Aseptic Technique
Competency Assessment Module

This competency assessment module discusses aseptic technique that includes OR attire, correct technique for surgical scrubbing of the hands and arms, and for the gowning and gloving of self and other members of the surgical team. The appropriate technique for prepping the patient for surgery and principles of draping the patient are also addressed.
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*Figures 1 through 7, and 9 through 20: Reprinted from Competency for Safe Patient Care During Operative and Invasive Procedures. M L Phippen, P C Ulmer, M P Wells. (Denver: Competency & Credentialing Institute, 2009).*

*Figure 8: Reprinted from Aseptic Technique Competency Assessment Module. H S Pashley. (Denver: Competency & Credentialing Institute, 2007).*
Overview and Objectives

Overview

This competency assessment module discusses aseptic technique. Aseptic technique stems from the principles of asepsis, which have developed over time as the microbiological science body of knowledge has evolved. The perioperative nurse and all members of the surgical team must adhere to the principles of aseptic technique to provide a safe environment of care and minimize wound contamination, thereby reducing the patient’s risk for surgical site infections. This module provides an overview of the infectious process in the surgical patient. The principles of aseptic technique and proper surgical attire are discussed. The proper techniques for gowned, gloved, and prepping the patient’s skin for surgery are described. Selected case studies provide the participant with an opportunity to synthesize the information and evaluate workplace scenarios regarding appropriate aseptic technique. After completion of the written educational activity and review questions, the participant should be able to demonstrate safe and effective aseptic technique, as applicable in the health care facility.

Objectives

Upon completion of this module, the participant should be able to:

1. Discuss how the infectious process affects patients undergoing surgical intervention.
2. Describe the principles of aseptic technique.
3. Identify appropriate surgical attire.
4. Demonstrate correct technique for surgical scrubbing of the hands and arms.
5. Demonstrate correct technique for gowned and gloved of self and others.
6. Discuss the appropriate technique for preparing the patient’s skin for surgery.
7. Describe the principles of draping the patient.
8. Apply the principles of aseptic technique to specific patient care situations.
Unit 1:

Overview of Aseptic Technique

Mankind has struggled with the concepts of disease transmission and infection prevention for thousands of years. Beliefs about the origins of disease have ranged from evil humors or sin as the cause of disease to our modern concepts about bacteria, viruses, and prions. In the past, people segregated or abandoned those who were ill to avoid the spread of illness without really understanding how or why transmission of infection and illness occurred. Major advances in the theory of disease transmission and prevention occurred in the nineteenth century. These discoveries built on the gradual increase in knowledge and understanding of anatomy, physiology, and disease that occurred during previous centuries.

Several sentinel events of the 1800s that led to a better scientific understanding of the infectious process are outlined below.

• In 1840, Friedrich Henle proposed that disease was caused by living organisms, though he was unable to offer proof.

• In 1843, Oliver Wendel Holmes advised doctors to wash their hands before examining patients to prevent the spread of puerperal fever in obstetric patients.

• In 1847, the Hungarian physician Ignaz Semmelweis (who, ironically, died of puerperal fever contracted from a patient) showed that puerperal fever was contagious and reiterated Holmes’ admonition to physicians to wash their hands.

• In 1850, Louis Pasteur discovered that bacteria (which he termed “germs”) caused fermentation and could be killed by heat, a process we know as pasteurization.

• In 1854, John Snow demonstrated that by removing access to a well (i.e., the well handle) contaminated by sewage, the incidence of cholera was reduced in the area near that well.

• In 1865, Joseph Lister, building on Pasteur’s ideas about germs, began using phenol as a disinfectant in surgery and reduced the surgical death rate by 30%.

• In that same year, Jean-Antoine Villeman showed tuberculosis to be a contagious disease.

• During the Crimean War, Florence Nightingale instituted sanitation and nursing care changes that reduced mortality significantly.

