who are granted privileges to care for the patients at AHCC by the Board hereby organize themselves into a Medical Staff in conformity with these Bylaws.

ARTICLE I
Medical Staff Name

The organized Medical Staff of the AHCC shall be known as the "Medical Staff of American Health Care Center."

ARTICLE II
Purpose

The Medical Staff of AHCC shall be accountable to the Board and shall be responsible for the quality of medical care provided to patients and for the ethical conduct and professional practice of its members and Allied Health Professionals who have been granted clinical privileges. In the proper discharge of these duties, the Medical Staff shall:

1. Recommend rules and regulations respecting clinical operations of the Center and the organization and operation of the Medical Staff to the Board for review and approval;
2. Conduct ongoing review and evaluation of its members and Allied Health Professionals and make recommendations to the Board respecting assignment and curtailment of clinical privileges and advancement and disciplinary action respecting such practitioners in accordance with these Bylaws and make recommendations to the Board respecting quality concerns and suggestions for improvement; and,
3. Ensure an appropriate liaison between the Medical Staff and the Board.

ARTICLE III
Medical Staff Membership

Section 1
Definition of Medical Staff Membership

Membership on the American Health Care Center is a privilege which shall be extended only to qualified, professional and competent physicians, dentists, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and in the rules, regulations, policies and procedures of the Medical Staff and the Center. Allied Health Professionals are licensed or certified health practitioners other than physicians, dentists, or podiatrists who through their training, experience and demonstrated competence are eligible to provide certain patient care services at the Center as recommended by the Medical Staff and approved by the Board.

Section 2
Qualifications for Membership

1. Every practitioner who seeks or enjoys appointment to the Medical Staff, or rights to perform patient care services as an Allied Health Professional shall, at the time of initial appointment and continuously thereafter, be qualified for membership or status as an Allied Health Professional, as the case may be, and the exercise of the clinical privileges granted to him or her. At a minimum, such practitioners shall:

a. Hold a valid, current, and unrestricted license to practice medicine, dentistry, or podiatry in the state of Illinois or, in the case of an Allied Health Professional, a valid, current, and unrestricted license or certification from the state of Illinois sufficient in scope to provide the patient care services for which privileges have been sought;

b. Possess the professional education, training, experience, ability, demonstrated competence, and judgment necessary to exercise the clinical privileges being sought;

c. With respect to physicians, dentists, and podiatrists:

i. Have completed post-graduate study at an accredited institution in the practitioner's specialty sufficient to qualify the practitioner for examination by an appropriate medical, osteopathic, dental, podiatric or specialty board (if such board exists in the practitioner's specialty) or professional training and professional credentials equivalent thereto;

ii. To the extent available and required in connection with the privileges requested, possess a current, unrestricted, and valid Drug Enforcement Agency registration necessary to permit such practitioner to dispense and/or administer controlled substances within limits of practitioner's specialty.

iii. Have and maintain clinical privileges at an accredited hospital which is either Medicare certified or satisfies the requirements for emergency services under 42 CFR 482.2 and which is located within approximately 35 miles from the Center, or have an established coverage arrangement with a physician or group of physicians having such clinical privileges so that the emergency needs of Center patients may be addressed through emergency admission;

iv. Participate in continuing education which satisfies the continuing education requirements of the State of Illinois, the American Medical Association Physician Recognition Award, the American Osteopathic Association, the American Podiatry Association, the American Dental Association, the practitioner's specialty board, or their equivalent;

d. With respect to Allied Health Professionals:

i. Have adequate training, experience and demonstrated current competence commensurate with the duties and responsibilities associated with the privileges being requested; and

ii. Where required by the State of Illinois, have in effect an agreement with a supervising practitioner who is a member of the Medical Staff and which covers oversight of the Professional's activities within the Center;

e. Demonstrate a willingness and capacity to work with and relate to other Medical Staff members, Allied Health Professionals, Center staff, patients, visitors, and the community in a cooperative and professional manner;

f. Possess current and valid professional liability insurance coverage that covers services to be rendered at the Center with limits acceptable to the Board;

g. Not have any significant physical or behavioral impairment which would interfere with the practitioner's ability to exercise his or her clinical privileges, discharge his or her duties as a member of the Medical Staff, satisfy any of the conditions for Medical Staff membership or classification as an Allied Health Professional, or otherwise provide quality health care, excepting such physical or behavioral impairments which may be reasonably

accommodated so as to eliminate the foregoing;

h. Adhere to the highest ethical standards and levels of professional competence of his or her licensing Board and profession; and,

i. Not be excluded from participation in any Federal health care program.

Section 3
Duration and Condition of Appointments

1. Action. All initial appointments and reappointments to the American Health Care Center Medical Staff shall be made by the Consulting Committee/Board. The Board of Directors shall act on appointments, reappointments, revocation, limitation or suspension of appointments or privileges only after there has been a recommendation from the Medical Advisory Committee as provided in these Bylaws; provided, however, that in the event of unwarranted delay on the part of the Medical Advisory Committee, the Board of Directors may act without such recommendations on the basis of documented evidence of the applicant's or the staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

2. Duration. Initial appointments shall be for a period of not more than two (2) years. Reappointments shall be for a period of not more than two (2) years.

3. Temporary Privileges. Temporary privileges may be granted by the Medical Director for a period of 60 days after a fully completed application has been presented to him or her and the following information has been obtained and verified:

a. An acceptable report from the National Practitioner Data Bank;

b. At a minimum, verbal verification of current, valid and unrestricted licensure or certification from the State of Illinois;

j. At a minimum, verbal verification of current medical staff privileges as required by Section II.ciii hereof;

k. Verification of professional liability insurance coverage as required by Section II.e hereof; and

l. Verification that the practitioner is not included on the List of Excluded Individuals/Entities maintained by the Office of Inspector General of the Department of Health and Human Services.

Temporary privileges may be extended for an additional period not to exceed 30 days for purposes of completion of the physician's credentials file or for a period not to exceed 60 days if the Medical Advisory Committee is not scheduled to meet with the first 30-day extension. In the event that the foregoing time periods are exceeded, the practitioner's temporary privileges shall terminate and his or her application will continue to be processed in due course.

1. Scope. The appointee will have and be permitted to exercise only those clinical privileges granted by the Board of Directors in accordance with these Bylaws.

2. Application. Every application for staff appointment shall be on a form approved by the Board, signed by the applicant and shall contain the applicant's specific acknowledgment of a Medical Staff Member's obligations to provide continuous care and supervision of his patients, to abide by the Medical Staff Bylaws, Rules and Regulations, the policies, procedures, rules and regulations of the Center and to accept committee assignments.

6. Condition of Appointments:

a. In order for a provider to maintain his or her medical staff appointment and clinical privileges at AHCC, he or she must perform at least four (4) surgeries per year at the Center. The exception to this bylaw is if the surgeon is an investor.

b. At the one-year mark, the Center will send a warning letter to physicians who are not maintaining the minimum number. At the end of the two-year reappointment period, failure of the provider to meet the above requirements will result in the provider's voluntary administrative resignation of clinical privileges and medical staff appointment to the Medical Staff of AHCC.

Section 4

Procedure for Appointment/Reappointment

1. Application packets for appointment or reappointment to the staff may be obtained from the AHCC upon request. Requests should be sent to:

American Health Care Center
c/o Medical Staff Services
3412 W. Fullerton Ave.,
Chicago, Illinois 60647

2. Physicians, dentists and podiatrists who wish to apply for appointment to the staff and for clinical privileges and Allied Health Professionals who wish to apply for rights to perform patient care services at the Center shall submit a written application on a form provided by the Center. The application form for physicians, podiatrists, and dentists shall contain a delineation of privileges for each specialty. There is a separate application for Allied Health Professional application forms and amendments to the forms shall be approved by the Board of Directors.

3. Completed application forms shall be submitted to AHCC Credentialing Department with a letter of reference from the applicant's Department Chairman in the primary hospital with which the application is presently affiliated. *NOTE: In the event the applicant works as Locum Tenens, a letter of reference from a physician with whom the applicant has worked on a consistent basis may be substituted.

4. The AHCC Credentialing Department shall be responsible for coordinating the gathering and verification of information necessary in the application process. The Medical Director shall be permitted to require the applicant to participate in the information gathering and verification process. Specifically, the applicant shall be responsible for updating all educational information, providing copies of proof of Illinois Licensure and DEA registration, providing all references required, completing appropriate Delineation of Privileges forms, and providing proof of professional liability insurance, (In addition, foreign graduates shall be required to supply copies of medical school transcripts and other materials necessary as set forth in the application form.) At all times during the application process the applicant shall have the burden of producing information in a timely fashion for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and membership requested, of resolving any doubts about these matters, and of satisfying requests for information. This burden may include submission to a medical or psychiatric examination, at the applicant's expense, if deemed appropriate by the Medical Advisory Committee, who may select the examining physician.

5. The Medical Director may request a personal interview with the applicant.

6. By applying for appointment or reappointment to the Medical Staff, each applicant thereby signifies his/her willingness to appear for interview in regard to his/her application, authorizes the AHCC to consult with members of the Medical Staffs or other

institutions with which the applicant has been associated, and with others who may have information bearing on his/her competence, character, and ethical qualifications, consents to the American Health Care Center's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges that have been requested, and to query the National Practitioner's Data Bank.

7. After all information required in the application form has been gathered and verified, and Data Bank report and sanctions check completed, the Medical Director shall submit the application to the Medical Advisory Committee appointed by the Board of Directors.

8. The Medical Advisory Committee shall review the application and may interview the applicant. Following its review, the Medical Advisory Committee shall submit the application, together with its recommendations as to whether the applicant should be appointed or reappointed to the Medical Staff and the recommended scope and delineation of clinical privileges or rights to perform patient care services in the AHCC to the Board of Directors.

9. The Board shall consider the recommendation of the Medical Advisory Committee at its next regularly scheduled meeting; provided, however, that the Board, in its sole discretion, may defer action on any application and/or request such additional information as it deems appropriate, through the Medical Director, from the applicant.

10. In the event that the Board denies an application for appointment or reappointment, or privileges granted to an applicant to the Medical Staff by the Board are less comprehensive than those requested, and the reasons for the Board's decision is not based solely on the practitioner's inability to satisfy the threshold qualifications or criteria for Medical Staff membership or the privileges requested, then the decision shall be considered an Adverse Action for purposes of Article VI hereof.

11. In the event that an applicant is dissatisfied with the decision of the Board, he/she may appeal the recommendation or action pursuant to Article VI of the Bylaws. (The applicant shall have thirty (30) days from his/her notification of the recommendation or action to submit a written request for an appeal to the Medical Director. In the event of an appeal, the Board of Managers shall appoint an Ad Hoc hearing committee to hear the appeal and to make a report to the Medical Advisory Committee, or the Board of Directors depending upon whose recommendation or action is being challenged. The applicant also shall have the right to an appellate review by the Board of Directors of any adverse recommendation or action).

ARTICLE IV
Parliamentary Procedure

Sturgis – Standard Code of Parliamentary Procedure shall govern all meetings in all cases to which they are applicable and in which they are not inconsistent with the Bylaws or Rules and Regulations of the Medical Staff of AHCC.

ARTICLE V
Corrective Action

1. Corrective action will be initiated against a member of the Medical Staff or an Allied Health Professional whenever their activities or professional conduct:

   a. Is contrary to the standards or aims of the Medical Staff or Professional conduct; or

   b. Is disruptive to the operation of American Health Care Center; or

   c. Brings discredit upon the Medical Staff or AHCC; or

   d. Is contrary to the provisions of the Medical Staff Bylaws, Rules and Regulations, or civil law.; or

   e. Raises issues respecting the practitioner's competence or continued satisfaction of the qualifications described in Article III, Section 2 hereof; or,

   f. Is inconsistent with the efficient delivery of patient care at generally recognized professional levels of quality or is reasonably probable of being disruptive to Center operations; or,

   g. Is indicative of a mental or physical impairment that might interfere with quality of care.

