Question of the Week #30

You work as a staff nurse in a busy freestanding ambulatory surgery center. Cases tend to be very brief (less than 1 hour) and any available staff are responsible for cleaning and helping turn over the rooms.

A new eye surgeon has just joined the staff. He is very efficient and expects the same from his OR team. Frequently he is finished with his paperwork, dictation, and orders before the patient leaves the room.

In an effort to decrease turnover times, a routine has been initiated to begin cleaning the room as soon as the eye patch has been applied. You sense that this may not be best practice. How would you discuss this with other staff members, and what is your rationale for a change, if necessary?

Response

The desire for shortened turnover times encourages shortcuts in cleaning technique, compounded by the variety of personnel who may be participating in room turnovers. Dedicated perioperative environmental services workers, hospital-wide environmental cleaning personnel who may or may not have been oriented to the special needs of the operative/invasive area, registered nurses, surgical technologists, and even the occasional well-meaning surgeon have all been known to wield a mop in the interests of turning over a room quickly. Inadequate staffing and excessive workloads have been found to increase the risk of infection (Dancer). Lack of knowledge related to appropriate cleaning methods means that even if the correct disinfectant is being used, it may not be effective in destroying microorganisms.

The “need for speed” does not always translate into best practice related to environmental cleaning practices, which may have just as important a role as hand washing in the battle against hospital-acquired infections (HAI’s). Little has been published on cleaning related to room turnovers; much of the discussion is bundled with terminal cleaning of rooms (AORN, 2012; Jefferson, et al, 2011). Several studies (Carling, et al, 2006; Dancer, 2009; Rutela & Weber, 2011) discussed monitoring the effectiveness of cleaning patient rooms. Unfortunately, even with the emphasis on aseptic practice, Carling et al found that the overall proportion of targeted items cleaned in the OR (46.6%) was similar to that found in post-discharge cleaning of patient rooms.

These studies confirm what nurses have known since Florence Nightingale published her “white paper” on the effect of the environment on patient health: prioritizing the cleaning of near-patient objects (which in our case includes the OR bed) and those sites frequently touched by hands could both decrease the number of pathogens present on these objects and the risk of transmission of the pathogens to other areas, patients, and health care personnel. Florence did not have the EPA-approved disinfecting agents or the methods of monitoring the effectiveness of cleaning that are available today. The fact that we now do provides small comfort: Jefferson et al’s study of terminal cleaning of OR’s (2012) found that the overall thoroughness of cleaning targeted surfaces was 25%. By definition terminal cleaning suggests a more in-depth cleaning than that conducted during room turnovers, leaving the reader to wonder what percentage of near-patient objects are being relieved of their pathogenic bio-burden during the expedited cleaning processes associated with room turnovers.

Startling evidence on the lifespan of today’s most tenacious – and unfortunately more frequently encountered-microorganisms provide additional incentive to thoroughly clean patient care areas. Methicillin resistant Staphylococcus aureus (MRSA) can survive in hospital dust for up to a year (Darling). The Hepatitis C virus can live up to 80 days in dry conditions. Vancomycin-resistant enterococci (VRE) are resistant to routine cleaning, even with bleach (Dancer, 2009). The risk of infection to a
patient being placed in a room previously occupied by a patient with one of these pathogens increases by 73% (Carling & Bartley, 2010).

When the source of these pathogens is the patient, it is impossible to eradicate them while the patient is present. Both the patient and improperly or ineffectively disinfected near-patient objects can re-contaminate the hands of personnel caring for the patient prior to discharge from the OR, and spread infection to other areas.

There is no lack of regulatory response to the environmental cleaning issue. The Centers for Disease Control and Prevention (CDC), The Joint Commission (JC), and The Centers for Medicare and Medicaid (CMS) all have guidelines related to ensuring standards of cleanliness are being achieved. With the patient’s permission, CMS surveyors may observe a surgery and cleaning the room afterwards (CMS, 2011). An excellent resource for environmental cleaning is the Association for the Healthcare Environment. This website includes webinars and educational resources. These organizations are listed in the references provided at the end of this discussion.

Infection control—or lack of it—is only one part of the equation. Additional personnel in the room may increase the noise and distraction factors, both of which have been implicated in increased numbers of nursing errors. As the patient’s advocate, the perioperative nurse should respect patient privacy by restricting access to the OR to those personnel necessary in the provision of patient care at that time.

Regardless of who is actually doing the cleaning, it is the perioperative nurse’s responsibility to provide a safe, clean environment for the patient (AORN, 2012). This includes eliminating clutter from workstations, returning unused items to their storage areas, and bagging trash as it is collected, all of which will help cut down on turnover times without compromising patient care. Designation of specific person(s) from Environmental Services may improve adherence to cleaning. Collaborating with Infection Control and Environmental Services personnel will assist in putting a plan in place for orienting all personnel involved in cleaning the OR, providing them with the appropriate tools and support to do their job, and consistently monitoring the effectiveness of the cleaning process to ensure that every surgical patient has a clean OR, every time.

References and resources:


