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Purpose/Goal

To provide the learner with knowledge of AORN's guidelines related to personnel wearing hijabs in the OR and isolation precautions for perioperative patient visitors.

Objectives

1. Discuss practices that could jeopardize safety in the perioperative area.
2. Discuss common areas of concern that relate to perioperative best practices.
3. Describe implementation of evidence-based practice in relation to perioperative nursing care.

Accreditation

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Conflict-of-Interest Disclosures

Amber Wood, MSN, RN, CNOR, CIC, has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.

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THIS MONTH

Personnel wearing hijabs in the OR
Key words: *hijab, head covering, hair covering, Muslim, Islam.*

Isolation precautions for perioperative patient visitors
Key words: *isolation, contact, droplet, airborne, visitor.*

Personnel wearing hijabs in the OR

QUESTION

How can we accommodate a perioperative team member wearing a hijab (ie, type of cultural head covering) in the OR and remain compliant with AORN's "Guideline for surgical attire"[1]?

ANSWER

A hijab, which is a traditional covering for the hair and neck that is primarily worn by women of the Islamic faith,[2] can be accommodated in the perioperative setting and remain compliant with AORN's "Guideline for surgical attire"[1] when the facility provides

- a disposable option that is a reasonable alternative for the hijab, such as a surgical hood; or
- a hijab made of fabric that is recommended in the surgical attire guideline (ie, low linting, tightly woven, stain resistant, and durable) and designed with a close-fitting style (eg, al-amira) that confines all hair, ears, and nape of the neck, and is laundered by a health care-accredited laundry facility after each daily use and when contaminated.[1]

The surgical attire guideline advises that perioperative team members should wear clean surgical head covers or hoods that are disposable or laundered at a health care-accredited laundry facility, confine all hair, and completely cover the ears, scalp skin, sideburns, and nape of the neck in the semi-restricted and restricted areas of the surgical suite.[1] To follow this guidance, health care organizations typically provide disposable bouffant caps at the entrance to the semirestricted area for perioperative team members. However, these caps often do not provide sufficient coverage for Muslim women who cover their hair and neck as part of cultural and religious practices.[3]

Under Equal Employment Opportunity Commission regulations,[4] employees have the right to ask an employer for a reasonable accommodation to their policy. In regard to surgical head covers, female Muslim employees may request an accommodation for a head cover that meets their cultural needs, and the request should be granted as long as it is reasonable and does not place undue hardship on the facility.[4] To illustrate this point, a request that is not compliant with the health care organization's laundering policies (eg, allowing a home-laundered hijab when the facility requires all surgical attire to be laundered at a health care-accredited laundry facility) may be an undue hardship for the health care organization if there were transmission of disease or if the facility were cited by a regulatory agency or accreditation body.

At least two reasonable accommodation options for the hijab are in compliance with AORN's "Guideline for surgical attire." The first option is for the facility to provide a disposable surgical hood (Figure 1) that confines all hair, the ears, and the nape of the neck.[1] The optimal length of the hood may depend on the individual's cultural preference. A traditional surgical hood may be an acceptable choice and a more comfortable alternative, although the hood may not allow the neck to be fully covered. A shoulder-length surgical hood (Figure 2), which is also used in pharmacy clean rooms and the chemical industry, provides full coverage of the neck. However, personnel wearing the shoulder-length style of surgical hood should take care to confine the hair with a cap under the hood to prevent the hair from falling out of the hood.

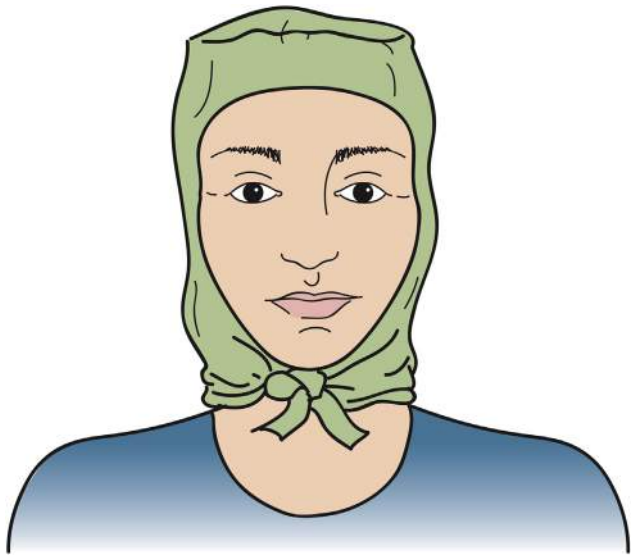

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Figure 1. Disposable traditional surgical hood. Illustration by Kurt Jones.