• Clara Barton made improvements in nursing care during the American Civil War.

• In 1883, Gustav Neuber was the first surgeon to suggest that the construction of an operating room (OR), how it was used (i.e., for clean or dirty cases), and the materials used in its construction could affect infection rates in patients. Some of Neuber’s ideas are still in use today (i.e., easily cleaned nonporous surfaces on walls and flooring, minimal furniture, specially constructed shelving and furniture, the use of heat sterilization).
Unit 2:

Principles of Aseptic Technique

Aseptic technique is used to establish, maintain, and monitor a sterile field. In the OR, a sterile field is the area in which personnel function to provide care to a patient during a surgical or invasive procedure. This area includes the patient (draped with sterile drapes); surgical team members in OR attire and sterile gowns and gloves; sterile instruments; and equipment (appropriately draped or covered).

The principles of aseptic technique can be reduced to the concept that if an item, area, or material is sterile, all efforts must be made to maintain that sterility. This means that the possibility of contamination must be avoided by all members of the health care team, and all members of that team have the responsibility for establishing, maintaining, and monitoring the sterile field. While providing any patient care activity, the risk of infection transmission is reduced as much as possible through the practice of aseptic technique.

All team members must have a surgical conscience (ie, they identify, report, and remove any contamination of the sterile field immediately), regardless of the inconvenience or discomfort that may cause. While some practitioners believe that current aseptic practices have become too ritualistic or lack scientific evidence to support their continued use, current infection control data support the application of aseptic principles for safe perioperative nursing care. Until research demonstrates that a technique is ineffective or even unnecessary, the basic principles of aseptic technique, as described below, should be followed.

Sterile drapes are used to create a sterile field.

Surgical drapes should establish an aseptic barrier that minimizes the passage of microorganisms between sterile and unsterile areas. All items included within the sterile field (eg, the patient, furniture, equipment) must be draped appropriately. Sterile drapes should be handled as little as possible and should not be moved after they are placed so that their sterility is not compromised.

Only sterile items are used within a sterile field.

All people assembling and maintaining the sterile field must inspect all items used within that field for proper processing and sterilization indicators. Packaging must be intact, dry, and sealed (if appropriate) and contain or be marked with a sterility indicator and an expiration date (if appropriate).

Items of doubtful sterility must be considered unsterile.

If there is any question about an item’s sterility, it must be considered unsterile. Any item with a sterile barrier that has been breached (eg, torn, punctured, partially opened, contaminated with moisture) and sterilized items without an integrator or other internal indicator, must be considered contaminated and not delivered to the sterile field.

Whenever a sterile barrier is permeated, it must be considered contaminated.

This principle applies not only to packaged items, but also to draping and gowned materials. Obvious contamination occurs from direct contact between sterile and unsterile objects; less apparent contamination occurs through passage of liquids through materials and undetected perforations. Moisture soaking through a package, drape, or gown is
Unit 3:

Appropriate Surgical Attire

This competency module focuses primarily on the surgical practice setting; the guidelines for appropriate attire, however, should be applied to any area where operative and other invasive procedures are performed. Adaptations can be made depending on the individual facility’s needs, as long as the basic criteria are met. The reader should consult the current edition of AORN’s “Recommended Practices for Surgical Attire” when considering any adaptations.

The use of appropriate surgical attire is one of the first steps in practicing aseptic technique; it is a means to prevent contamination from staff members and patients and to prevent bringing contaminants into the OR from outside environments. Under normal conditions, the human body continually sheds hair, skin cells, and bacteria. This bacterial and particle contamination should be reduced or contained as much as possible in the OR to prevent patient infection and contamination of sterile supplies and the sterile field.

