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The “Smart” detergent pump flow meter monitors and controls the precise amount of detergent into the sink. An alarm will alert the technician any time the chemical supply is low or in the event of a failure of the detergent pump or pump tube.

Flushing
The flushing function is designed to replace cumbersome syringe-type flushing through the Air/Water channels, Suction Valve, Auxiliary Water or Elevator Wire channels. The “Smart” flow meters monitor and control the flow of the flush water into the endoscope channels.

Visual Display and Internal Memory
In addition, the system provides visual display of each process as well as internal memory which logs validation of the step-by-step process. Each pre-cleaning session can be traced and logged to an individual technician as well as to a particular endoscope by using its serial number and model number.

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Surgical equipment for benign prostate surgery: The relative merits of unipolar diathermy resection, plasma kinetic resection and laser vaporisation of the prostate

Since the 1960’s an endoscopic approach to reducing obstructive symptoms from benign prostatic enlargement has replaced open surgical resection. However, while recovery times are faster and hospital stays shorter, with this technique, it is still associated with significant morbidity and mortality.

The standard method for endoscopic removal of the enlarged prostate (Trans-Urethral Resection of Prostate [TURP]) uses unipolar diathermy loops which cut out sections of the prostate. These sections (or chips) are washed out of the bladder at the end of the surgery. A non-conducting irrigant is used (normally an isotonic glycine solution) to offer visibility during this procedure without dissipating the diathermy current.

As the prostate is cut, small arteries and veins are opened and can bleed. These are sealed with the diathermy throughout the surgery. However, the irrigant pressure is usually higher than venous pressure and because of this and the presence of raw tissue, throughout the surgery, glycine can force its way in to the bloodstream. In serious cases this can lead to haemodilution and hyponatremia. This can cause the patient to suffer from confusion, electrolyte imbalance, cardiac arrhythmias and occasionally death. This is called TUR syndrome.

Maintaining a short operating time (less than 1 hour) by selecting patients with smaller prostates for such surgery minimises but does not eradicate the risk. Haemorrhage is the other major risk and this also increases with increasing prostate size.

In recent years several new technologies have been introduced to reduce further the risks of TURP. Two of the current favourites are the use of lasers and plasma kinetic energy to reduce the bulk of the prostate. These techniques allow the treatment to be conducted with a normal saline solution as the irrigant. This dramatically reduces the risk of hyponatremia although it can still sometimes be seen. The exact mechanism of this complication is not entirely clear.
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Lasers can be used either to resect the prostate in sections like a standard TURP or to evaporate the prostate. The benefit of resecting the prostate, usually with a holmium laser, is the retrieval of resected tissue for histological examination. The benefit of evaporation, usually with a KTP (Potassium [K] Titanyl Phosphate) laser, is the ease of the technique. Both techniques reduce the risk of TUR syndrome and haemorrhage. The equipment however is expensive and the cost of disposables is high.

Plasmakinetic resection of the prostate outwardly appears identical to standard TURP. However, the loop electrode used has two conducting surfaces essentially making it bipolar. It can resect with normal saline as the irrigant and appears to coagulate vessels better than standard TURP loops although there is still some dispute about this. It produces tissue for histological examination and reduces the risk of TUR syndrome. The cost of the equipment is similar to standard TURP equipment as are the costs of the disposables. The training is essentially the same as for standard TURP. For all these reasons it has essentially made the standard TURP obsolete. Indeed, standard TURP can now be considered to put patients at unjustifiable risk.

With both the laser and plasmakinetic treatments patients many patients go home the same day or the next day, some with and some without a catheter. The catheter is usually removed at 24-48 hours.

Owing to these newer techniques it is possible to treat patients with larger prostates safely, reducing the need for retropubic prostatectomy, for benign prostatic enlargement, almost totally.

G Michael Flannigan
MB ChB, ChM, FRCS
Consultant Urologist, The Yorkshire Clinic, Bingley
Orthopaedic implants: a cautionary tale

A box of replacement hip implants delivered from stores, need checking in. In the near future these implants will be collected by a member of your team, and shown to you as scrub nurse: what do you next?

Most of you will say – check implant, yes, but how?

- AFPP (2011) Standards and Recommendations for Safe Perioperative Practice gives guidance on how to record minimum information needed to allow tracking and traceability, but not on how to undertake a pre-implant check, is this enough?

