

Perforations of the Colon during Colonoscopy (Continued)

facilities will understand the importance of gathering in-depth information on this complication; the burden will be small for any single facility, and the benefit large when the experience of the entire state is aggregated.

3. In order to understand which patient and procedure factors are not only commonly found with perforations, but more commonly found with perforations than with safe, uncomplicated procedures, it will be necessary to collect similar information on an equivalent-sized set of safely done procedures. The PA-PSRS team is looking for volunteer providers and facilities to provide this comparable information in order to identify the risk factors for perforation.

Armed with this information, the Authority will be able to identify controllable risk factors for perforation during colonoscopy, develop an educational program to inform Pennsylvania providers about these controllable risk factors, and assist them in developing system improvements to eliminate avoidable risks of perforation during colonoscopy.

To assist in this program, the PA-PSRS team will recruit an advisory panel. Members of the panel will represent various specialties and geographic areas. The advisory panel will help the PA-PSRS team develop a list of relevant questions, critique the analysis,

If you are a provider or represent a facility that does colonoscopy, we need your help. If you would like to volunteer to participate in this special program, please contact:

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advise the team on the development of an educational program, and suggest system improvements to create an effective risk-reduction program.

We will begin this special safety improvement program in January 2007.

Notes

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Oxygen-Enriched Environments Increase the Fire Risk from Alcohol-Based Hand Sanitizers

Ignition of alcohol-based hand sanitizers in oxygen-enriched environments in healthcare facilities can lead to serious fires, according to a hazard report published in the October 2006 issue of ECRI's *Health Devices*.

The hazard report discussed a reported event in which a nurse in a neonatal intensive care unit was rubbing sanitizer into her hands as she approached an oxygen/air proportioner to change a setting. An investigation into the event concluded that the nurse's movements created a static electric charge that discharged to the grounded proportioner when she reached for the device's control knob.

Because the three requisite components of a fire were in place—an ignition source (i.e., the electrostatic discharge), a fuel (i.e., the hand sanitizer), and oxygen (i.e., present in the room air and in the oxygen-enriched environment surrounding the proportioner)—a fire ignited the sanitizer on the nurse's hand and on the control knob. The nurse's hand was

burned; however, nearby clinicians were able to disconnect the device and extinguish the flames before additional injuries occurred or the fire spread. In the presence of normal oxygen concentration in the room air, the electrostatic discharge may have only ignited the sanitizer on the nurse's hand, but because of the oxygen-enriched environment surrounding the control knob, the knob also caught fire.

Suggestions from the hazard report for users of alcohol-based hand sanitizer include the following:

- Alerting users to this potential problem.
- Directing users to ensure that sanitizer fully evaporates from their hands before they touch devices, bed linens, or patients.

Source: ECRI. Fire risk from alcohol-based hand sanitizers worsens in oxygen-enriched environments. *Health Devices* 2006 Oct;35(10):390.