A request for corrective action may be initiated by a Medical Staff member, the Medical Director, the Administrative Director, a Committee of the Medical Staff or Board, the Medical Advisory Committee, or the Board. All requests for corrective action shall be in writing and shall be submitted to the Medical Director and shall be supported by reference to the specific activities of conduct which constitutes grounds for the requested action.

2. If the Medical Director finds sufficient cause, he/she shall appoint an Ad Hoc

Committee, within ten (10) calendar days, of three members of the Medical Staff. To the extent possible, the Medical Director shall avoid appointing individuals to the committee who are in direct competition with the practitioner being reviewed. The Ad Hoc Committee will investigate the allegations and shall make recommendations to the Medical Director within fourteen (14) days of appointment.

3. After reviewing the report of the Ad Hoc Committee, the Medical Director will report in writing his/her own investigation and recommendations on the matter to the Medical Advisory Committee. To the extent that an ad hoc committee has not been appointed, the Medical Director will provide the Medical Executive Committee with a report of his or her investigation.

4. The Medical Director shall then arrange a meeting with the practitioner being investigated and the Medical Advisory Committee. At this meeting, the practitioner shall be given an opportunity to discuss, explain, or refute the circumstances giving rise to the request for correction action. The Medical Director, in conjunction with the Medical Advisory Committee, shall make their recommendations in writing to the Board within fourteen (14) days of this meeting. A copy of the Medical Advisory Committee's recommendations shall be provided to the practitioner.

5. The practitioner may submit a written response to the Medical Advisory Committee's recommendations to the Board.

After considering all recommendations and evaluating the information presented, the Board may take corrective action. Such action may include, but is not limited to, (1) issuing a warning or a letter of admonition, or a letter of reprimand; (2) imposing terms of probation or a requirement for consultation or monitoring; (3) reduce, suspend, revoke, or otherwise limit clinical privileges or rights to provide clinical services or (4) continue or modify an already imposed summary suspension of clinical privileges. The action so taken shall be communicated to the practitioner in writing within ten (10) days of the decision.

6. The practitioner may appeal any adverse action taken by the Board pursuant to Article VI hereof.

7. The Medical Director, the Medical Executive Committee, the Administrative Director or the Board may summarily suspend any practitioner if such person or body reasonably determines that:

a. Continued exercise of privileges by the practitioner would endanger the safety of patients or staff of the Center; or,

b. The practitioner has breached or failed to comply with the requirements of these Bylaws, the rules and/or regulations of the Medical Staff, or the rules, regulations, policies or procedures of the Center, and such breach or failure to comply was intentional or done with willful disregard; or,

c. The practitioner has acted beyond the scope of his or her delineated privileges and such action cannot be justified as the only recourse in response to an emergency situation.

A summary suspension described in this Section 7 shall be considered an Adverse Action for purposes of Article VI hereof, but notwithstanding any provision of Article VI hereof to the contrary, any appeal from a summary suspension shall be limited to the issue of whether the person or body imposing the suspension was arbitrary or capricious in making the determination that a summary suspension was warranted.

8. The clinical privileges of a practitioner shall be automatically suspended in the event that:

a. The practitioner's license is suspended or revoked or is restricted in such a way as to interfere with his or her legal ability to exercise the privileges he or she has been granted;

b. The practitioner is listed on the List of Excluded Individuals/Entities maintained by the Office of Inspector General of the Department of Health and Human Services;

c. The practitioner's professional liability insurance coverage no longer satisfies the requirements imposed by the Board; or

d. The practitioner's privileges or coverage arrangements as described in Article III, Section II(c)(iii) are terminated, suspended, or revoked.

A suspension pursuant to this Section 8 shall not be an Adverse Action for purposes of Article VI hereof; provided, however, that the practitioner who is the subject of the suspension shall have the right to provide to the Board evidence that the circumstances giving rise to the suspension did not, in fact, occur. Any suspension invoked pursuant to this Section 8 shall be effective for a period commencing with the occurrence giving rise to the suspension and shall continue until such time as: (a) the occurrence giving rise to the suspension ceases to be effective; (b) the

practitioner submits a completed application for appointment to the Medical Staff; and (c) the Board, after consideration of the recommendations of the Medical Advisory Committee, determines that the practitioner again qualifies for Medical Staff privileges, taking into account the occurrence giving rise to the suspension, any information respecting the practitioner's activities during the period of the suspension, and any remedial actions taken by the practitioner after such occurrence.

ARTICLE VI

Appeal

1. In the event that an Adverse Action (as hereinafter defined) is taken against a practitioner who is a member of the Medical Staff, said practitioner shall have 30 calendar days from the date of the Board's notice of such Adverse Action (or the notice of the Medical Director in the event of a summary suspension) in which to deliver a request for an appeal of such Adverse Action. Any such request must be in writing, forwarded by certified or registered mail, return receipt requested, and addressed to the Medical Director. Failure on the part of a practitioner to submit a request for a hearing in compliance with the requirements of this Paragraph 1 shall constitute a waiver of the practitioner's right to a hearing.

2. The Board shall have 30 days from the date of the practitioner's request for an appeal in which to appoint a hearing committee and a hearing officer. The hearing committee shall be composed of clinicians who may or may not be members of the Medical Staff who are not in direct economic competition with the practitioner requesting the hearing.

3. The Hearing Officer shall be responsible for establishing procedural protocols applicable to preparation for and the conduct of the hearing, including without limitation, establishing protocols for the provision of witness and exhibit lists. The Hearing Officer shall preside over the conduct of the hearing and shall be responsible for resolving disputes which arise during the hearing.

4. Each of the parties to the hearing shall have the right, at the hearing, to be represented by counsel, call and examine witnesses (including the practitioner who requested the appeal), introduce exhibits and present relevant evidence, cross-examine adverse witnesses, make opening and closing arguments, and submit a written statement at the close of the hearing. A stenographic transcript or its equivalent shall be made so that an accurate record of the proceedings is maintained.

5. The person or body who took the Adverse Action shall initially have the burden of showing that the action taken was supported by substantial evidence. The practitioner shall thereafter have the burden of showing by clear and convincing evidence that the grounds for the Adverse Action lack any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary or capricious.

6. The Hearing Committee shall issue a written report of its findings within 10 days of final adjournment of the hearing and shall deliver such report to the Board. Within 30 days of its receipt of the report, the Board shall consider its contents and recommendations and affirm, modify, or reverse the hearing committee's recommendations. The decision of the Board shall be final. Written notice of the Board's decision shall be forwarded to the practitioner within 10 days.

7. For purposes of this Article VI, an "Adverse Action" is:

a. An action described in Article III, Section 4(11) or Article V, Section 7 hereof; and,

b. Any action by the Board which results in the limitation of, restriction on or revocation or suspension of the clinical privileges of a member of the Medical Staff which is based on the clinical competence of the practitioner; provided, however, that the following shall not be Adverse Actions hereunder:

i. Requirements that a practitioner's services within the Center be monitored , supervised, proctored, or reviewed unless such monitoring, proctoring supervision or review involves a requirement that the practitioner obtain permission prior to exercising his or her privileges;

ii. An action that is based on a practitioner's failure to satisfy established qualifications or criteria for privileges or membership on the Medical Staff or duly adopted modifications to such qualifications or criteria; or,

iii. An action abased on a practitioner's failure to follow established administrative rules, regulations, policies, or procedures and not based upon the clinical competence of the practitioner.

ARTICLE VII

Administration

Section I

Administration and Management of Operations

The Director of American Health Care is a full time, on site person who is responsible for the operation of the AHCC at all times. Under the direction of the Vice President of Physician Practices, the Director is responsible for the development, implementation, and administration of all policies and procedures relating to the daily operation and marketing of the AHCC.

The Medical Director is a board certified physician who reports to the Board of Directors of AHCC. The Medical Director is responsible for ensuring that appropriate, high quality medical patient care is delivered at AHCC.

Medical Advisory Committee

The Medical Advisory Committee shall be appointed by the Medical Director and the Board. This committee will meet on a quarterly basis. Quality Improvement activities will be reviewed on a quarterly basis. The Medical Advisory Committee shall be charged with:

1. **Credentialing** -- Review the credentials and qualifications of those practitioners requesting initial and renewed operating privileges at the Summit Surgery Center; and Allied Health Professionals requesting the right to provide clinical services at the Center and making recommendations respecting such requests to the Medical Advisory Committee.

2. **Quality Improvement** — Conduct of an ongoing quality assurance and improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. The Committee=s quality improvement activities shall be conducted pursuant to the Quality Assurance Plan adopted and modified from time to time by the Board. At a minimum, the Committee shall be responsible for:

    a. Peer review of the clinical performance of practitioners with clinical privileges and Allied health Professionals who provide clinical services at the Center;

    b. Surgical case and tissue review;

    c. Anesthesia services review, including the types of anesthesia utilized, the appropriateness of such anesthesia, and adherence to and proposed modifications of anesthesia policies and procedures and

standards of practice;

d. Review of nursing services and policies and procedures and standards of practice;

e. Review of arrangements for pharmaceutical, pathology, and radiology services, the appropriateness of such arrangements, and policies and procedures and standards of practice respecting or applicable to such services;

f. Review of the procedures performed in the Center and their necessity and appropriateness;

g. Review of the types of procedures which may be performed in the Center;

h. Review of reports of accidents, injuries and safety hazards;

i. Evaluation of data submitted as part of the quality assurance program.

The Committee shall make recommendations resulting from its activities to the Board, including without limitation, changes in policies and procedures, staffing and assignment changes, appropriate education and training, adjustments in clinical privileges, and modifications to the Center's equipment or physical plant. The Committee shall monitor the effectiveness of any measures implemented to resolve identified problems or concerns.

3. **Infection Control.** The Medical Advisory Committee will be responsible for:

a. The prevention, control and investigation of infection in the Center and for assuring the effectiveness of current procedural techniques in all areas of operation; and,

b. The designation of an individual responsible for developing and monitoring the infection control program and reporting back to the Committee respecting its development, implementation, and effectiveness, regulatory requirements and modifications thereto to the Board for approval.

The Medical Advisory Committee shall be appointed from time to time by the Board and shall consist, at a minimum, of the following: (a) the Medical Director, (b) the Vice President of Physician Practices; (c) the Chair of the Board; (d) the Administrative Director or representative; and (e) such other practitioners and administrative representatives as are deemed appropriate by the Board.

Section II
Additional Committees

The Medical Director shall be responsible for the appointment of any additional committees of the Medical Staff. The Medical Director, Administrative Director and Chairman of the Board of Managers shall be voting members of all committees. The appointment of these committees shall be January 1 to December 31. Special Committees may be appointed from time to time by the Medical Director in order to carry out properly the duties of the Medical Staff. Such committees shall meet as directed by their respective chairperson and shall confine their work to the purpose for which they were appointed and shall submit a report to the Medical Advisory/Credentials Committee.

ARTICLE VIII
Rules and Regulations

The Medical Advisory Committee shall recommend such Rules and Regulations as may be necessary for the proper conduct of the work of the Medical Staff of the American Health Care Center. Subject to the approval of the Board of Directors, such Rules and Regulations shall be part of these By-Laws and shall be amended as provided for in Article X.

ARTICLE IX

Adoption

These By-Laws and the Rules and Regulations of the Medical Staff will be initially adopted by the Board.