In a busy UK orthopaedic department over a recent three month period, three wrong sized (outer diameter O.D.) metallic femoral heads were implanted into patients. Each scrub practitioner had checked the implant with the circulating practitioner and it had been verified by the operating surgeon. Implant labels were placed in patients’ notes and reference numbers recorded in the electronic theatre perioperative record. The team members believed they had implanted the correct sized implants.

No one had identified that instead of the 28mm O.D. head that had been requested by the surgeon, a 26mm O.D. head had been collected from implant store, checked, opened and placed on the trunion of the femoral stem!

Never events were identified when operation details were entered onto the National Joint Register (www.njrcentre.org.uk) some time later by the author. If entered implants mismatch each other in size: a ‘component combination validation comment’ will occur and entered data will not save.

Each event was identified in this manner and reported, critical incident reports were commenced and I was asked to investigate.

I identified probable evidence of human error, complicated by a manufacturer processing / packaging anomaly:

- Each scrub nurse (x3), circulator (x3) and surgeon(x3) – nine practitioners - had misread the printed numerical 26mm O.D. figures as 28mm O.D.
- Remaining stock held in implant store, 28mm/26mm heads were stored close together – had circulator just picked up the wrong head?

No. The problem lay with implant packaging:

- Font size identifying appeared quite small, less than 4mm
- Font was obscured by a seal on the outer protective wrapping, which ran in front of the text identifying implant size.
- Visual acuity issues in practitioners, wearing of eye protection reacting with glare of operating lights bouncing off polythene wrapper.
- The distance the circulator held the implant box from the scrubbed practitioner and surgeon.

These issues were reported to clinical team managers and to the Medicines and Healthcare products Regulatory Agency (www.mhra.org.uk) who investigated incident.

No other events were identified nationally, such that a hazard warning or safety bulletin was deemed unnecessary, however the implant company has since changed the font size on existing implants supplied to your department.

These incidents were distressing for all staff involved, informative and for two of the patients required revision surgery.

Discussion

Following these events, Haene et al in their (2009) article make the following recommendations regarding font size on label for orthopaedic implants.

1. A separate label on one side of the pack containing only the following information: (i) implant description; (ii) a graphic (photograph or clear line drawing); (iii) implant size; (iv) expiry date; and (v) matching component dimensions.

2. The following standards should be observed: (i) text height should be a minimum of 4 mm; (ii) information should be presented in one language only; (iii) good visual contrast should exist between text colour and background colour (ideally black text on a white background); (iv) information should not be repeated on the same label; and (v) the seams or folds of transparent outer sleeves should not obscure the label.

3. Larger text size need not automatically require larger labels or even larger implant boxes. Labels can be kept at an acceptable size by decluttering the information, as decluttering will improve visual acuity by increasing the clear space surrounding the letters or digits.10, 11 This can be achieved by presenting the following information elsewhere on the box: (i) manufacturer’s address; (ii) sterilising information; (iii) proprietary and legal notices; (iv) reference numbers; and (v) barcodes.

Clearly this is a complex issue, each theatre team needs to be assured of all its implant checking methodology and recording processes to ensure the following does not occur.

The never events list

2012/13

Never event: Number 2.
Wrong implant/prosthesis (DH 2012)

- Surgical placement of the wrong implant or prosthesis where the implant / prosthesis placed in the patient is other than that specified in the operating plan either prior to or during the procedure. The incident is detected at any time after the implant/prosthesis is placed in the patient and the patient requires further surgery to replace the incorrect implant/prosthesis and/or suffers complications following the surgery.

- Excludes where the implant / prosthesis placed in the patient is intentionally different from the operating plan, where this is based on clinical judgement at the time of the operation.

- Excludes where the implant / prosthesis placed in the patient is intentionally planned and placed but later found to be suboptimal.
Setting: All healthcare premises.
I have described a “never”, “I don’t believe it!” event, with clear implications for those of you handling implants today.

Adrian Jones
Orthopaedic Surgical Care Practitioner, Norfolk & Norwich University NHS Trust

References:
Department of Health 2012
The “never events” list 2012/13


This is a complex issue, each theatre team needs to be assured of all its implant checking methodology and recording processes to ensure mistakes do not occur.

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Never underestimate the importance of understanding material technology in the theatre

Looking into the complexities of the material technology your gowns and drapes are made from appears at face value to be a dry and questionable discussion. Yet the material attributes of these items in theatres can have a major impact on infection control and safety to both patients and staff.

There have actually been severe cases of burns and the transmission of infectious diseases caused by drapes being accidentally ignited and the lint residue of some drapes and gowns harbouring dangerous micro-organisms.

