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Letter to the Editor

Updates to our web-based infection prevention data toolkits

Dear Editor:

We would like to thank the readership for their interest in 2 of our recent manuscripts, each outlining free, open-source, web-based tools to support data needs of infection preventionists and health care epidemiologists.[1,2] Recently, 2 changes have been made to the applications that may impact individuals who use these tools. First, all of our applications have been merged into 1 toolkit, now called "IPStat." We hope this will facilitate ease of use of each application, and will simplify future additions. Second, and more important, owing to constraints on the prior server, the web address of the tool has moved. Those interested can now access IPStat at the following web address: http://capo.ctrsu.org:3838/shiny/ipstat/.

As always, no data are saved, stored, or otherwise eavesdropped upon by these applications or anyone on our study team. We feel strongly that the intense data needs of the practitioner can be simplified so everyone can get back to their critical patient safety efforts. We hope these free tools can help.

References

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2. Wiemken TL, Furmanek SP, Mattingly WA, Haas J, Ramirez JA, Carrico RM. Googling your hand hygiene data: using Google forms, Google sheets, and R to collect and automate analysis of hand hygiene compliance monitoring. Am J Infect Control 2018;46:617-9.

Conflicts of interest: None to report.

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Response to the letter to the editor regarding "Ultrasound probe use and reprocessing: Results from a national survey among U.S. infection preventionists"

To the Editor:

Thank you for the opportunity to comment on and discuss some of the questions posed by Gase et al[1] regarding the ultrasound use survey. Ultrasound use is 1 of the fastest growing procedures in health care, across virtually all settings and departments, so continued dialogue and practice investigation are important parts of our shared patient safety priorities.

This response will lay out in logical detail the application of the Spaulding Classification to ultrasound guided procedures, as well as address other questions from Gase et al.[1]

Gase et al[1] then requested clarification on the guidelines used to categorize ultrasound procedures under the Spaulding Classification and Figure 2[2] from the survey report. The authors write, "The figure cites CDC, AIUM and AAMI recommendations as the source [the figures provide algorithms for decision-making]. However, it is not clear that those three organizations intended to support this level of processing for these low risk uses of ultrasound probes."[1] The assertion that these probes are low risk is not supported by any specific evidence, and, as described below, they are likely to be considered high-risk items by Spaulding. Although we do not know the intent of those organizations (Centers for Disease Control and Prevention, American Institute of Ultrasound in Medicine [AIUM], and Association for the Advancement of Medical Instrumentation [AAMI]), relevant statements from those guidelines and recommendations shown below cannot be discounted. In these guidelines, critical medical devices are those that "are introduced directly into the human body, either into or in contact with the bloodstream or other normally sterile areas of the body";[3] "enter sterile tissue or the vascular system" and "contact sterile body sites";[4] and "during use contact normally sterile tissue or body spaces."[5]

When applied to ultrasound, the consensus of these definitions is that an ultrasound probe that contacts sterile tissue (eg, the puncture site) during a guided procedure would be considered critical by Spaulding. The Spaulding Classification is a rational approach to reusable medical device processing that has been used for decades. By necessity, in many procedures, ultrasound probes must be in very