Certain unrestricted areas of the surgical suite (eg, areas that monitor and control access to the OR, dressing rooms, scheduling offices, patient admitting areas, postanesthesia care unit (PACU)) are designed to allow people from outside the suite access without the use of special attire. All surgical suites have semi-restricted areas (eg, areas where sterile supplies are stored or contact with scrubbed personnel may occur; work areas for processing instruments; scrub sink areas; corridors) and restricted areas (eg, rooms in which invasive or operative procedures occur; clean core area) in which all personnel are required to wear appropriate surgical attire. Increasing environmental controls, as well as surgical attire, as progression is made from the unrestricted areas to restricted areas reduces the risk for cross-contamination.

Unrestricted Areas

Street clothes are permitted in the unrestricted (ie, transitional) areas where patients, personnel, and materials are monitored.

Semi-Restricted Areas

In semi-restricted areas, personnel are required to wear freshly hospital-laundered surgical attire (ie, pants and tops [worn close to the body or tucked in], scrub dresses) made of multi-use, non-linting fabric or of disposable, limited-use, nonwoven material. Non-scrubbed personnel should wear long-sleeved jackets made of the same material as scrub clothes (ie, either woven or disposable), completely buttoned, covering their arms to the wrists. This prevents bacterial and skin shedding from the arms and contamination from flapping garment edges. Home laundering of surgical attire is not recommended. Visibly soiled, contaminated, or wet surgical attire should be removed as soon as possible and replaced with fresh, clean attire. Surgical attire that is visibly contaminated with blood or other body fluids must remain at the facility and be laundered by the facility or a commercial laundry.

Hair (including facial hair, sideburns, and necklines) must be completely covered by hats or hoods that can be laundered by the hospital or are disposable (Figure 1). Certain types of hair coverings are preferred (ie, hoods and bouffant disposable hats) because they completely cover the hair and contain any shedding that occurs. Any head covering that does not completely cover the hair, including the side of the head and nape of the neck, should not be used. Reusable head coverings should be laundered in a commercial laundry or the facility after each use; contaminated head coverings must be removed as soon as possible and laundered by the facility.
Unit 4:
Surgical Scrubbing
of the Hands and Forearms

The primary potential source of surgical site infections (SSIs) is the microbial contamination of the hands of health care workers; therefore, a critical step in preventing SSIs is good hand hygiene by all members of the health care team. Hand hygiene has been recognized as the single most important method of decreasing HAIs. In the OR, hand hygiene includes surgical hand antisepsis, which is more structured than general hand hygiene.

Personnel who directly participate in a surgical or other invasive procedure (ie, a scrubbed member of the team) should be dressed in appropriate surgical attire and perform a standardized surgical hand scrub before donning sterile gloves. The hand scrub uses either an antimicrobial surgical scrub agent intended for surgical hand antisepsis, or an alcohol-based surgical hand rub with documented persistent and cumulative activity that has met the U.S. Food and Drug Administration (FDA) regulatory requirement for surgical hand antisepsis. The objective of a surgical hand scrub is to reduce both transient and resident flora and maintain the bacterial level below baseline, which may also reduce HAIs.

Surgical hand antisepsis is performed because the skin is a major source of microbial contamination and the hands are a prime vector for disease transmission. Obviously, the skin can never be rendered sterile, but it should be as clean as possible and in the best of health if one is to participate in a surgical or invasive procedure. This is important both to prevent infection to the patient and transmission of infection to oneself. Scrubbed personnel should wash their hands before performing the surgical hand scrub and again after glove removal.

Products currently on the market allow surgical personnel to apply antiseptic, alcohol-based products to the hands and arms in place of the traditional surgical scrub. All surgical hand hygiene products should be selected based on an analysis of product effectiveness, application requirements, and user acceptance; further, selection of products should be made with the guidance of an infection prevention professional or other health care personnel with specialized knowledge in infection prevention and control. These products should always be used according to the manufacturers’ written instructions.

General Considerations

Scrubbed persons should be in good health; their hands and arms should be free from cuts and abrasions to reduce sites where bacteria can enter or multiply. No gown, glove, or mask can protect the wearer or the patient from disease transmission 100% of the time; therefore, persons who are ill or with poor condition of the hands and forearms should refrain from scrubbing.