ARTICLE X
Amendments to By-Laws

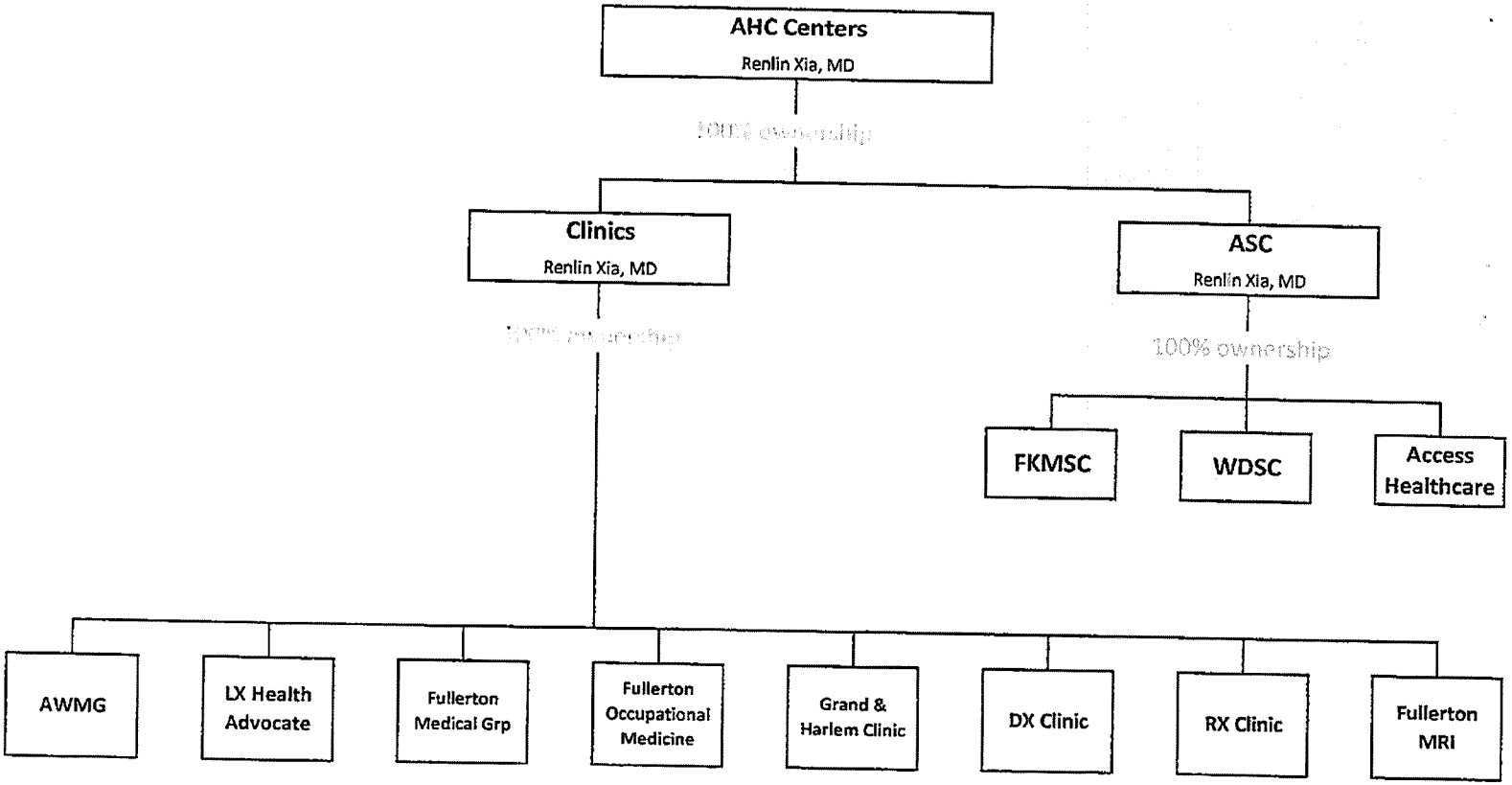
These By-Laws, Rules and Regulations of the Medical Staff may be amended as follows:

1. Proposed amendments should be presented to the Consulting Committee Meeting for review and to be entered into the minutes. Amendment and/or changes may be proposed by any member of the Medical Staff, Medical Director, Administrative Director, the Board of Managers, or the Medical Advisory Committee.
2. The Medical Director will review the proposed amendments and advise the Medical Staff on whether the proposed changes are in conformity with the provisions of the Federal and State Laws, and By-Laws, Rules and Regulations of American Health Care Center.
3. Proposed amendments will be distributed to the Medical Staff 30 days prior to the Consulting Committee meeting for comment and recommendations.
4. A proposed amendment will be adopted upon a two-thirds affirmative vote by the Consulting Committee.

Adopted: August 2008
Amended: June 25, 2019

AMERICAN HEALTH CARE CENTERS

STRUCTURE



updated: 04-2019

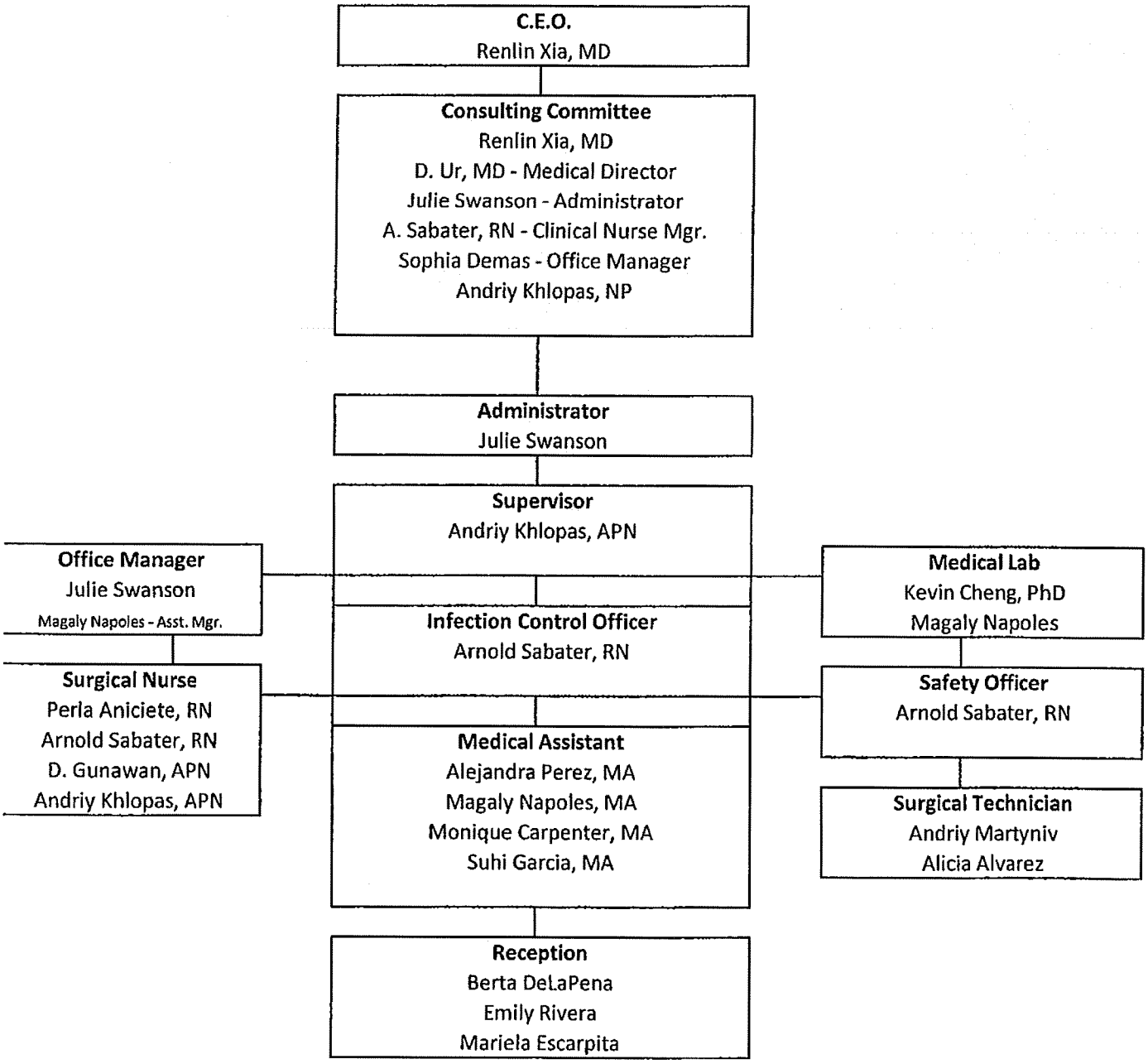
aps

AMERICAN HEALTH CARE CENTERS

Western-Diversey Surgical Center

2744 N. Western Ave., Chicago, IL 60647

ORGANIZATIONAL PLAN



updated: 06-2019

aps

Policy and Procedure

Title: **Surgical Attire**
Section: **Infection Control**
Policy No. **07.04.20**
Date Adopted: **07-24-2019**
Date Revised:
No. of Pages: 4

Purpose

To provide guidance to perioperative personnel for surgical attire, including scrub attire, shoes, jewelry, head coverings, and surgical masks worn in the semi-restricted and restricted areas. Guidance is also provided for personal items and personal electronic devices taken into the semi-restricted and restricted areas. The expected outcome is that the patient will be free from signs and symptoms of infection.

Policy

It is the policy of **American Health Care Center** that:

- Clean surgical attire will be worn in semi-restricted and restricted areas.
- Individuals who enter semi-restricted and restricted areas will wear scrub attire that has been laundered at the health care-accredited laundry facility or wear single-use scrub attire provided by the facility and intended for use within perioperative areas.
  - Scrub attire will be laundered in the health care-accredited laundry facility after each daily use and when contaminated.
  - Personal clothing that is not covered by the scrub attire will be laundered in the health care-accredited laundry facility after each daily use and when contaminated.
  - Reusable head coverings will be laundered in the health care-accredited laundry facility after each daily use and when contaminated.
  - Reusable cover apparel will be laundered in the health care-accredited laundry facility after each daily use and when contaminated.
- Scrub attire that has been penetrated by blood, body fluids, or other potentially infectious materials must be removed immediately or as soon as possible and replaced with clean attire.
  - When extensive contamination of the body occurs, a shower or bath will be taken before the clean attire is donned.
  - Scrub attire contaminated with visible blood or body fluids must be laundered at the health care-accredited laundry facility.
  - Wet or contaminated scrub attire must not be rinsed or sorted in the location of use.
- Perioperative personnel will change into street clothes whenever they go outside of the building.
- Cover apparel (eg, lab coats) worn over scrub attire will be clean or single-use.
- Identification badges will be worn by all personnel authorized to enter perioperative areas.
- Jewelry that cannot be contained or confined within the scrub attire will not be worn in the semi-restricted or restricted areas.
- Shoes worn within the perioperative environment must
  - meet Occupational Safety and Health Administration standards for protective footwear;
  - be constructed to prevent exposures to blood, body fluids, and other potentially infectious materials; and
  - have closed toes and backs, low heels, and non-skid soles.
- Surgical masks, in combination with eye protection devices (eg, goggles, glasses with solid side shields, chin-length face shields), must be worn whenever splashes, spray, spatter, or droplets of

Title: **Surgical Attire**
Section: **Infection Control**
Policy No. **07.04.20**
Date Adopted: **07-24-2019**
Date Revised:
No. of Pages: 4

blood, body fluids, or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.
- Personnel entering the semi-restricted and restricted areas will cover the head, hair, ears, and facial hair.

Procedure Interventions

Scrub Attire

- Don clean scrub attire daily in the designated dressing area before entering the semi-restricted and restricted areas.
- Prevent clean scrub attire from contacting the floor or other contaminated surfaces while donning.
- Ensure all personal clothing is covered by the scrub attire.
- Tuck the top of the scrub suit into the pants if it does not fit close to the body.
- Wear scrub dresses over scrub pants or leggings that are laundered in the health care-accredited laundry facility after each daily use and when contaminated.
- Wear close-fitting long-sleeved jackets with the snaps closed and with the cuffs down to the wrists when
  - in the restricted areas,
  - performing preoperative patient skin antisepsis, and
  - performing preparation and packaging of items in the clean assembly section of the sterile processing area.
- Discard single-use scrub attire in a designated trash container or place reusable items in a designated laundry container.
- Leave reusable scrub attire at the health care facility for laundering.
- Do not store reusable scrub attire that has been worn in a locker for future use.
- People entering the semi-restricted or restricted areas for a brief time (eg, law enforcement officers, parents, biomedical engineers) will don either clean scrub attire, single-use scrub attire, or a single-use jumpsuit (eg, coveralls, bunny suit) designed to completely cover personal apparel.

Shoes

- Wear shoes that are clean and dedicated for use within the perioperative area.
- Wear shoe covers when gross contamination can reasonably be anticipated.
- Remove single-use shoe covers worn as personal protective equipment immediately after use, discard, and perform hand hygiene.

Surgical Masks

- Wear a mask when open sterile supplies and equipment are present.
- Don a fresh, clean surgical mask before performing or assisting with each new procedure.
- Cover the mouth and nose with the mask and tie it securely.
- Do not wear the mask hanging down from the neck.
- Replace and discard the mask whenever it becomes wet or soiled, or has been taken down.
- Remove the mask by handling only the mask ties and perform hand hygiene after removing the mask.

- Clean reusable protection devices worn with surgical masks, (eg, goggles, personal glasses supplemented with solid side shields) according to the manufacturer's instructions for use before and after performing or assisting with each new procedure.

Identification Badges

- Secure identification badges in a visible location on the scrub attire top or long-sleeved jacket.
- Do not wear lanyards around the neck.
- Clean identification badges with a low-level disinfectant regularly and when the badge becomes soiled.

Stethoscopes

- Do not wear stethoscopes around the neck.
- Do not use fabric covers for stethoscopes.
- Clean stethoscopes before and after each use with a low-level disinfectant.

Personal Items

- Clean briefcases, backpacks, and other personal items taken into the semi-restricted or restricted areas with a low-level disinfectant and do not place them on the floor.
- Clean cell phones, tablets, and other personal communication or hand-held electronic equipment according to the manufacturer's instructions for use with a low-level disinfectant before and after taking them into the semi-restricted or restricted areas.

Head Coverings

- Wear a clean surgical head cover or hood that confines all hair and completely covers the ears, scalp skin, sideburns, and nape of the neck.
- Do not remove the surgical head covering when wearing surgical attire and leaving the perioperative areas.
- Remove the surgical head covering when changing into street clothes and going outside the building.
- Remove single-use head coverings at the end of the shift or when contaminated and discard in a designated receptacle.

Competency

Perioperative personnel working in semi-restricted and restricted areas of the facility will receive education and complete competency verification activities on surgical attire worn in the perioperative areas.

Quality

Perioperative personnel working in semi-restricted and restricted areas of the facility will participate in quality assurance and performance improvement activities related to surgical attire worn in the perioperative areas.

Glossary

Title: **Surgical Attire**
Section: **Infection Control**
Policy No. **07.04.20**
Date Adopted: **07-24-2019**
Date Revised:
No. of Pages: 4

Scrub attire: Nonsterile apparel designed for the perioperative practice setting that includes two-piece pantsuits, scrub dresses, long-sleeved cover jackets, and head coverings.

Surgical attire: Nonsterile apparel designated for the perioperative practice setting that includes two-piece pantsuits, scrub dresses, cover jackets, head coverings, shoes, masks, and protective eyewear.

Surgical mask: A device worn over the mouth and nose by perioperative team members during surgical procedures to protect both the patient and perioperative team member from transfer of blood, body fluids, and other potentially infectious materials. Surgical masks prevent the transmission of large droplets (ie, greater than 5 microns). Surgical masks are evaluated for fluid resistance, bacterial filtration efficiency, differential pressure, and flammability.

References

Occupational Safety and Health Administration. 1910.136: Occupational foot protection. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9786. Accessed September 14, 2014.

Occupational Safety and Health Administration. 1910.1030: Bloodborne pathogens. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051. Accessed September 14, 2014.

Petersen C, ed. *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2011:254-276.

Guideline for surgical attire. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc, 2015:97-120.

American Health Care Center
Competency Verification Tool—Perioperative Services
Surgical Attire

Name:_____ **Date:** _____

Competency Statement: The perioperative RN or team member has completed facility- or health care organization-required education and competency verification activities related to recommended surgical attire in the perioperative setting.[1]

1. Guideline for surgical attire. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc; 2015:97-120.

Outcome Statement: The patient is free from signs and symptoms of infection.[2]

2. Petersen C, ed. Infection. In: *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2011:254-276.

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
1. Wears clean surgical attire in the semi-restricted and restricted areas.							
2. Wears scrub attire provided by the facility and intended for use in the perioperative areas.							
3. Wears scrub attire that is laundered in the health care-accredited laundry facility after each daily use and when contaminated including a. personal clothing not covered by the scrub attire,							
b. personal leggings worn under scrub dresses,							
c. reusable head coverings, and							
d. reusable cover apparel.							
4. Removes scrub attire that has been penetrated by blood, body fluids, or other potentially infectious materials immediately or as soon as possible and dons clean scrub attire and a. takes a shower or bath before donning clean attire if extensive contamination occurs,							
b. leaves contaminated scrub attire at the facility for laundering, and							
c. does not rinse or sort contaminated scrub attire in the location of use.							
5. Dons clean scrub attire daily in the designated dressing area before							

DEM/DO/DA = Demonstration/Direct Observation/Documentation Audit
S/SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
RWM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)

KAT = Knowledge Assessment Test
V = Verbalization
O = Other: _____

American Health Care Center
Competency Verification Tool—Perioperative Services
Surgical Attire

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	-O-	
entering the semi-restricted and restricted areas.							
6. Prevents clean scrub attire from contacting the floor or other contaminated surfaces while donning.							
7. Ensures all personal clothing is covered by the scrub attire or is laundered after each daily use and when contaminated in the health care-accredited laundry.							
8. Wears close-fitting long-sleeved jackets with the snaps closed and with the cuffs down to the wrists when a. in the restricted areas,							
b. performing preoperative patient skin antisepsis, and							
c. performing preparation and packaging of items in the clean assembly section of the sterile processing area.							
9. Discards single-use scrub attire in a designated trash container or places reusable items in the designated laundry container.							
10. Leaves reusable scrub attire at the health care facility for laundering.							
11. Does not store reusable scrub attire that has been worn in a locker for future use.							
12. Ensures that people entering the semi-restricted or restricted areas for a brief time (eg, biomedical engineers) don either clean scrub attire, single-use scrub attire, or a single-use jumpsuit (eg, bunny suit) designed to completely cover personal apparel.							
13. Changes into street clothes when going outside of the building.							
14. Wears clean or single-use cover apparel (eg, lab coat).							
15. Wears identification badge in a visible location on the scrub attire top or long-sleeved jacket.							
16. Cleans identification badge with a low-level disinfectant regularly and when the badge becomes soiled.							
17. Does not wear stethoscopes around the neck.							
18. Does not use fabric covers for stethoscopes.							

DEM/DO/DA = Demonstration/Direct Observation/Documentation Audit
S/SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
RWM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)
KAT = Knowledge Assessment Test
V = Verbalization
O = Other: _____

American Health Care Center
Competency Verification Tool—Perioperative Services
Surgical Attire

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
19. Cleans stethoscopes before and after each use with a low-level disinfectant.							
20. Does not wear jewelry that cannot be contained or confined within the scrub attire in the semi-restricted and restricted areas.							
21. Cleans briefcases, backpacks, and other personal items taken into the semi-restricted or restricted areas with a low-level disinfectant and does not place them on the floor.							
22. Cleans cell phones, tablets, and other personal communication or hand-held electronic equipment according to the manufacturer's instructions for use with a low-level disinfectant before and after being taken into the semi-restricted or restricted areas.							
23. Wears shoes that are clean and a. dedicated for use within the perioperative area,							
b. meet Occupational Safety and Health Administration standards for protective footwear,							
c. are constructed to prevent exposures to blood, body fluids, and other potentially infectious materials, and							
d. have closed toes and backs, low heels, and non-skid soles.							
24. Wears shoe covers when gross contamination can reasonably be expected.							
25. Removes shoe covers worn as personal protective equipment immediately after use, discards, and performs hand hygiene.							
26. Wears surgical mask in combination with eye protection devices (eg, goggles, glasses with solid side shields, chin-length face shields) whenever splashes, spray, spatter, or droplets of blood, body fluids, or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.							
27. Dons a fresh, clean surgical mask before performing or assisting with each new procedure.							

DEM/DO/DA = Demonstration/Direct Observation/Documentation Audit
S/SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
RWM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)

KAT = Knowledge Assessment Test
V = Verbalization
O = Other: _____

American Health Care Center
Competency Verification Tool—Perioperative Services
Surgical Attire

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
28. Covers the mouth and nose with the mask and ties it securely.							
29. Does not wear the mask hanging down from the neck.							
30. Replaces and discards the mask whenever it becomes wet or soiled, or has been taken down.							
31. Removes the mask by handling only the mask ties and performs hand hygiene after removing the mask.							
32. Cleans reusable protection devices worn with surgical masks (eg, goggles, personal glasses with solid side shields) according to the manufacturer's instructions for use before and after performing or assisting with each new procedure.							
33. Covers head, hair, ears, and facial hair when entering the semi-restricted and restricted areas.							
34. Wears a clean surgical head cover or hood that confines all hair and completely covers the ears, scalp skin, sideburns, and nape of the neck.							
35. Does not remove the surgical head covering when wearing surgical attire and leaving the perioperative areas.							
36. Removes the surgical head covering when changing into street clothes and going outside the building.							
37. Removes single-use head coverings at the end of the shift or when contaminated and discards them in a designated receptacle.							
38. Verbalizes a review of facility or health care organization policies and procedures related to surgical attire.							
39. Participates in assigned quality improvement activities related to surgical attire.							

)EM/DO/DA = Demonstration/Direct Observation/Documentation Audit
/SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
:WM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)

KAT = Knowledge Assessment Test
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O = Other: _____

American Health Care Center
Competency Verification Tool—Perioperative Services
Surgical Attire

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
Concurrent competency verification of the following is recommended							
• Standard precautions,			• airborne precautions, and				
• droplet precautions,			• additional competencies related to surgical attire as determined by the facility or health care organization.				
• contact precautions,			•				

DEM/DO/DA = Demonstration/Direct Observation/Documentation Audit
SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
RWM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)

KAT = Knowledge Assessment Test
V = Verbalization
O = Other: _____

American Health Care Center

Policy and Procedure

Title: **Sterilizer Monitoring**
Section: **Infection Control**
Policy No: **07.04.17**
Date Adopted: **03/01/08**
Date Revised: **04/02/18**
Pages: 1 of 2

I POLICY

It is the policy of American Health Care Center to monitor the efficacy of the sterilizing process to insure the sterility of instruments, and to maintain a documented monitoring control system to meet national guidelines.

II PROCEDURES

A. Spore testing will be conducted ~~weekly~~ daily when sterilizer is in use and on every load for implantable.
(see accompanying inserts for manufacturers instruction for use (41482V)

~~1. Biological indicators are placed in a test pack representative of the load.~~
~~2. When removed, the vial (result test) is placed in a biological spore testing machine with a biological indicator vial (control test) that has not been placed in the sterilizer.~~
~~3. After the appropriate time has elapsed (48 hours), read the result.~~
~~The indicator in the result test should be negative (-); the control test should be positive (+).~~
~~4. Record the result of the test on the spore test log, and sign as confirmation of physical parameters being attained.~~

B. If the result of the spore test from the vial is positive, the sterilizer is not used, and the result is reported to the Surgical Coordinator.

1. The Surgical Coordinator will perform a second test. If the second test is positive, the sterilizer is repaired and not used until all tests are negative.
2. All instruments and packages processed with a positive test result are pulled from the shelves and re-sterilized.
3. The spore test log with a positive test will be compared to the surgical log. Patients indentified will be called and asked to come into the office to check for infection.
~~4. *All loads will be sequestered and placed on hold for use until the biological indicator result turns negative.*~~

C. Bowie-Dick Type test will be carried out on days sterilizer will be used.
(see manufacturers instruction for use)

~~Note: A rapid Biological Testing kit is in evaluation and will be used soon as after they have arrive and in serviced.~~

3M™ Attest™ Super Rapid 5 Steam-Plus Challenge Pack 41482V

Product Description

The 3M™ Attest™ Super Rapid 5 Steam-Plus Challenge Pack 41482V is specifically designed for routinely challenging and conducting qualification testing of 270°F (132°C) and 275°F (135°C) dynamic-air-removal (pre-vacuum) steam sterilization processes in healthcare facilities. The challenge pack consists of multiple layers of medical index cards, some of which are die-cut to contain the monitoring products. The stacked cards are wrapped with a sterilization wrap. Each challenge pack has a process indicator on the pack label that changes from yellow to brown or darker when exposed to steam. This convenient disposable challenge pack presents a challenge to the sterilization process equivalent to the user-assembled biological indicator (BI) challenge test pack (towel PCD) recommended by the Association for the Advancement of Medical Instrumentation (AAMI). The challenge pack is a single use device.

