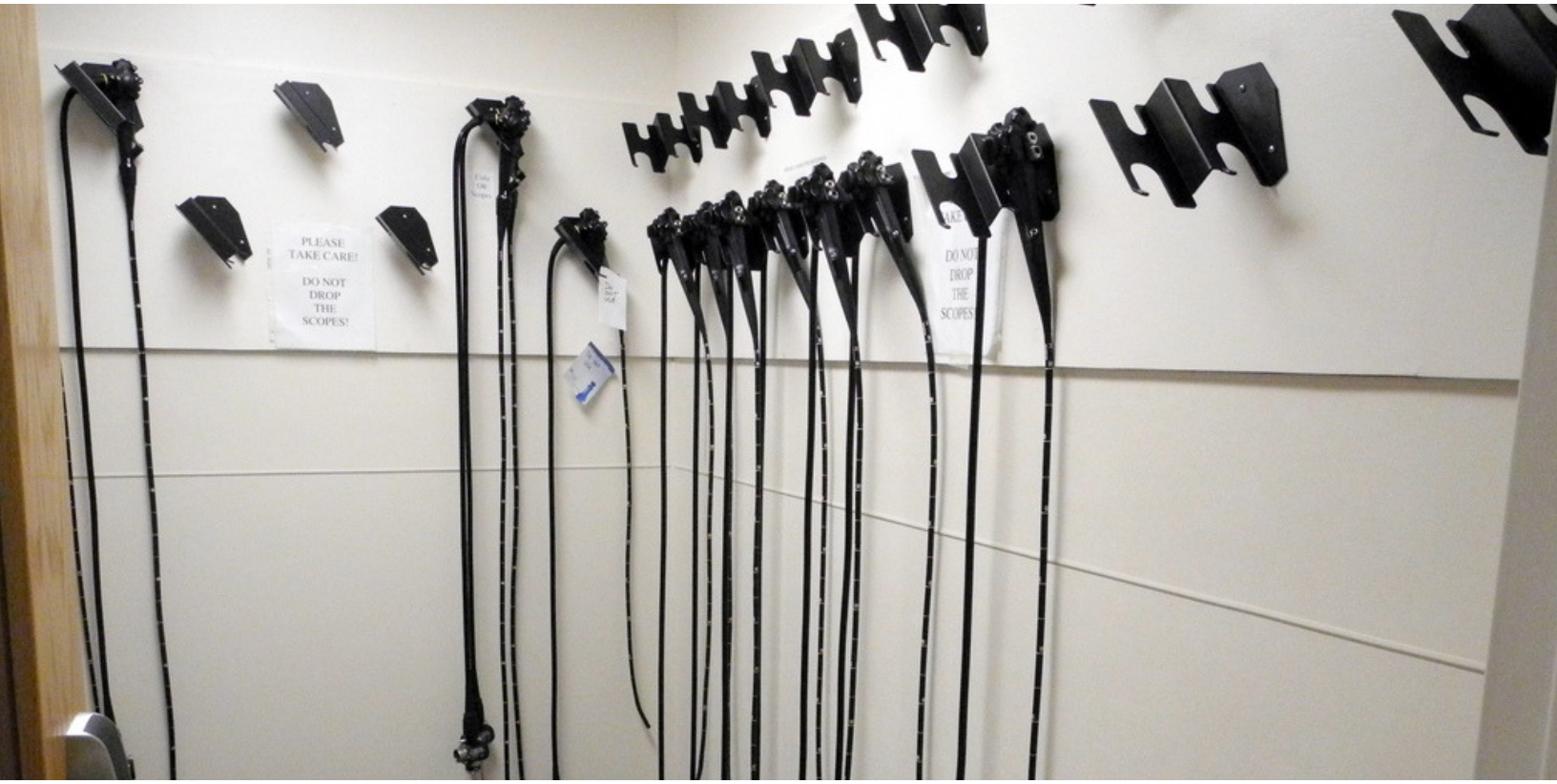
# How To Stop Dirty Scopes From Being Stored With Your Clean Scopes




## A Common Feeling

Does this scenario sound familiar to you? Your hospital has a great set of processes and protocols in place when it comes to reprocessing your flexible endoscopes. You even have a great system for logging clean scopes in and out of your scope storage areas. You believe that your staff are properly trained, re-certified and following all of the processes that your hospital has carefully researched and meticulously put into place. But do you really know where all your scopes are going? Do you feel comfortable that only properly trained staff are handling your scopes? And can you guarantee that 100% of the scopes that are going into clean storage are absolutely ready for patient-use?

If any of these issues are in the back of your mind from time to time (or constantly) then read on to see what you can do to help you get better control of your scopes and maybe even help you sleep better at night.

## Consequences of Poor Scope Visibility

Hospitals tend to do a great job of making sure that all of the scopes that enter sterile processing or their other scope reprocessing areas are being properly disinfected or sterilized. But many of these same hospitals have very poor visibility into what happens from the time a scope leaves their automated endoscope reprocessor to the time it comes back again for reprocessing. During that time, a myriad of issues could have arisen with a scope that could lead to very negative outcomes for your hospital:

1. Poor chain of custody issues result in a dirty endoscope being stored with clean endoscopes.
2. Staff are in a hurry to get the right scope, and in doing so they don't follow proper safety protocols.
3. An unauthorized user accessed your scope, resulting in the scope going missing.

These issues could result in compromised patient safety, negative financial consequences or in some cases both.