Surgical attire (except the long-sleeved jacket), including a mask, should be in place before scrubbing. All hair should be contained within an appropriate hair covering; facial hair should be contained within a hat, hood, or mask. Eye protection, and any additional PPE that is necessary, should be in place before beginning the surgical scrub.

As previously noted, jewelry, including rings, watches, and bracelets, should be removed. Nails should be short, clean, and healthy; artificial nails should not be worn. If visibly soiled, hands and forearms should be prewashed with plain soap and water or an antimicrobial agent. The subungual areas of both hands should be cleaned carefully under running water using a disposable nail cleaner.
To be in contact with and maintain the sterile field, scrubbed personnel must don sterile gowns and gloves after completing the surgical hand antisepsis procedure. Gowns and gloves provide a sterile barrier between scrubbed personnel and the patient and are important components of aseptic technique.

It is important for the perioperative nurse to know the proper technique for gowning and gloving himself or herself unassisted and also for assisting other members of the surgical team with gowning and gloving. The scrub person is the first to gown and glove; therefore, it is important that the scrub person be aware of the surroundings and can gown and glove without contaminating the sterile field. It is never appropriate to wave hands and arms in the air to facilitate drying, as this may contaminate surrounding areas with droplets from the arms and hands and increase the risk of contamination from accidental contact.

The scrub person’s gown and a towel (usually provided with the sterile gown) should be set up on a separate sterile area (e.g., table or Mayo stand) away from the main instrument table to prevent contamination of the sterile field. Both the gown and the towel will have been folded in a way that enables the scrub person to pick them up and unfold them easily (Figure 7). Some points to remember regarding gowns and gloves follow:

- Gloves (except for their interior after donning) are considered sterile.
- The front of a sterile gown is considered sterile from the chest to the level of the sterile field. Gown sleeves are considered sterile from two inches above the elbow to the cuff, circumferentially. The neckline, shoulders, underarms, sleeve cuffs, and gown back are not effective microbial barriers and are not considered sterile.
- Gown cuffs should be considered contaminated when the scrubbed person’s hands pass beyond the cuff during gloving.

**Unassisted Gowning**

To gown yourself, approach the set up where the sterile gown and towel are placed and carefully reach out and remove the towel from the gown. If hands and forearms are wet, avoid dripping on the gown. Step back away from the gown and allow the towel to unfold in front of you without it coming into contact with your clothing. Open the towel and begin drying one of your hands with half the towel (Figure 8a). Proceed from the finger tips to above the elbows. Grasp the untouched part of the towel with your dry hand, release the wet half, and repeat the drying process on your other hand (Figures 8b and 8c). When finished, drop the towel in an appropriate receptacle.
Unit 6:

Preparing the Patient’s Skin

Similar to the surgical hand antisepsis, the goals of surgical skin preparation are to reduce the risk of postoperative SSI by removing soil and transient microorganism from the skin; reduce the resident microbial count to subpathogenic levels in a short time frame and with the least amount of tissue irritation; and inhibit rapid, rebound growth of microorganisms.18

Preoperative Preparation

Though many factors can contribute to a surgical site infection, one of the best measures for reducing the risk for infection is surgical site preparation. For the surgical site to be as clean as possible for an operative or invasive procedure, the following general preoperative preparations should be performed according to facility policy and procedure.18,19

- A preoperative shower or shampoo with an antiseptic agent cleans the patient’s surgical site and surrounding areas and prevents large amounts of debris from accompanying the patient into the OR. Unless contraindicated, the patient should perform two preoperative showers with CHG to achieve maximum antiseptic effectiveness.

- The patient should be dressed in a clean, hospital provided gown; his or her hair should be covered with a disposable bouffant head covering.