Each challenge pack contains a 3M™ Attest™ Super Rapid Readout Biological Indicator 1492V (brown cap, hereinafter referred to as a 1492V BI), a 3M™ Comply™ SteriGage™ Steam Chemical Integrator, and a record keeping sheet. AAMI recommends that steam sterilization loads containing an implant be monitored with a process challenge device containing a biological indicator and an integrating indicator. Comply™ SteriGage™ Steam Chemical Integrators are Type 5 (Category i5) Integrating Indicators as categorized by ISO 11140-1:2014. Comply™ SteriGage™ Steam Chemical Integrators are single-use chemical indicators consisting of a paper wick and a steam and temperature sensitive chemical pellet contained in a paper/film/foil laminate. The chemical pellet melts and migrates as a dark color along the paper wick. The migration is visible through a window marked ACCEPT or REJECT; the extent of migration depends on steam, time, and temperature. The Comply™ SteriGage™ Steam Chemical Integrator offers an immediate Accept/Reject reading that allows for implant load early release in emergency situations as defined in AAMI ST-79.

The 1492V BI is a self-contained dual readout biological indicator specifically designed for rapid and reliable monitoring of the steam sterilization process when used in conjunction with the 3M™ Attest™ Auto-reader 490, hereinafter referred to as the 490 Auto-reader. When steam processed, the process indicator on the top of the 1492V BI cap changes color from pink to light brown or darker. 3M™ Attest™ 1492V biological indicator controls are provided with the challenge packs.

The 1492V BI utilizes the α-glucosidase enzyme system, which is generated naturally within growing cells of *Geobacillus stearothermophilus*. The α-glucosidase in its active state is detected by measuring the fluorescence produced by the enzymatic hydrolysis of a non-fluorescent substrate, 4 methylumbelliferyl-α-D-glucoside (MUG). The resultant fluorescent by-product, 4-methylumbelliferone (MU), is detected in the 490 Auto-reader. The presence of fluorescence within 1 hour of incubation of the 1492V BI in the 490 Auto-reader indicates a steam sterilization process failure.

The 1492V BI can also indicate the presence of *G. stearothermophilus* organisms by a visual pH color change reaction. Biochemical activity of the *G. stearothermophilus* organism produces metabolic by-products that cause the media to change color from purple to yellow which also indicates a steam sterilization process failure. Use of this indication method is optional and is typically restricted to special studies.

Readout Times

The 1-hour super rapid readout and the optional 48-hour visual pH color change incubation times have been correlated with a 7-day incubation period (at 56+/-2°C) following the FDA's Reduced Incubation Time protocol. Processed indicators were examined at 48 hours and 7 days for detection of a visual pH color change. The 1-hour fluorescence change readings and the 48-hour visual pH color change readings were compared to the 7-day visual pH color change readings to determine the readout time of the indicator.

1-hour Fluorescence Change Result

1492V BIs have 1-hour reduced incubation time results that correlate to the 7-day (168 hours) visual readout result ≥ 97% of the time.

48-hour Visual pH Color Change Result

1492V BIs have 48-hour reduced incubation time results that correlate to the 7-day (168 hours) visual readout result ≥ 97% of the time.

Due to the high reliability of the 1-hour fluorescent result, there is no advantage to incubating 1492V BIs beyond 1 hour.

1492V BIs meet ANSI/AAMI/ISO 11138-1:2006/(R)2010, ANSI/AAMI/ISO 11138-3:2006/(R)2010 and EN/ISO 11138-1:2006, EN/ISO 11138-3:2006.

Indications for Use

United States

Use the 3M™ Attest™ Super Rapid 5 Steam-Plus Challenge Pack 41482V in conjunction with the 3M™ Attest™ Auto-reader 490 to qualify or monitor dynamic-air-removal (pre-vacuum) steam sterilization cycles of 4 minutes at 270°F (132°C) and 3 minutes at 275°F (135°C). The 3M™ Attest™ Super Rapid Readout Biological Indicator 1492V contained in the challenge pack provides a final fluorescent result in 1 hour. An optional visual pH color change result is observed in 48 hours.

Outside the United States

Use the 3M™ Attest™ Super Rapid 5 Steam-Plus Challenge Pack 41482V in conjunction with the 3M™ Attest™ Auto-reader 490 to qualify or monitor 270°F (132°C) to 275°F (135°C) dynamic-air-removal (pre-vacuum) steam sterilization cycles.

Contraindications

None.

Warnings

There is a glass ampoule inside the plastic vial of the biological indicator. To avoid the risk of serious injury or death from flying debris due to a ruptured ampoule:

- Allow the biological indicator to cool for the recommended time period before activating. Activating or excessive handling of the BI before cooling may cause the glass ampoule to burst.
- Wear safety glasses when activating the biological indicator.
- Handle the biological indicator by the cap when crushing and flicking.
- Do not use your fingers to crush the glass ampoule.

Precautions

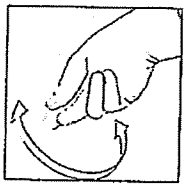
1. To ensure the challenge pack delivers the intended challenge:
   - DO NOT OPEN challenge pack prior to sterilization;
   - DO NOT reuse challenge pack.
2. DO NOT use the challenge pack to monitor sterilization cycles which it is not designed to challenge:
   a. Gravity-displacement steam sterilization cycles;
   b. 250°F (121°C) dynamic-air-removal (pre-vacuum) steam sterilization cycles;
   c. 270°F (132°C) dynamic-air-removal (pre-vacuum) steam sterilization cycles having exposure times <4 minutes or 275°F (135°C) dynamic-air-removal (pre-vacuum) steam sterilization cycles having exposure times <3 minutes;
   d. Dry heat, chemical vapor, ethylene oxide or other low temperature sterilization processes.
3. After 1492V BI activation, ensure media has flowed to the spore growth chamber.

Monitoring Frequency

Follow facility Policies and Procedures which should specify a biological indicator monitoring frequency compliant with professional association recommended practices and/or national guidelines and standards. As a best practice and to provide optimal patient safety, 3M recommends that every steam sterilization load be monitored with a biological indicator in an appropriate Process Challenge Device (i.e., BI challenge test pack).

Directions for Use

1. Place an Attest™ Super Rapid 5 Steam-Plus Challenge Pack 41482V flat, with the label side up, in a full load in the most challenging area for the sterilant to reach. This is generally on the bottom shelf, over the drain. Do not place objects (e.g. another pack) on top of the challenge pack. This will create too great of a challenge for air removal and steam penetration.
2. Process the load according to established procedures.
3. After completion of the cycle, while wearing heat resistant gloves, retrieve the challenge pack.
4. Check to see that the external process indicator on the outside of the challenge pack has changed from yellow to brown or darker. Open the challenge pack and allow the 1492V BI to cool outside the challenge pack for 10 minutes prior to activation.
5. Check the Comply™ SteriGage™ Steam Chemical Integrator. The dark color should have entered the ACCEPT window. If the dark color has not entered the ACCEPT window, this indicates a REJECT result which means the load was not exposed to sufficient steam sterilization conditions. This load should not be released for use but reprocessed. Record integrator result.
6. Check the process indicator on the top of the 1492V BI cap. A color change from pink to light brown or darker confirms that the biological indicator has been exposed to the steam process. This color change does not indicate that the steam process was sufficient to achieve sterility. If the process indicator is unchanged, check the sterilizer physical monitors.
7. Identify the processed 1492V BI by writing the sterilizer, load number, and processing date on the indicator label. Do not place another label or indicator tape on the biological indicator.
8. For a permanent record, fill out the required information on the record keeping card. Record the 1492V BI result when available.
9. Discard the challenge pack. Using the challenge pack more than once will invalidate subsequent test results.
10. To activate the 1492V BI, place it in a 490 Auto-reader incubation well which is color-coded brown (i.e., configured to incubate 1492V BIs). While wearing safety glasses, press the cap of the BI down firmly to close the cap and crush the glass ampoule. Immediately remove the BI and flick it (see picture at right). Visually verify that media has flowed into the growth chamber at the bottom of the vial. If the media hasn't filled the growth chamber, hold the BI by the cap and flick it until media fills the growth chamber. Return the activated 1492V BI to the incubation well and wait for the result. See the 490 Auto-reader Operator's Manual for further information related to its use.



11. Each day that a processed 1492V BI is incubated, activate and incubate at least one non-processed 1492V BI to use as a positive control. Follow the activation instructions provided in Step 10 above. Write a "C" (for "control") and the date on the BI label. The positive control should be from the same lot code as the processed biological indicator. The positive control BI helps confirm:
    - correct incubation temperatures are met;
    - viability of spores has not been altered due to improper storage temperature, humidity or proximity to chemicals;
    - capability of media to promote rapid growth; and
    - proper functioning of the 490 Auto-reader.
12. Incubation and Reading:

    Incubate the positive control and steam processed 1492V BIs at 56 ± 2°C in a 490 Auto-reader. See the 490 Auto-reader Operator's Manual for the proper use of this equipment. Positive 1492V BI results are available within 1 hour. The 490 Auto-reader will display a positive result as soon as it is obtained. The final negative 1492V BI reading is made at 1 hour. After the results are displayed and recorded, the 1492V BIs may be discarded.

Interpretation of Results:

Fluorescent Results

The positive control (unprocessed) 1492V BI must provide a positive fluorescent result (+ on the 490 Auto-reader LCD display). Processed 1492V BI results are not valid until the positive control reads fluorescent positive. The positive control should read positive (+ on the LCD display) at or before 1 hour. If the positive control reads negative (- on the LCD display) at 1 hour, check the 490 Auto-reader Operator's Manual Troubleshooting Guide. Retest the 490 Auto-reader with a new positive control.

With processed 1492V BIs, a positive (+ on the LCD display) result indicates a sterilization process failure. A final negative (- on the LCD display) result for the processed 1492V BI after 1 hour of incubation indicates an acceptable sterilization process.

Act immediately on any positive results for processed BIs. Determine the cause of the positive BI following facility policies and procedures. Always retest the sterilizer and do not use sterilizer for processing loads until qualification testing yields satisfactory results (typically three consecutive cycles with negative BI results and three consecutive cycles with passing Bowie-Dick test results).

Optional Visual pH Color Change Result

The 1492V BI is normally discarded after the fluorescent result has been recorded. If, however, special studies are desired, 1492V BIs may be further incubated for a visual pH color change result. After activation and during incubation, the white Nonwoven Material will absorb the bromocresol purple indicator, the pH-sensitive indicator dye in the growth media, and appear blue. In the case of the positive control BI a yellow color change of the growth media and/or Nonwoven Material will appear within 48 hours. Any observation of a yellow color within the vial indicates a positive result.

In the case of a processed 1492V BI, a media and/or Nonwoven Material color change from purple to yellow indicates a sterilization process failure. A negative pH color change result, i.e., media and Nonwoven Material remain purple/blue, can be assessed at 48 hours.

Storage

- Best stored under normal room conditions: 59-86°F (15-30°C), 35-60% relative humidity.
- Store away from direct sunlight. Do not store challenge packs near sterilants or other chemicals.
- After use, the Comply™ SteriGage™ Steam Chemical Integrator will not change visually within 6 months when stored at above conditions.

Disposal

Dispose of used 1492V BIs according to your health care facility policy. You may wish to steam sterilize any positive biological indicators at 270°F (132°C) for 4 minutes or at 275°F (135°C) for 3 minutes in a dynamic-air-removal steam sterilizer prior to disposal.

Explanation of Symbols

 Caution, see instructions for use

 Do not reuse

 Use by date

 Batch code

 Manufacturer

 Date of manufacture

 Product is designed for use with steam sterilization cycles.

