The Decontamination of Endoscopes - a review in Northern Ireland

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Background

- May 2004 – leakage
- Investigation – channel not cleaned
- DHSSPS Audit – all flexible endoscopes
- Review Commissioned – by DHSSPS

Terms of Reference 1

- To review the effectiveness of arrangements in place at a regional and local level for the decontamination of endoscopes, taking into account, in particular, identified shortcomings in process at local trusts.

Terms of Reference 2

- Effectiveness of selection, procurement, commissioning and replacement of endoscopes and reprocessors
- Effectiveness of staff training
- Effectiveness of procedures and monitoring
- Appropriateness of roles and responsibilities
- Regional arrangements

Methodology

- Phase I – Data and information collection including visits / interviews
- Phase II – Analysis
- Phase III - Reporting

Key Findings: Selection and Procurement

- Lack of planned equipment replacement programmes
- Purchase decisions do not involve all interested parties
- Over reliance on information from manufacturers and suppliers
- Complex, lengthy tendering process

Key Findings: Commissioning

- New equipment commissioning – new features and training identified
- Visible warnings

Key Findings: Equipment

- Cost and complexity of equipment
- Advice about return for repair
- Transfer of equipment
- Single brush use
- Range of size / colour of connectors
- AERs / Endoscopes rarely made by same manufacturers
- Inappropriate use of equipment

Key Findings: Staffing

- Dedicated
- Advantages / disadvantages of rotation
- Designated individual
- Microbiological advice

Key Findings: Training

- Needs analysis
- Induction
- Ongoing training
- Regional centre
- E-learning
- Training records

Key Findings: Guidance

- Accessibility
- State of files
- Trust policies / national guidance
- Profusion of national guidance
- Profusion of notices
- Trust wide Policy Committee

Key Findings: Environment

- Variation within / between Trusts
- Better where procedures performed regularly
- Poor ventilation / lighting
- Inadequate storage
- Poor hand-washing facilities
- Too small
- Lack of hanging cupboards

The Decontamination Process

NB: Core to the Review

- Use of endoscopes
- Multiple systems / manual pre-cleaning essential
- Compatibility of endoscopes / reprocessors
- Confusion about number and position of channels
- Staff acknowledge importance of process

Cleaning / Rinsing

- Manual cleaning done well
- Flushing of channels not always carried out
- Manufacturers – new details in manuals and additional labelling
- Microbiological testing of rinse water

Disinfectants

- Glutaraldehyde
- Forum to discuss and decide on use of disinfectants

Governance

- Isolation of decontamination sites
- Unclear lines of accountability
- Lack of clarity regarding Policy formulation
- Mapping committees

Record Keeping / Auditing

- Full / appropriate records kept of process
- Few comprehensive audit arrangements
- Critical Resources Efficiency Support Team – CREST

Regional Arrangements

- Departmental Priority
- Confused lines of accountability
- Confused communications – status of HTM2030
- Compliance with HTM2030 currently impossible
- Connection between departmental policies

Health Estates Agency (HEA)

- Limited decontamination testing service
- Lack of resources
- Trusts value HEA
- Clarification needed regarding key roles, eg TP / AP

Trusts – Roles and Responsibilities

- Board level
- Trust wide Operational Manager
- Lines of accountability unclear
- Workloads – Directors of Nursing

Post Review

- Report to Minister December 2005
- Public launch
- DHSSPS to monitor