Patients are at their most vulnerable during the surgical procedure and the drapes and gowns used can seriously impact upon outcomes and safety for all in the theatre environment.

The debate was strengthened when the European standard EN 13795 was introduced. This was necessary to provide a standard for better protection for patients and staff, and defines methods and limits for establishing effective protection against penetration of infectious micro-organisms and bodily fluid.

As single-use alternatives began to replace traditional multi-use linen, a marked drop in infection rates in some hospitals demonstrated just how significant it was to understand the importance of material technology. Many hospitals now use single-use products made from either spunlace or SMS polypropylene.

There is however a strong debate as to the risks still associated with some single-use materials. A conversion from one type to another can often be seen as a complex and lengthy process with financial implications attached.

We look at some of the arguments made about the differences between spunlace and SMS polypropylene.

**Claims:**

Linting - when looking at both spunlace and SMS polypropylene it is possible to see that the lint shed (dust particles) caused by spunlace is far greater than SMS, due to the paper based material spunlace is created from. An easy way to visualise this is to take a sample of each material and simply rub the fabric. Alternatively, you can often see the lint very clearly on theatre equipment where spunlace has been present. As linting is seen as a method for transferring micro-organisms it is clear to see why SMS would be selected as the material of choice for both forensic and clean room purposes and as the preferred choice in a healthcare environment.
The risk of linting and its relationship with infection control was confirmed during an outbreak of MRSA in a Scottish hospital who confirmed that dust was highlighted everywhere. Another report from the Glasgow Royal Infirmary implicated MRSA cases to a lack of hygiene as the floors and windows were filthy and thick with dust.

Flammability - SMS polypropylene recedes from a flame, making its risk of flammability far lower than that of spunlace. Again, this is due to the nature of spunlace being a paper/polyester mix.

Although rare, there have been incidents in the UK where paper/polyester surgical drapes have ignited whilst applied to the patient. Where the use of an alcohol based prep solution is used in conjunction with a heat source the risk is clearly higher.

The risk of burns in theatre is very real, as a patient found out earlier this year at a Yorkshire hospital when a woman received superficial burns during surgery when an error was made with a spirit based solution which was then ignited and in turn ignited the facial drapes.

Obstacles:
Education and clinical advice from suppliers can often be forgotten or misleading. It is important to assess the needs of each procedure and apply the most appropriate gowns and drapes dependent on what is involved i.e. levels of fluid, length of procedure, and use of equipment or prep solutions.

Budget restrictions can be an obstacle to any gown and drape conversion, however, often spunlace is more expensive than SMS and therefore the cost of conversion can be quickly offset.

One solution:
Full Support Healthcare told us that they provide simple and cost effective conversions from linen and spunlace to their range of hi-tech SMS drapes and gowns. They are one provider who understands the benefit from a clinical and financial perspective.

Sarah Stoute, CEO said: "My aim when I started FSH was to promote an understanding of the benefits of single use surgical drapes and gowns, as well as educate my customers as to the advantages of SMS polypropylene material, which was developed to overcome issues with excessive linting and flammability risk. This is why FSH have always worked with SMS.

“We understand that any conversion can be a laborious task, and as such we provide free education and clinical advice about the correct use of single use non-woven material.

“We understand that any conversion can be a laborious task, and as such we provide free education and clinical advice about the correct use of single use non-woven material (SMS). We work closely with hospitals to ensure an effective and smooth conversion process so that they benefit from cost effective single-use solutions that provide short and long term benefit both clinically and financially.”

For more information about Full Support Healthcare’s conversion support process or to find out more about the attributes of non-woven technology; contact their head office on 01933 672 180 or go to www.fullsupporthealthcare.com.
GCM new safety initiative in IV administration

There have been many attempts by medical device companies to combat some of the dangers of intravenous therapy. Most of these are to be welcomed but an overall consideration to specific IV applications has not really been addressed.

Global Components Medical Ltd and Global Components Inc have worked hard to bring to the world marketplace a new range of dedicated IV administration sets. Initially they have launched TIVA-TCI (Multiple Infusion) Sets and Sedation/PCA Sets. All of these products have enhanced and well thought through safety attributes making TIVA-TCI and PCA administration considerably safer. Great attention to detail has been given in the light of the SALG (Safe Anaesthesia Liaison Group) Report-2009 and ‘Project Orcadian’ (UK Department of Health) 2004 and ‘key’ safety benefits are listed below which makes these sets the most advanced ever.