 Catalogue Number

Made in U.S.A. by
3M Health Care
2510 Conway Ave.
St. Paul, MN 55144
1-800-228-3957
3M.com/infectionprevention

Issue Date: 2016-02
34-8718-7365-8

Western-Diversey Surgical Center

REVIEW OF PERFORMANCE MEASUREMENT/MONITORING

YEAR:

Indicator	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Infection Control													
# of surgical patients with nosocomial infections													
OR cleaned prior to surgery													
Sterilization of Insturments													
Spore Testing													
Management of Information													
100% Review content, accuracy, legibility, adverse outcomes													
Random sample reviewed for appropriateness annually													
Medications													
Reagents, drugs, chemicals, checked for expiration													
Emergency equipment/medications checked proir to surgery													
# Of medications recalled													
# of incidents/controlled substances													
Human Resources													
No. of Staff New Hires - Orientation													
Competency reviewed													
Staff Training - Infection Control, BioHazards, Environment of Care													
Performance Evaluation/Appraisal													

AMERICAN HEALTH CARE CENTER

FKMSC
WDSC

IN-SERVICE

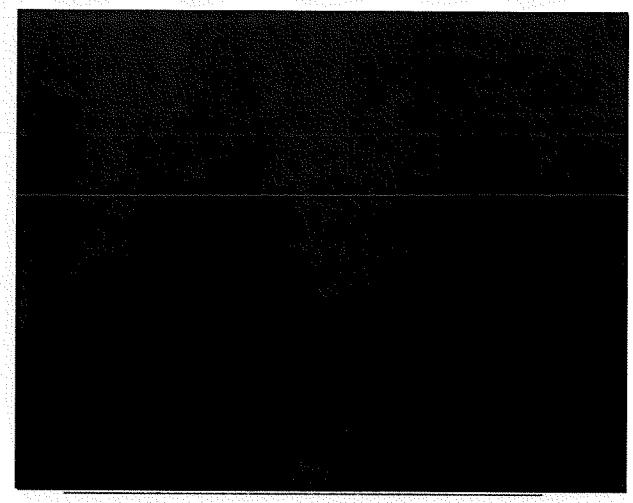
DATE: 06-21-2019

TOPIC/ SUBJECT: Sterilizer Monitoring (Biological Testing)

PRECEPTOR: A. Sabater, RN, BSN

Attendees:
(Print and Sign)

Andriy Martynyuv
ANDRIY KHLOBAS
Monique Carpenter
ALEJANDRA PEREZ
Alicia Alvarez



American Health Care center
FKMSC
WDSC

In-Service Sign in Sheet

Date: June 27, 2019

n-Service Title: Surgical Attire (Infection Control

Preceptor: A. Sabater RN

	Attendees Printed Name	Signatures
1.	Andriy MARTYNIV	[redacted]
2.	Suhi Garcia	
3.	Magaly Napoles	
4.	Yesika Napoles	
5.	ANDRIY KHLOPAS	
6.	Julie	
7.	Joseph Kim MD	
8.	Sophia Demas	
9.	Marie Frukacz	
10.	Betty DeLaPena	
11.	Emily RIVERA	
12.	Monique Carpenter	
13.	SESHAGIRI RAO/AVILLA	
14.	PERLA ANICIETE	
15.	ALEJANDRA PEREZ	
16.	KASSOY MAZ	
17.	DANIEL LOR	
18.	Kaulin Xie	
19.	Alicia Alvarez	
20.		

American Health Care Center

FKMSC
WDSC

IN-SERVICE LOG

DATE: 06-20-2019

TOPIC/ SUBJECT: Guideline Implementation: Hand Hygiene

PRECEPTOR: A. Sabater, RN, BSN – Infection Control Coordinator

Attendees:
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Guideline Implementation: Hand Hygiene 1.1

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JUDITH L. GOLDBERG, DBA, MSN, RN, CSSM, CNOR, CHL, CRCST

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Session: #0001
Fee: For current pricing, please go to: *http://www.aornjournal.org/content/cme*.

The contact hours for this article expire February 29, 2020. Pricing is subject to change.

Purpose/Goal

To provide the learner with knowledge specific to implementing the AORN "Guideline for hand hygiene."

Objectives

1. Discuss hand hygiene considerations related to maintaining healthy fingernails in the perioperative setting.
2. Explain methods perioperative personnel can use to prevent dermatitis.
3. Describe proper hand hygiene practices.
4. Discuss considerations for surgical hand antisepsis.
5. Discuss the implications of wearing jewelry on the hands and wrists in the perioperative setting.
6. Describe ways to engage patients in hand hygiene initiatives.

Accreditation

AORN is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Approvals

This program meets criteria for CNOR and CRNFA recertification, as well as other CE requirements.

AORN is provider-approved by the California Board of Registered Nursing, Provider Number CEP 13019. Check with your state board of nursing for acceptance of this activity for relicensure.

Conflict-of-Interest Disclosures

Judith L. Goldberg, DBA, MSN, RN, CSSM, CNOR, CHL, CRCST, has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.

The behavioral objectives for this program were created by Liz Cowperthwaite, BA, senior managing editor, and Helen Starbuck Pashley, MA, BSN, CNOR, clinical editor, with consultation from Susan Bakewell, MS, RN-BC, director, Perioperative Education. Ms Cowperthwaite, Ms Starbuck Pashley, and Ms Bakewell have no declared affiliations that could be perceived as posing potential conflicts of interest in the publication of this article.

Sponsorship or Commercial Support

No sponsorship or commercial support was received for this article.

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Guideline Implementation: Hand Hygiene 1.1

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JUDITH L. GOLDBERG, DBA, MSN, RN, CSSM, CNOR, CHL, CRCST

ABSTRACT

Performing proper hand hygiene and surgical hand antisepsis is essential to reducing the rates of health care–associated infections, including surgical site infections. The updated AORN "Guideline for hand hygiene" provides guidance on hand hygiene and surgical hand antisepsis, the wearing of fingernail polish and artificial nails, proper skin care to prevent dermatitis, the wearing of jewelry, hand hygiene product selection, and quality assurance and performance improvement considerations. This article focuses on key points of the guideline to help perioperative personnel make informed decisions about hand hygiene and surgical hand antisepsis. The key points address the necessity of keeping fingernails and skin healthy, not wearing jewelry on the hands or wrists in the perioperative area, properly performing hand hygiene and surgical hand antisepsis, and involving patients and visitors in hand hygiene initiatives. Perioperative RNs should review the complete guideline for additional information and for guidance when writing and updating policies and procedures. *AORN J 105 (February 2017) 203-212.* © *AORN, Inc, 2017. http://dx.doi.org/10.1016/j.aorn.2016.12.010*

Key words: *hand hygiene, surgical hand antisepsis, dermatitis, fingernail polish.*

A health care–associated infection after a surgical intervention can be devastating for a patient. The transmission of pathogens is a major concern for perioperative personnel that can be addressed through proper hand hygiene and surgical hand antisepsis. The removal of both transient and resident microorganisms from the hands of perioperative team members before they come in contact with patients is imperative.[1] Using proper technique for both hand hygiene and surgical hand antisepsis decreases the risk that a patient will acquire a surgical site infection.[2] Proper hand hygiene also provides for the safety of health care workers who come in contact with contaminated surfaces.[3]

The AORN "Guideline for hand hygiene"[4] was updated in September 2016. AORN guideline documents provide guidance based on an evaluation of the strength and quality of the available evidence for a specific subject. The guidelines apply to inpatient and ambulatory settings and are adaptable to all areas where operative and other invasive procedures may be performed.

Topics addressed in the hand hygiene guideline include proper maintenance of hands and fingernails; wearing of jewelry on the wrists or hands; proper performance of hand hygiene and surgical hand antisepsis; selection of hand hygiene products, including how to analyze their effectiveness, cost, and acceptance by health care personnel; and quality assurance and performance improvement considerations. This article elaborates on key takeaways from the guideline document; however, perioperative RNs should review the complete guideline for additional information and for guidance when writing and updating policies and procedures.

Key takeaways from the AORN "Guideline for hand hygiene" include the following recommendations:

- Perioperative team members should
  - maintain healthy fingernail condition,
  - maintain healthy skin condition by taking measures to prevent hand dermatitis,
  - perform hand hygiene, and

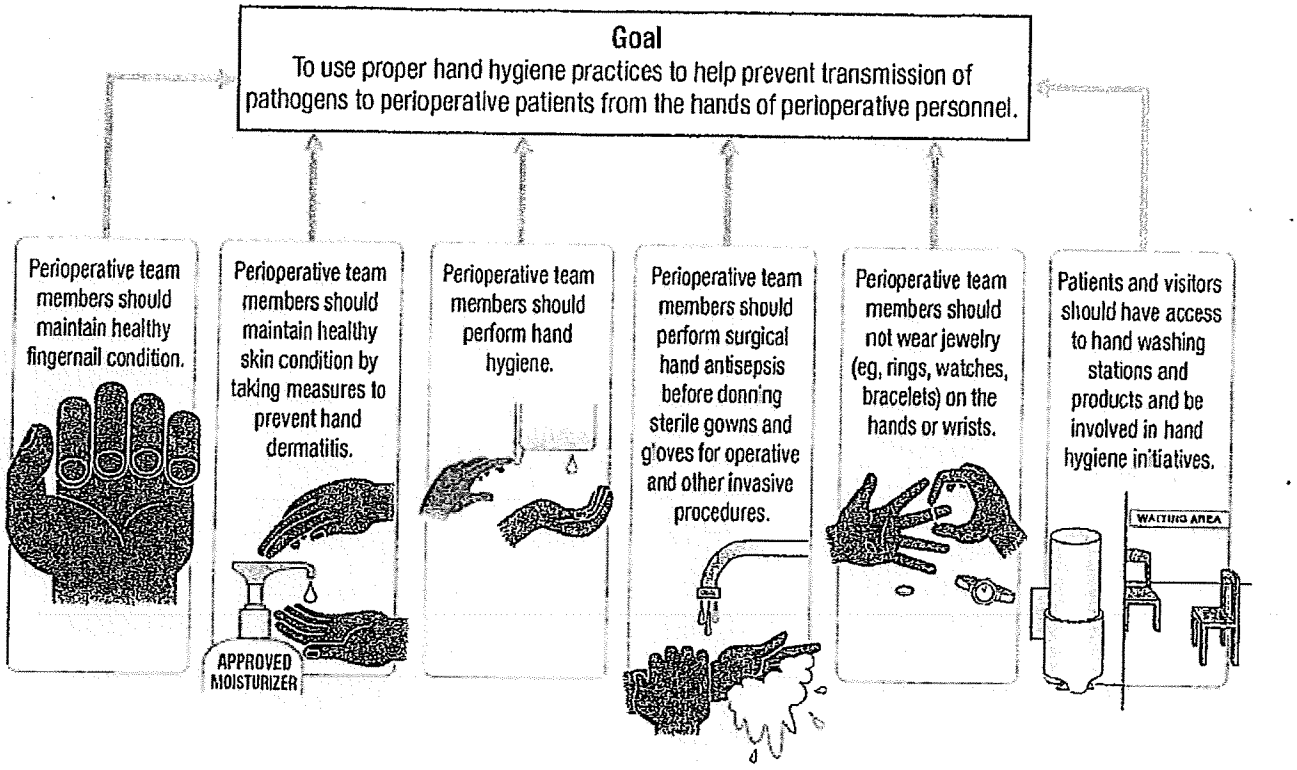

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Figure 1. Key takeaways from the AORN "Guideline for hand hygiene."

- perform surgical hand antisepsis before donning sterile gowns and gloves for operative and other invasive procedures.
- Perioperative team members should not wear jewelry (eg, rings, watches, bracelets) on the hands or wrists.
- Patients and visitors should have access to hand washing stations and products and be involved in hand hygiene initiatives (Figure 1).

The following scenario highlights the key takeaways and other aspects of the AORN guideline. Each key takeaway is then discussed in detail after the scenario.

SCENARIO

Nurse S, a perioperative RN, arrives at the community hospital where she works and goes to the locker room to change into her hospital scrubs. Her nails are short, with freshly applied polish, which her hospital policy allows. Before entering the OR, Nurse S removes the rings from her fingers and places them on a long necklace that she tucks into her scrub top.

