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Loaner instrumentation: processing the unknown

AORN Journal, March, 2007 by [Thomas G. Winthrop](#), [Barbara A. Sion](#), [Clifford Gaines](#)

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Use of loaned surgical instruments has become standard practice in many of today's hospitals because of high instrument costs and rapidly developing technological advances in surgical instrumentation. The American Society for Healthcare Central Service Professionals and the International Association of Healthcare Central Service Materiel Management recently issued a joint position statement on loaner instrumentation. (1) The statement addresses the need to develop standard operating procedures for the acquisition, accountability, and disposition of loaner instruments.

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In most practice settings, staff members assume that all instruments or instrument sets coming into a facility will need to be reprocessed according to institutional policy. This does not mean, however, that a facility expects to receive contaminated instruments routinely. In fact, facilities expect all instruments to be thoroughly decontaminated before they arrive.

Walter Reed Army Medical Center, Washington, DC, receives or has on hand as "in-house loaners" (ie, instruments sets owned by the vendor or company but loaned to the hospital for a contractually agreed upon time period) approximately 300 instrument sets every month. These sets either are brought by a vendor representative or are sent directly from the vendor's headquarters. Sets that come from vendors' headquarters are assumed to be meticulously reprocessed, while those coming from a vendor representative may have been decontaminated just before delivery to the next facility.

COMPLICATIONS OF PROCESSING LOANER INSTRUMENTS

The issue of reprocessing loaner instruments has implications for infection control and patient, employee, and vendor safety because of the rise of multidrug resistant organisms, Creutzfeldt-Jakob disease, and bioterrorism threats. The question to ask when considering reprocessing loaner instrumentation is whether the sets have been properly decontaminated before they are issued to the next user. Many times, a procedure involving loaner instrumentation goes late, and the set may get a cursory wipe down or may be run through a flash sterilization cycle before being given to the vendor representative or courier. The set is then transported to the next facility where it may be received in any number of places including the logistics department, hospital front desk, OR, or central processing department, depending on time constraints and the courier's or

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vendor representative's familiarity with the institution. Additionally, many institutions do not perform quality improvement checks on the initial decontamination process other than a visual inspection before assembly. This may occur at both the lending and receiving facilities.

Each of these scenarios presents an infection control issue that may or may not be known to the hospital's infection control committee. To the untrained eye, these instruments may appear to be clean and to pose no health risk. Further, there is no documentation to say whether the instrumentation has been decontaminated and by what process.

THE PROJECT

Central processing department personnel at Walter Reed Army Medical Center conducted a two-month project to determine whether loaner instruments that came into the facility actually had been decontaminated. This included checking hard-to-clean instruments, especially cannulated reamers and drills. The loaner instrumentation was delivered in one of three ways:

- * in shipping containers not marked as biohazardous material (Figure 1),
- * in instrument cases that could be sterilized, or
- * as loose instrumentation without any case or covering.

[FIGURE 1 OMITTED]

Some of the instruments coming from the vendor processing facility had sterilization indicators in each pan but were not accompanied by paperwork that indicated the method and parameters of the decontamination process.

Each set received was annotated as to its origin and whether it was delivered by a vendor representative or sent from the company's main distribution center. A visual inspection was performed first followed by a chemical test for blood residue.

The test kit came in a protective pouch that contained an indicator vial with a transparent cap, an activator vial with a green cap, and a cotton swab. If an instrument was wet, it was swabbed vigorously with the dry cotton swab. If the instrument was dry, the swab was moistened with a drop of clean, non-chlorinated water, and the sample area was swabbed vigorously (Figure 2).

[FIGURE 2 OMITTED]

The central processing employee then opened the indicator vial, which contained the liquid medium that reacts to the presence of blood, and transferred the liquid to the activator vial. He or she then placed the sample swab into the liquid in the vial, capped the vial and shook it at least five times, and observed the swab for 30 seconds. A color change of the liquid to blue-green indicated blood residue on the tested surface (Figure 3). In the presence of a large amount of blood, the entire quantity of indicator solution would change to dark blue. Tests were recorded on a tracking form as either negative (ie, clear); positive (ie, blue-green); or strongly positive (ie, dark blue). The name of the vendor company, type of instrument set, and type of instrument swabbed also were recorded.

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