Alan Walton, Director at Global Medical says: “Spending a lot of time with Anaesthetists and truly understanding their needs has meant that we have listened carefully to their concerns and have acted in the best interests of the patients on the other end of our administration sets. We know that some other medical device manufacturers have gone some of the way to solving IV safety problems and that is to be welcomed but, for us, ‘some’ was simply not good enough!”

The safety profile that GCM have introduced into their TIV-TCI sets is stunning and offers the maximum protection possible for the anaesthetised patient and should be welcomed. These are:

- Red proximal end caps—this means that the caps can be easily seen if they should migrate in to the PBC (patient breathing circuit) (Requested by the UK Department of Health/Project Orcadian)
- Kink-resistant multiple-lines—no danger of occlusion of flow and very high tensile strength so can be used in emergency situations.
- Coloured drug identification tags as recommended by AAGBI with all commonly used drugs provided in product pouch.
- Adjustable ‘Line Lok™’—To ensure line is completely secure and no stress is possible at cannula connection. Can be positioned anywhere.
- High-Flow anti-gravity valve on distal limb—will run at >280mls/min so Anaesthetist practitioner always has the option of high-flow volumetrics. Makes it an ideal product also for emergency applications c/w multiple-infusions.
- ‘U-Guard™’—Addition protection at cannula site with unique distal protection to ensure no possible occlusion: even with attempted manual ‘tampering’
- ‘i-Loks™’—To keep eye(s) closed during anaesthesia and non-traumatic on removal. Reduces the chance of another portal of infection.
The GCM range of TIVA-TCI (Multiple Infusion) Sets caters for all elective surgery applications, cardiac, neuro, ophthalmic, dental and A&E applications. All of these sets have the above enhanced safety.

Initial Comments (on: www.global-medical.co.uk)

Testimonial from a keen and expert ‘vapour free’ TIVA-TCI enthusiast:

‘The integrity of the cannula is, in my opinion, as important as the airway itself. LineLoK™ adjustable line fixation device that comes as standard with these high-quality sets is a very secure way of protecting the cannula from detaching.

There are several other important safety benefits which should be welcomed such as always having a high-flow volumetric facility, complete protection from distal kinking of the line, drug identification tags to ensure syringe contents match the identified line and i-Loks to protect the eyes during surgery without subsequent trauma.’

Dr Anup Biswas FRCA, Consultant Anaesthetist, University Hospitals NHS Trust, Nottingham, Hon Lecturer at NEMSA (School of Anaesthesia), Committee Member SIVA (Society for Intravenous Anaesthesia)

‘Having been employed as technical support for anaesthetics over the last 12 years, I have seen many changes in the delivery of anaesthesia during this time. The most exciting development in this specialised field, has undoubtedly been the advancement of target controlled infusion (TCI) technology and Total Intravenous Anaesthesia (TIVA).

The safety profile that GCM have introduced into their TIV-TCI sets is stunning and offers the maximum protection possible for the anaesthetised patient and should be welcomed.

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"An ordinary blanket isn’t very effective and the temperature management products currently used by hospitals are just too complicated", says Dr. Mark Kyker, M.D, a US cardiac anaesthesiologist and the inventor of the active self-warming blanket. “This product is the first true easy-to use solution for perioperative warming.”

Inadvertent Perioperative Hypothermia (IPH) is a common and recognised side effect of anaesthesia and surgery, the incidence of which is still believed to be as high as 70%1. After the induction of anaesthesia the core temperature of patients can rapidly decrease between 1.0 – 1.5°C during the first hour2 which can then cause:

• Increased risk of medical complications, including delayed wound healing, hemorrhaging and a greater risk of morbidity3
• Increased risk of surgical site infection3
• Further treatment and prolonged hospital stay, resulting in higher costs3
• Increased discomfort and anxiety for patients3

Outside of the operating theatre, hypothermia also poses a risk for patients awaiting treatment including those in A&E departments or being transferred under ambulance care. Minimizing the risk of infection also reduces length of hospitalisation. Preventative measures such as preoperative patient warming and active warming during surgery, have been demonstrated to have a positive outcome in avoiding hypothermia.

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You can find out more about this issue from the convenience of your own home by registering for the Barrier® EasyWarm® Webinar – simply register at http://www.warmingupdate2012.com. The Webinar runs at 5.30pm, on November 8th 2012.

References:

For further information please contact: Simon Price Molnlycke Health Care Simon.Price@molnlycke.com
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