Nurse S performs hand hygiene with an alcohol-based hand rub product. She recently experienced hand dermatitis from the cold weather and has worked with her employee health department to resolve the dermatitis so she can continue to work. Recommendations from the employee health nurse were to use the alcohol-based hand rub rather than soap and water unless her hands are visibly soiled and to regularly use a moisturizing skin care product approved by the health care facility. She was also encouraged to make sure her hands are fully dried before she dons surgical gloves.

Nurse S joins the surgical technologist in opening the sterile supplies for the first procedure of the day. After the OR is prepared, Nurse S goes to the ambulatory surgery area to meet her patient and perform her assessment. As she enters the room and introduces herself, Nurse S performs hand hygiene in view of the patient and family members by using the alcohol-based hand rub from a dispenser placed just inside the door of the room. The patient will undergo a left knee arthroscopy, so Nurse S verifies the procedure with her patient and then checks the left knee for the hospital-approved site mark, which is the word "yes." She asks whether the patient or the family members have any questions she can answer for them before she returns to the OR to complete the preparations for surgery. After answering their questions, Nurse S lets her patient know that it is okay to remind health care providers to perform hand hygiene before participating in her care. As she leaves the room, Nurse S again performs hand hygiene using the alcohol-based hand rub.

Hand hygiene products are readily available throughout the facility. Nurse S has recently noticed that new dispensers have been installed outside elevators and stairwells, outside and inside all patient rooms, throughout hallways, in nursing stations, and at all entrances to the hospital. Perioperative personnel have also recently begun a campaign to improve hand hygiene compliance. They remind coworkers and surgeons to perform hand hygiene whenever they see a lapse in compliance. As a visual cue, they have placed containers of hand hygiene product on the bedside stands of every patient. This quickly reminds both personnel and physicians to perform hand hygiene before any patient contact, and allows patients and family members to also perform hand hygiene before eating, after shaking hands, and whenever they feel it is necessary.

When Nurse S returns to the OR, the surgical technologist is just completing surgical hand antisepsis using the approved surgical hand antiseptic product. With the recent emphasis on hand hygiene at the facility, including the perioperative area, various staff members have been engaged to audit hand hygiene, as well as surgical hand antisepsis, and to provide real-time feedback to colleagues in the OR suite. Nurse S observes that the technologist has performed her hand antisepsis appropriately, following the product manufacturer's instructions for use. In the past, however, Nurse S has seen improper performance of surgical hand antisepsis when observing surgeons and scrub personnel at scrub sinks. Although it can be difficult to begin the conversation, Nurse S always asks these individuals to return to the scrub sink and properly perform hand antisepsis before they are gowned and gloved.

Data captured through random audits of hand hygiene in the perioperative department have demonstrated that compliance has steadily increased during the past few months since the hand hygiene campaign measures were implemented. The infection prevention practitioners have also recognized perioperative services for this steady improvement in hand hygiene compliance.

KEY TAKEAWAYS DISCUSSION

Adhering to proper hand hygiene is the first step in reducing health care–associated infections. The key takeaways from the AORN "Guideline for hand hygiene"[1] do not cover the entire guideline. Rather, they help the reader focus on important or new information that should be implemented into perioperative practice.

Fingernails

Maintaining short fingernails decreases the risk of puncturing gloves, harboring pathogens under the nails, impeding proper hand hygiene, and possibly injuring patients. Studies have demonstrated that both artificial nails and nail extenders contribute to contamination of the hands and have led to outbreaks of infection.[2,9] The hospital where Nurse S is employed allows personnel to wear nail polish, as long as it is freshly applied and not chipped. Difficulty in monitoring fingernail polish for chips and length of application may lead some organizations to prohibit perioperative personnel from wearing nail polish. Whether wearing of nail polish is allowed in the perioperative setting should be determined by a multidisciplinary committee that reviews the evidence and makes an informed decision. The determination should also address wearing of gel nail polishes that are dried under ultraviolet light, because it is currently not known whether wearing these types of polishes carries the same risk of harboring pathogens as wearing artificial nails does.[2,3,8,10,11]

Skin Condition

Maintaining healthy hands and skin can be difficult in the perioperative setting. Personnel frequently perform hand hygiene as well as surgical hand antisepsis. Dermatitis can be painful and prevent personnel from properly washing their hands or performing hand hygiene.[3,12] In addition, damaged skin may harbor more pathogens than healthy skin does.[3] Therefore, it is essential that personnel take measures to prevent dermatitis. As Nurse S did, employees who are experiencing skin breakdown should work with employee health or infection prevention personnel to determine the cause of the dermatitis and find appropriate treatments. The use of moisturizers should be limited to those approved by the health care organization. Some lotions can alter the integrity of gloves and change the effects of hand antiseptics.[2,4,12,13]

A key component of maintaining healthy hands is to ensure they are fully dried after washing and before donning gloves.[3] This is especially important when donning sterile gloves that will be worn for an extended amount of time. Another important factor in skin breakdown is the use of water that is too hot.[12] Employees should be aware of this and regulate water temperatures both at work and home to decrease the potential for skin breakdown. Temperatures of between 70° F and 80° F (21.1° C and 26.7° C) have been recommended by the Facility Guidelines Institute.[12] The use of alcohol-based hand rubs is recommended rather than soap and water, unless hands are visibly soiled, because hand rub products are better tolerated and result in less dermatitis.[3,5]

Hand Hygiene

It is crucial that perioperative personnel do not assume that wearing gloves negates the necessity for hand hygiene. Hand

Resources for Implementation

- Guideline implementation topics: hand hygiene. AORN, Inc. *http://www.aorn.org/guidelines/guideline-implementation-topics/aseptic-technique/hand-hygiene.*
- AORN Syntegrity. *http://www.aorn.org/syntegrity.*
- ORNurseLink. *http://www.ornurselink.org/home.*
- *Perioperative Competency Verification Tools and Job Descriptions* [USB drive]. Denver, CO: AORN, Inc; 2016. *http://www.aorn.org/guidelines/clinical-resources/publications/document-collections/perioperative-competency-verification-tools-and-job-descriptions.*
- *Policy and Procedure Templates* [CD-ROM]. 4th ed. Denver, CO: AORN, Inc; 2015. *http://www.aorn.org/guidelines/clinical-resources/publications/document-collections/policy-and-procedure-templates.*

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Web site access verified December 1, 2016.

hygiene should be performed both before and after any patient contact; before handling of clean or sterile items; whenever a possible exposure to blood or body fluids has occurred; after handling of items that have been in contact with the patient, including stretchers, beds, and linens; when hands are soiled; before and after a meal; and after use of a restroom.[2-4,18-21] In some instances, performing hand hygiene once allows the person to complete several clean tasks, such as opening all sterile items before a procedure.[1]

Soap and water should be used whenever hands are visibly soiled, after a blood or body fluid exposure, after care is provided to patients who are infected with spore-forming organisms or norovirus, and after use of the restroom.[3,4] When hands show no visible soiling, alcohol-based hand rub products should be used, and hands should be rubbed together until they are dry.[3,4] Personnel should always follow the manufacturer's instructions for use for any product used for hand hygiene, including the recommendation for the amount of product needed to cover all hand surfaces.[3]

In the scenario, Nurse S performed hand hygiene in view of the patient and family members before she greeted them and before she left the room. It is important that patients and family members see hand hygiene being performed by those who will be caring for them. Because Nurse S had to uncover the patient to confirm that the surgical site was marked, her patient could be confident that Nurse S had not touched anything else before touching her.

What Else Is in the Guideline?

Read the AORN "Guideline for hand hygiene"[1] to learn what the evidence says about the following topics:

- At what length should perioperative personnel maintain their fingernails? (Recommendation I.a.)
- When should the activities of health care personnel with dermatitis or other skin conditions be restricted? (Recommendation I.e.)
- When should perioperative team members weigh the risks and benefits of delaying hand hygiene? (Recommendation III.b.)
- What are the requirements for placement of hand hygiene product dispensers? (Recommendations III.h.1. and III.h.2.)
- What is the standardized surgical hand antisepsis protocol for using a surgical hand rub? (Recommendation IV.a.1.)
- What is the standardized surgical hand antisepsis protocol for using a surgical hand scrub? (Recommendation IV.b.1.)
- What are the considerations for selecting hand hygiene products for use in the perioperative setting? (Recommendation V.)

Reference

1. Guideline for hand hygiene. In: *Guidelines for Perioperative Practice.* Denver, CO: AORN, Inc; 2017:29-50.

Surgical Hand Antisepsis

Preoperative surgical hand antisepsis is considered the primary defense for protecting patients from any pathogens that might exist on the hands of personnel in suites for operative and other invasive procedures. Sterile gloves serve as a secondary defense.[22] The documented risk for failure of surgical gloves[23] makes it crucial that personnel perform surgical hand antisepsis before donning gowns and gloves and initiating a surgical procedure. Just as important, using proper technique for surgical hand antisepsis is necessary, and the manufacturers' instructions for use should be followed for the particular products used in the workplace.

Surgical hand antisepsis may be performed using a surgical hand scrub or a surgical hand rub. If a surgical hand scrub is used, sinks should be located in the semirestricted area and near entrances to operating and procedure rooms. It is preferable that sinks have electronic sensor controls or be operated by the knee or foot.[1,4] In addition, the evidence indicates that surgical hand scrubs should not be performed using a brush,

because scrubbing with a brush may damage skin and increase bacterial shedding from the hands.[3,4,24,35]

Nurse S observed the surgical technologist completing surgical hand antisepsis and was able to determine that the product had been properly applied. The RN has a duty to speak up when any break in technique occurs, including someone not performing hand hygiene or improperly performing surgical hand antisepsis, to help keep the patient safe.

Jewelry

In the scenario, Nurse S removed her rings before entering the OR, ensuring that she could properly perform hand hygiene throughout her day. Proper hand hygiene can be impeded when rings, watches, and bracelets are worn in the perioperative setting. Microorganisms under jewelry can be difficult to remove and may result in higher bacterial counts on the hands because of improper use of hand hygiene products.[5,7] These microorganisms may then be transferred to patients during care and could cause a health care–associated infection. The World Health Organization recommends the removal of all rings and other hand and wrist jewelry in the perioperative environment.[3]

Involving Patients

The importance of accessible hand hygiene stations and hand rub dispensers cannot be overemphasized. Easy accessibility increases compliance with hand hygiene by personnel and physicians.[1,14] When patients observe that all personnel who come in contact with them stop to perform hand hygiene, it may reinforce the importance that they should also comply with this simple-to-perform activity that can reduce the risk for surgical site infections as well as other health care–associated infections. One way to increase engagement is to involve patients in hand hygiene product evaluations.[3] It is possible that patients will have sensitivities to various chemicals or fragrances, so involving patients in product testing may also improve patient satisfaction.

Engaging patients and visitors in protecting themselves against infection also empowers them to stop anyone who has not performed hand hygiene from touching them. In the scenario, patients and family members were encouraged to speak up if they did not see personnel and physicians perform hand hygiene, which demonstrates to them that the organization takes protecting everyone from infection seriously. In addition, it may increase their awareness of the importance of hand hygiene in general, not just in health care settings.

CONCLUSION

Patients undergoing a surgical or other invasive procedure put themselves in the hands of the perioperative team. They trust that everyone they interact with is taking the proper precautions to protect them from developing a health care–associated infection. Proper hand hygiene and surgical hand antisepsis are the most significant interventions perioperative personnel can take to prevent or reduce the transmission of pathogens, thus decreasing patients' risk for surgical site infections.[1] Perioperative personnel have an evidence-based resource in the AORN "Guideline for hand hygiene" that can be used to guide practice.