- Hair at the surgical site should be left in place — not removed — whenever possible. Shaving often results in microscopic skin damage, which increases the possibility of infection. If hair removal is in the best interest of the patient, it should be performed the day of the procedure, outside of the operating or procedure room; only hair interfering with the procedure should be removed; and hair should be clipped using a single-use, electric or battery-operated clipper or a clipper with a reusable head that can be disinfected between patients.

- The skin and area around the surgical site should be inspected before skin preparation begins. Any conditions present (eg, moles, warts, rashes, skin damage) should be documented, and care should be taken in these areas when prepping is performed.

- A history of any allergies or adverse reactions to skin preparation agents should be elicited from the patient, family members, or other caregivers and documented. This information may alter the preparation agent used; therefore, the nurse should discuss this with the surgeon and use an appropriate agent.

- The Joint Commission’s “Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery,” as well as facility policies and procedures to identify and verify the correct patient, site, and procedure before surgery, should be followed.20,21

- Certain preps (eg, extremities) may require assistance from other members of the surgical team or require the use of equipment to position the patient or hold a patient’s extremity during the prep. The nurse should assess the surgical area and plan for this, if needed.

Many situations (eg, trauma, the patient’s willingness and/or ability to cooperate, emergent situations) can prevent
An integral part of establishing a sterile field is the draping of the patient, the furniture, and equipment with sterile drapes. Drapes isolate the incision site and prevent microbial migration from unsterile to sterile areas. The draped area includes the patient from the anesthesia screen, including arm boards, to the foot of the bed; team members in sterile attire; the Mayo stand and back table; ring stands; and any other furniture or equipment used during the procedure.

As with surgical attire, there are many types of surgical drapes available, but they should be resistant to penetration by blood and other body fluids, as necessitated by their intended use. As with all products used in perioperative practice settings, drapes should be safe, meet identified needs, promote both patient and personnel safety, and be based on criteria specific to the products’ function and use. Any draping material, whether woven and reusable or nonwoven and disposable, should have the following characteristics:

- be an appropriate barrier to microorganisms, particulate matter, and fluids;
- be appropriate to the method(s) of sterilization;
- maintain its integrity during use and sterilization;
- be durable;
- resist tears, punctures, fiber stains, and abrasions;
- be non-toxic, low-linting, and free of damage;
- be cost-effective within the practice setting; and
- resist combustion.

Draping material and its ability to withstand strike-through, tears, punctures, or other damage that can occur during an operative or invasive procedure is particularly important in certain areas of the sterile field known as patient critical areas or critical zones. The area immediately surrounding the incision, where the procedure occurs, constitutes a critical zone that is at high risk for fluid strike-through because of the presence of high concentrations of blood, body fluids, and irrigation fluids. This also is an area where the use of surgical instruments and equipment can cause tears or punctures to sterile drapes. This critical zone should be draped carefully to avoid compromising the drapes, and therefore the sterile field.

Draping tables or Mayo stands also require care, as these areas hold heavy containers of instruments, basins of fluids, and other equipment that can cause strike-through or damage to the draping material, resulting in contamination of the sterile field. Fluid-proof draping materials, impervious barriers, and protective pouches or basins to contain sharps, equipment with sharp tips, or large amounts of fluid run-off should be used to drape these pieces of furniture.
Aseptic technique requires that the perioperative nurse understands the principles of asepsis; this includes distinguishing what items and areas are and are not sterile; the ability to keep these areas and items separate; and the awareness to monitor the sterile field at all times in order to report and correct any breaks in technique immediately. Establishing and maintaining a sterile field involves all the topics discussed in this competency module (ie, aseptic technique; appropriate OR attire; scrubbing, gowning, and gloving; preparing the patient’s skin; and draping the patient and equipment) as well as demonstrating critical thinking skills in developing a plan of care. Most importantly, by understanding aseptic technique and implementing aseptic practices effectively in the OR, the perioperative nurse serves as the patient’s advocate in reducing the risk for surgical site infection, thereby promoting positive patient outcomes.