> We had written logs. We were using an honor system and hoping people were writing down information as they were taking scopes in and out of clean storage. At the end of the day, we weren't sure who was taking out a lot of our scopes or where they were going.
>
> *Central Sterile Department manager at an academic medical center in New York*

## Poor chain of custody

In the hectic areas of the endoscopy and perioperative suites, a lot of coordination is required between staff members to make sure that operations are running smoothly. Staff have to rely on each other to transport patients, supplies and instruments for each procedure to make sure that the schedule for the day is running on time. When it comes to endoscope-related procedures, staff often need to hand off scopes to other members of their team to run to different areas of the hospital.

But what happens when there's a miscommunication between two staff members? A scenario we have seen is when a team member is in a hurry and asks another member of the team to help them run a scope from a procedure room down to reprocessing. The requesting staff member may assume that the other team member will give the scope its bedside cleaning, or ensure that it has already happened, while the other team member may have assumed that the bedside cleaning already happened. The end result is a scope that missed its bedside cleaning and therefore is reprocessed outside of hospital protocols. Although the scope in question may receive all of the other requisite disinfection steps, the missed bedside cleaning should make it unavailable for patient use until the bedside cleaning steps have first been taken. Instead, because the proper checks and balances aren't in place, the scope is erroneously hung in clean storage after removal from the endoscope reprocessor.

> We needed to be able to hold the staff accountable. To see who is doing the work and who isn't, and to make sure they're following all the standards we've put in place.
>
> *Central Sterile Department manager at an academic medical center in New York*

## Staff breaches of safety protocols

Staff in the endoscopy and perioperative areas are often faced with daunting challenges. They are being pulled in several different directions to help make procedures run smoothly. Physicians and nursing staff have their own demands that must be met to ensure the best outcome for the patient, and staff must quickly respond to these demands. When this happens, established processes can be overlooked or skipped even though staff have only the best intentions.

An example we've seen many times in these areas is when a staff member brings a certain scope into a room for a procedure, only to be instructed by the attending physician to bring another scope that she would prefer. Knowing that the physician and patient are waiting, the staff member quickly swaps the returned scope for the desired scope in the clean storage area. The new scope is brought and the procedure can continue as planned, but were all the proper procedures followed? Many hospitals have standards that dictate that any scope that enters a procedure room or touches a surface must be sent for reprocessing before the next patient use. In this situation, where the staff member is running quickly through the hospital to ensure the best outcome for the patient, this standard may be overlooked. This breach in protocol is undetectable as the scope that should have been sent for reprocessing is now sitting in clean storage and is ready for another procedure, defying the hospital's standard.

> Over an 18-month period, we had 8 or 9 scopes disappear on us. They were walking away, and we weren't even sure where. At an estimated $25,000-$40,000 per flexible endoscope, the disappearing scopes were having a sizeable financial impact.
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> *Central Sterile Department manager at an academic medical center in New York*

## Lost Scopes

People from all over the hospital come into contact with flexible endoscopes every day: techs, runners, SPD staff, nurses, physicians, residents, and so on. With so many people handling scopes, how can you be sure that scopes only end up in the hands of those who need them? Many hospitals have no system at all for logging scopes in/out of clean storage, while many other hospitals rely on an honor system, where people are supposed to sign in/out scopes from clean storage.

We have seen in practice that these honor systems typically result in 50% compliance or less, which means that most scopes are taken from clean storage without any record. And with so many scopes hanging in unlocked cabinets or freestanding hooks, anyone can remove any scope at any time and for any reason. Unfortunately, a scope might go missing from time to time, whether with good or bad intentions. In these situations, without a proper audit trail, the scope may go missing for days or weeks, or maybe even permanently, because administrators don't have any information to turn to for tracking down the missing scope. These situations can result in poor patient outcomes when physicians have to use alternative scopes for procedures due to missing scopes, or financial harm if the very expensive instrument has to be replaced.

# There's a better way: automation

Make no mistake, your situation is not unique. With hospitals having dozens of scopes traveling across multiple floors and buildings, it's nearly impossible to keep an eye on every scope at all times to make sure that protocols are being followed from a safety and accountability standpoint across the hospital. Systems such as iRIScope from Mobile Aspects have been introduced in the last several years to provide an additional layer of oversight and security for your valuable flexible endoscopes, providing financial and patient safety benefits to your endoscopy practice.

When endoscopes pass through multiple hands during each usage cycle, it is difficult to make sure that everyone is following the correct processes. iRIScope will act as an additional layer of intelligence to challenge any behavior that does not meet hospital guidelines and protect patients from potential harm. If an endoscope does not pass through all of the required reprocessing steps (or skips reprocessing entirely) before returning to clean storage, an administrator will be notified about the breach so they can take the appropriate action. iRIScope will also lock the cabinet that the flagged scope is stored in to ensure the scope can't be used again until further investigation is conducted and the alert is cleared. iRIScope also allows for hospitals to keep scopes away from those who shouldn't have access to them. The system's smart cabinets allow only authorized users to unlock the cabinets and access scopes for procedures. Any personnel or vendors who aren't granted access will be unable to handle your valuable scopes. Because the cabinets keep track of who is pulling scopes, you also have an audit trail of who accessed a scope last when a scope goes missing and also know which procedure, patient and physician the scope was used for, greatly aiding the process of tracking down your missing scopes.

Gone are the days when you have to rely solely on your own eyes to track the degree to which your staff are following standard operating procedures in endoscopy. iRIScope helps by providing a second set of eyes to ensure reprocessing standards are being followed for each scope every time, safety protocols are being followed across the hospital, and scopes are being handled by only designated personnel.

> We're able to hold the staff accountable because they're logging in and out of the systems with their badge. If someone misses a step at a reprocessor, I can go back and check with the cleaner or check the machine to make sure it was washed properly…I'm not worried about losing scopes any more. I'm not worried about what my staff is doing. It's one less thing to worry about – I know your cabinets are there and they're working, and people can't get around them.
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> *Central Sterile Department manager at an academic medical center in New York*