Improper infection prevention practice associated with ultrasound probe use has been linked to increased infection risk, outbreaks, and death. Although guidelines for reprocessing and use of probes exist, it is unclear how extensively these have been adopted in practice” Carrico et al (2018).

Abstract:

Background: Improper infection prevention practice associated with ultrasound probe use has been linked to increased infection risk, outbreaks, and death. Although guidelines for reprocessing and use of probes exist, it is unclear how extensively these have been adopted in practice.

Methods: Infection preventionists from U.S. health care facilities were surveyed (N = 358). The anonymous survey had 31 multiple choice, sliding scale, and text response questions. The survey was developed and deployed and the data were stored in the REDCap system.

Results: A high degree of noncompliance with U.S. guidelines was identified. Surface probes used in invasive procedures were not high-level disinfected or sterilized 15% (intraoperative) to 78% (peripheral line placements) of the time. Of invasive procedures, 5%-47% did not use sterile gel (same procedures, respectively). Of the participants, 20% were aware of instances where an ultrasound probe was used but was not correctly reprocessed. Extensive breaches of infection control guidelines were reported. The rapid expansion in use of ultrasound has brought clinical benefit but may be exposing patients to preventable infection risk.

Conclusions: Infection preventionists are well placed to act as major drivers of change based on their expertise and experience in the management of infection risk across facilities and health systems. They, along with clinicians responsible for probe use and reprocessing, should review practices relating to ultrasound in their facilities. Where practice does not comply with guidelines, policy and training should be updated to ensure patient safety.
Reference:


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