Documentation of aseptic practices should be completed according to facility policy. When a break in aseptic technique occurs and cannot be corrected immediately, facility policy will outline how it should be reported and recorded. The wound classification should be adjusted accordingly and documented on the patient’s operative record.\(^6\)
Unit 9:

Case Studies

The following case studies are presented to allow the learner to apply the concepts discussed in the previous units to patient care scenarios. Read the scenarios carefully, integrating the patient data and information regarding aseptic technique. Focus on the appropriate perioperative interventions, based on the patient assessment factors. (See Case Studies Response Guide on page 45.)

Case Study #1 — Mr. RC

Mr. RC is a 78-year-old man admitted for repair of a right hip fracture after sustaining a fall at home when he slipped on a rug. He is 5’ 10” tall and weighs 150 pounds. He lives alone and does not appear to be in overall good health. He has been unable to participate in a preoperative shower due to his broken hip. The nurse notes that he does not appear to have completed any personal hygiene tasks (eg, shaving, bathing) in the recent past and he has several areas of skin damage in places visible to easy access (eg, elbows, knees). What is your assessment of this situation and what would be your interventions, if any?

Case Study #2 — Scrub Person MS

After scrubbing, gowning, and gloving, MS is assembling her back table when she notices what appears to be a superficial gouge in the impervious back table cover near where she has set the pan of instruments. It is unclear to her whether this gouge has penetrated to the surface of the unsterile back table. She discusses it with the circulating nurse, and neither can determine the extent of the damage or when it occurred. The case is a complicated general surgery case that has all surgical team members anxious, and this apparent gouge on the back table will probably require breaking down and reassembling the entire back table and replacing or resterilizing a major abdominal instrument set, thus delaying an already difficult case. What is your assessment of this situation and what would be your interventions, if any?

Case Study #3 — Ms. JR

Ms. JR is a 57-year-old woman who is in the OR for reanastomosis of her colon following surgery for acute diverticulitis. The patient has a colostomy stoma from the previous surgery. She appears in good health, her skin is in good condition, and she has no known allergies. She relates to the circulating nurse that she reacted “funny during an x-ray I had; I think it was the iodine dye.” It is unclear, however, about the type of reaction or what was done to treat it. There does not appear to be any information regarding this on her current chart.

The circulating nurse knows that the surgeon prefers povidone iodine for his preps. In discussing it with the surgeon, he relates that the “reaction” was not an allergic one. The patient hyperventilated in reaction to anxiety about the procedure. She apparently did fine during the x-ray and had no reaction to the use of the dye. He suggests that if the nurse is worried about using povidone iodine, she should use chlorhexidine gluconate to do the prep and leaves the decision up to her. What is your assessment of this situation and what would be your interventions, if any?

Case Study #4 — Nurse JM

JM, a registered nurse, is a new perioperative nurse and is observing the circulating nurse, her preceptor who is an
Glossary of Terms

Alcohol-based hand rub — An alcohol-containing preparation for application to the hands for reducing the number of viable microorganisms on the hands.

Antimicrobial agent — A broad-spectrum cleansing agent used during surgical hand scrubs and patient preps to reduce the number of resident organisms on the skin surface and prevent their regrowth during an operative procedure or surgical intervention.

Antisepsis — The prevention of sepsis by preventing or inhibiting the growth of resident and transient microbes.

Antiseptic — A product with antimicrobial activity that formerly may have been referred to as an antimicrobial agent.

Artificial nails — Substances or devices applied or added to the natural nail to augment or enhance the wearer's own nail.

Asepsis — The absence of infectious organisms.

Aseptic technique — Methods by which contamination with microorganisms is prevented.

Assisted gloving — A method by which a gowned and gloved person assists another gowned person to don sterile gloves.