References

1. Guideline for hand hygiene. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc, 2017:29-50.
2. Ellingson K, Haas JP, Aiello AE, et al. Strategies to prevent healthcare-associated infections through hand hygiene. *Infect Control Hosp Epidemiol*. 2014;35(8):937-960.
3. *WHO Guidelines on Hand Hygiene in Health Care*. Geneva, Switzerland: World Health Organization; 2009.
4. Boyce JM, Pittet D; Healthcare Infection Control Practices Advisory Committee, Society for Healthcare Epidemiology of America, Association for Professionals in Infection Control Infectious Diseases Society of America Hand Hygiene Task Force. Guideline for hand hygiene in health-care settings: recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *Infect Control Hosp Epidemiol*. 2002;23(12 suppl):S3-S40.
5. Fagernes M, Lingaas E. Factors interfering with the microflora on hands: a regression analysis of samples from 465 healthcare workers. *J Adv Nurs*. 2011;67(2):297-307.
6. Rupp ME, Fitzgerald T, Puumala S, et al. Prospective, controlled, cross-over trial of alcohol-based hand gel in critical care units. *Infect Control Hosp Epidemiol*. 2008;29(1):8-15.
7. Hautemaniere A, Cunat L, Diguio N, et al. Factors determining poor practice in alcoholic gel hand rub technique in hospital workers. *J Infect Public Health*. 2010;3(1):25-34.
8. AST standards of practice for surgical attire, surgical scrub, hand hygiene and hand washing. Association of Surgical Technologists. http://www.ast.org/uploadedFiles/Main_Site/Content/About_Us/Standard_Surgical_Attire_Surgical_Scrub.pdf. Published April 13, 2008. Accessed November 28, 2016.
9. Infection prevention and control guidelines for anesthesia care. American Association of Nurse Anesthetists. http://www.aana.com/resources2/professionalpractice/Pages/Infection-Prevention-and-Control-Guidelines-for-Anesthesia-Care.aspx. Published February 2015. Accessed November 28, 2016.
10. *Surgical Site Infection. Evidence Update June 2013* (Evidence Update 45). Manchester, UK: National Institute for Health and Care Excellence; 2013.
11. Wood N. Ultraviolet UV-cured nail polish (Clinical Issues). *AORN J*. 2015;101(6):701-704.

12. van der Meer EWC, Boot CRL, van der Gulden JWJ, et al. Hands4U: the effects of a multifaceted implementation strategy on hand eczema prevalence in a healthcare setting. Results of a randomized controlled trial. *Contact Dermatitis.* 2015;72(5):312-324.
13. Harnoss JC, Brune L, Ansorg J, Heidecke C-D, Assadian O, Kramer A. Practice of skin protection and skin care among German surgeons and influence on the efficacy of surgical hand disinfection and surgical glove perforation. *BMC Infect Dis.* June 10, 2014;14:315. doi:10.1186/1471-2334-14-315.
14. Facility Guidelines Institute. *Guidelines for Design and Construction of Hospitals and Outpatient Facilities.* Chicago, IL: American Society for Healthcare Engineering of the American Hospital Association; 2014.
15. Loftus RW, Muffly MK, Brown JR, et al. Hand contamination of anesthesia providers is an important risk factor for intraoperative bacterial transmission. *Anesth Analg.* 2011;112(1):98-105.
16. Cosgrove MS. Infection control in the operating room. *Crit Care Nurs Clin North Am.* 2015;27(1):79-87.
17. Munoz-Price LS, Birnbach DJ. Hand hygiene and anesthesiology. *Int Anesthesiol Clin.* 2013;51(1):79-92.
18. Rowlands J, Yeager MP, Beach M, Patel HM, Huysman BC, Loftus RW. Video observation to map hand contact and bacterial transmission in operating rooms. *Am J Infect Control.* 2014;42(7): 698-701.
19. Allen G. Hand hygiene and the surgical team. *Perioper Nurs Clin.* 2010;5(4):411-418.
20. Krediet AC, Kalkman CJ, Bonten MJ, Gigengack ACM, Barach P. Hand-hygiene practices in the operating theatre: an observational study. *Br J Anaesth.* 2011;107(4):553-558.
21. Fernandez PG, Loftus RW, Dodds TM, et al. Hand hygiene knowledge and perceptions among anesthesia providers. *Anesth Analg.* 2015;120(4):837-843.
22. Adams AB. Surgical hand antisepsis: where we have been and where we are today. *Perioper Nurs Clin.* 2010;5(4):443-448.
23. Guideline for sterile technique. In: *Guidelines for Perioperative Practice.* Denver CO: AORN, Inc; 2017:75-104.
24. Abdelatiff DA, El-Haiyk KS, Noura HG, El-Oudaa RF, El-Sabouni RS. Comparing of using sterile brush during surgical scrubbing versus brushless for surgical team in operating room. *Life Sci J.* 2014;11(1):387-393.
25. da Cunha ÉR, Matos FGOA, da Silva AM, de Araújo EAC, Ferreira KASL, Graziano KU. The efficacy of three hand asepsis techniques using chlorhexidine gluconate (CHG 2%) [in Portuguese]. *Rev Esc Enferm USP.* 2011;45(6):1440-1445.
26. Okgün Alcan A, Demir Korkmaz F. Comparison of the efficiency of nail pick and brush used for nail cleaning during surgical scrub on reducing bacterial counts. *Am J Infect Control.* 2012;40(9): 826-829.

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Continuing Education: Guideline Implementation: Hand Hygiene 1.1

CE www.aornjournal.org/content/cme

PURPOSE/GOAL

To provide the learner with knowledge specific to implementing the AORN "Guideline for hand hygiene."

OBJECTIVES

1. Discuss hand hygiene considerations related to maintaining healthy fingernails in the perioperative setting.
2. Explain methods perioperative personnel can use to prevent dermatitis.
3. Describe proper hand hygiene practices.
4. Discuss considerations for surgical hand antisepsis.
5. Discuss the implications of wearing jewelry on the hands and wrists in the perioperative setting.
6. Describe ways to engage patients in hand hygiene initiatives.

The Examination and Learner Evaluation are printed here for your convenience. To receive continuing education credit, you must complete the online Examination and Learner Evaluation at *http://www.aornjournal.org/content/cme*.

QUESTIONS

1. Maintaining short fingernails decreases the risk of
   1. contracting dermatitis.
   2. harboring pathogens.
   3. impeding hand hygiene.
   4. injuring patients.
   5. puncturing gloves.

   a. 2 and 4 b. 1, 3, and 5
   c. 2, 3, 4, and 5 d. 1, 2, 3, 4, and 5

2. Wearing nail polish is always prohibited in the perioperative setting.

   a. true b. false

3. Some moisturizing hand lotion products can
   1. alter the integrity of gloves.
   2. be used as a substitute for surgical hand scrubs.
   3. be used instead of soap and water when hands are visibly soiled.
   4. change the effects of hand antiseptics.

   a. 1 and 4 b. 2 and 3
   c. 1, 2, and 3 d. 1, 2, 3, and 4

4. To help prevent dermatitis, perioperative personnel should
   a. leave hands slightly damp before gloving.
   b. use an alcohol-based hand rub instead of soap and water.
   c. use soap and water instead of an alcohol-based hand rub.
   d. wash with water hotter than 80° F (26.7° C).

5. Hand hygiene should be performed
   1. after a meal.
   2. after patient contact.
   3. before handling of clean or sterile items.
   4. before patient contact.
   5. when a possible blood or body fluid exposure has occurred.

   a. 2 and 4 b. 1, 2, and 3
   c. 2, 3, 4, and 5 d. 1, 2, 3, 4, and 5

6. Soap and water should be used instead of an alcohol-based hand rub when hands are visibly soiled.

   a. true b. false

7. Sterile gloves are the primary defense for protecting patients from pathogens on the hands of health care personnel.
   a. true b. false

8. Surgical hand antisepsis
   1. may be performed using a surgical hand rub.
   2. may be performed using a surgical hand scrub.
   3. should be performed using a brush.
   4. should not be performed using a brush.
      a. 1 and 3 b. 2 and 4
      c. 1, 2, and 3 d. 1, 2, and 4

9. Wearing of rings, watches, or bracelets in the perioperative setting may
   1. cause dermatitis.
   2. impede proper hand hygiene.
   3. result in a higher bacterial count on hands.
   4. result in microorganisms being transferred to patients.
      a. 1 and 3 b. 2 and 4
      c. 2, 3, and 4 d. 1, 2, 3, and 4

10. Easy-to-access hand hygiene stations and hand wash dispensers can
    1. help reduce the risk of health care–associated infections.
    2. engage patients and visitors in protecting themselves against infection.
    3. increase compliance with hand hygiene by personnel and physicians.
    4. reinforce the importance of hand hygiene to patients.
       a. 1 and 3 b. 2 and 4
       c. 1, 2, and 4 d. 1, 2, 3, and 4

American Health Care Center
Competency Verification Tool—Perioperative Services
Practice: Hand Hygiene

Name:_____ **Date:** _____

Competency Statement: The perioperative RN or non-RN team member has completed facility- or health care organization-required education and competency verification activities related to hand hygiene.[1]

1. Guideline for hand hygiene. *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc; 2016.

Patient Outcome: The patient is free from signs and symptoms of infection.[2]

2. Petersen C, ed. Infection. In: *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2011:254-276.

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
1. Follows established perioperative hand hygiene practices for maintaining healthy skin and fingernail condition.							
2. Keeps nails at a length where the nails do not extend beyond the tips of the fingers when the hands are held vertically and viewed from the palmar side.							
3. Removes chipped nail polish before entering the restricted area.							
4. Does not wear artificial fingernails or other fingernail enhancements in the perioperative environment.							
5. Uses facility or health care organization-approved hand hygiene products and hand lotions.							
6. Removes rings, watches, and other jewelry that cannot be contained within the scrub attire before entering the semirestricted and restricted areas.							
7. Identifies when hand hygiene should be performed, including a. before and after every patient contact,							
b. before performing a clean or sterile task,							
c. after risk for blood or body fluid exposure,							
d. after contact with patient surroundings,							
e. before and after eating,							

DEM/DO/DA = Demonstration/Direct Observation/Documentation Audit
S/SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
RWM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)
KAT = Knowledge Assessment Test
V = Verbalization
O = Other: _____

American Health Care Center
Competency Verification Tool—Perioperative Services
Practice: Hand Hygiene – RN or Non-RN

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
f. after using the restroom, and							
g. when hands are visibly soiled.							
8. Performs hand washing with soap and water by a. adjusting water to a comfortable temperature, avoiding hot water;							
b. wetting hands thoroughly with water;							
c. apply amount of soap needed to cover all surfaces of the hands;							
d. rubbing hands together vigorously covering all surfaces of the hands and fingers;							
e. washing for at least 15 seconds;							
f. rinsing well to remove all soap;							
g. drying hands thoroughly with a disposable towel, and							
h. using a disposable towel to turn the water off and open the door if hands-free controls are not available.							
9. Identifies when an alcohol-based antiseptic hand rub may be used (ie, when hands are not visibly soiled).							
10. Performs hand hygiene using an alcohol-based antiseptic hand rub product by a. applying the amount of alcohol-based hand rub recommended by the manufacturer to cover all surfaces of the hands and							
b. rubbing hands together, covering all surfaces of the hands and fingers until they are dry.							
11. Describes symptoms of irritant or allergic contact dermatitis (eg, redness, itching) and reasons to report these symptoms as soon as they are noted.							
12. Follows established protocols for reporting if cuts, abrasions, weeping dermatitis, or fresh tattoos are present on exposed skin, and does not work in the perioperative areas until the condition is healed and clearance for work has been received by **[facility-specific personnel]**.							

)EM/DO/DA = Demonstration/Direct Observation/Documentation Audit
:SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
:WM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)

KAT = Knowledge Assessment Test
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American Health Care Center
Competency Verification Tool—Perioperative Services
Practice: Hand Hygiene – RN or Non-RN

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
13. Verbalizes a review of facility or health care organization policies and procedures related to hand hygiene.							
14. Participates in quality improvement activities related to hand hygiene as assigned.							

Concurrent competency verification of the following is recommended	
• [Additional competencies related to hand hygiene as determined by the facility or health care organization]	•
•	•
•	•

DEM/DO/DA = Demonstration/Direct Observation/Documentation Audit
S/SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
RWM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)

KAT = Knowledge Assessment Test
V = Verbalization
O = Other: _____