Brush stroke method — A scrub method in which the scrub person counts the number of strokes applied with a brush or sponge to the surface of the hands, fingers, forearms, and elbows during a surgical hand scrub.

Closed-gloving technique — A glove donning technique used when wearing a sterile gown to prevent exposure of bare skin during gowning and donning of sterile gloves, in order to reduce the risk of contamination.

Cover gown — A garment (eg, lab coat, gown, jacket) that is worn over surgical attire to prevent contamination.

Cumulative effect — A progressive decrease over time, usually measured in days, in the number of microorganisms after repeated applications of a skin antiseptic product.

Hand hygiene — A generic term applicable to all measures related to hand condition and decontamination.

Hospital acquired infection (HAI) — An infection acquired by patients during hospitalization, with confirmation of diagnosis by clinical or laboratory evidence. The infective agents may originate from endogenous or exogenous sources. HAI, also known as nosocomial infections, may not become apparent until the patient has been discharged from the hospital.

Impervious — Material that does not allow the penetration of liquids.

Invasive procedure — The surgical entry into tissues, cavities, or organs or repair of major traumatic injuries.

Neurotoxic — Poisonous or destructive to nerves, nerve tissue, or nervous system.

Non-woven material — A sheet, web, or batting of natural and/or synthetic fibers or filaments, excluding paper, that have not been converted into yarns and that are bonded to each other by several means (eg, friction and/or cohesion and/or adhesion). Materials commonly used to produce surgical gowns and drapes that mimic woven cloth but retard strike-through of liquids and other materials encountered during a surgical procedure.
Glossary of Terms

Open-gloving technique — A glove donning technique used when changing a glove during a procedure in which the everted cuff of the sterile glove allows the gowned person to touch the inner side of the glove with ungloved fingers and the other side of the glove with gloved fingers.

Ototoxic — Having a toxic or injurious effect on the ear, especially the nerve supply, affecting hearing and balance.

Persistence — Prolonged or extended antimicrobial activity, usually measured in hours, which prevents or inhibits regrowth of microorganisms after application of the product.

Personal protective equipment (PPE) — Protective equipment (eg, masks, gloves, fluid-resistant gowns, goggles, face shields) designed to protect the wearer from injury. PPE is used whenever it is necessary by reason of hazards of process or environment or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any body part through absorption, inhalation, or physical contact.

Restricted area — Areas of the surgical suite that include the OR and procedure rooms, clean core, and scrub sink areas. Personnel in this area are required to wear full surgical attire, wear masks when sterile supplies are open or scrubbed persons are present, have all head and facial hair (including sideburns, beards, and necklines) covered, and wear sterile scrub attire if scrubbed.

Scrub attire — Additional sterile clothing (ie, sterile gowns) worn to cover surgical attire to present sterile boundaries during a sterile invasive procedure.

Semi-restricted area — Areas of the surgical suite that include the peripheral support areas, storage areas for clean and sterile supplies, work areas for processing and storing instruments, and corridors leading to the restricted areas. Personnel should wear surgical attire and cover head and facial hair, including sideburns and necklines, in this area.

Surgical attire — Unsterile apparel designated for the surgical practice setting that includes two-piece pantsuits, cover jackets, head coverings, shoes, masks, protective eyewear, and other protective barriers.

Surgical conscience — The identification, reporting, and removal of any contamination of the sterile field immediately.

Surgical hand antiseptic agent — A product that is a broad-spectrum, fast-acting, and nonirritating preparation containing an antimicrobial ingredient designed specifically to reduce the number of microorganisms on intact skin. These agents demonstrate both persistent and cumulative activity.

Surgical hand scrub — The use of mechanical scrubbing and broad spectrum antimicrobial agents to remove as many microorganisms as possible from the hands and forearms before participating in a surgical intervention or operative procedure.

Unrestricted area — A central point established to monitor the entrance of patients, personnel, and materials. Street clothes are permitted in this area; traffic is not limited.
References


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