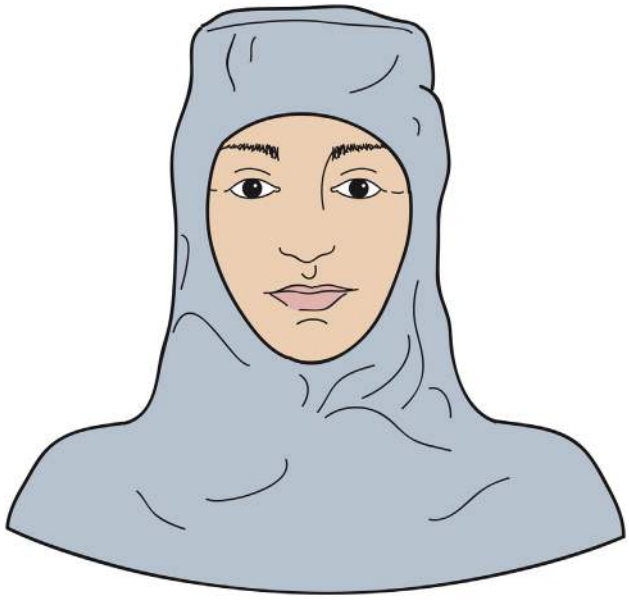

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Figure 2. Shoulder-length surgical hood. Illustration by Kurt Jones.

Another important consideration when selecting a disposable surgical hood is the transparency of the material. Depending on cultural preference, the hair should ideally not be visible through the hood. If the available hoods are not an acceptable thickness, wearing multiple hoods may provide the amount of coverage desired. Considerations should also be made for comfort. For example, a softer disposable fabric-style hood is likely more comfortable than an opaque plastic hood. Color of the surgical hood may be limited to the available options that meet the coverage needs, and special consideration of color may be necessary if the facility uses color-coding of surgical head coverings to identify personnel roles, such as health care industry representatives. Finally, the cost of the disposable surgical hood options should be considered when comparing alternative options.

If a disposable surgical hood is a reasonable alternative to the employer and the employee, accommodation should be made for the perioperative team member to don the disposable surgical hood in privacy in the designated changing area before entry into the semirestricted area. As with all surgical head coverings, the employee should change the disposable surgical hood before reentry to the semirestricted area if worn outdoors, even if travelling between buildings at the facility.[1] Used disposable surgical hoods should be removed at the end of the shift, when contaminated, or before leaving the facility and discarded in a designated receptacle.[1]

The second option is for the facility to provide a reusable hijab made of fabric that complies with the recommendations in the "Guidelines for surgical attire" (ie, low linting, tightly woven,

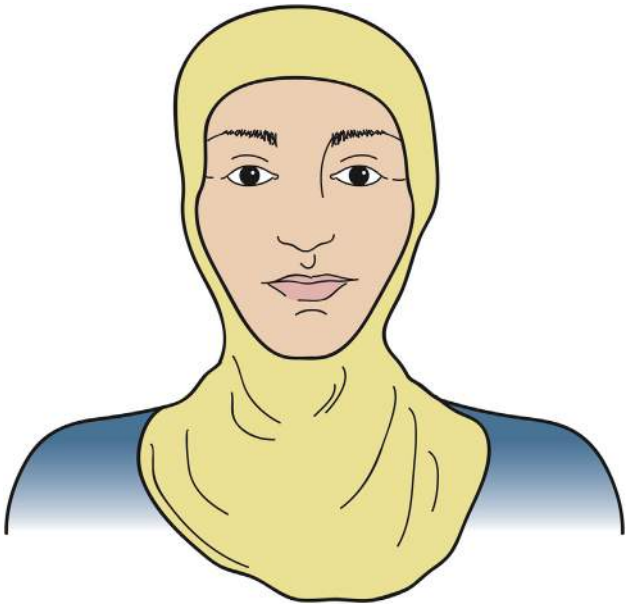

Figure 3. Hijab (al-amira style) laundered at a health care-accredited laundry facility. Illustration by Kurt Jones.

stain resistant, and durable).[1] This should be a close-fitting style (eg, al-amira) that confines all hair, covers the ears and the nape of the neck, and may be laundered by a health care-accredited laundry facility after each daily use and when contaminated (Figure 3). A style of hijab that is close fitting and tucked into the surgical attire top is preferred to reduce the risk of contaminating the hijab, sterile gown, or sterile field.

Reusable head coverings are part of the surgical attire, and as such, they should be laundered in a health care-accredited laundry facility after each daily use and when contaminated.[1] Health care-accredited laundering of reusable hijabs may protect patients from potential exposure to pathogens that can cause surgical site infection and may protect the outside community from workplace pathogens by providing control of the laundering process.[1] Laundered hijabs should be protected during transport to the practice setting by being transported and stored in enclosed carts or containers and in vehicles that are cleaned and disinfected regularly.[1]

As with all surgical head coverings, the employee should change the reusable hijab before reentry to the semirestricted area if worn outdoors, even if travelling between buildings at the facility.[1] A reusable hijab should be removed at the end of the shift, when contaminated, or before leaving the facility and placed in the laundry receptacle for laundering at a

Characteristics of Head Covering Alternatives

Disposable surgical hood	Reusable cloth hijab
☐ Complete coverage of hair, ears, and nape of the neck	☐ Complete coverage of hair, ears, and nape of the neck
☐ Length provides acceptable neck coverage	☐ Length provides acceptable neck coverage
☐ Transparency and color	☐ Fabric (low-linting, tightly woven, stain-resistant, and durable)
☐ Comfort	☐ Close fitting style (eg, al-amira)
☐ Cost	☐ Laundering at health care-accredited laundry facility
	☐ Transparency and color
	☐ Comfort
	☐ Cost

Figure 4. Hijab alternative product selection considerations.

health care-accredited laundry facility.[1] Reusable hijabs should not be stored in personal lockers for later use.[1]

Figure 4 summarizes the considerations to evaluate when comparing these two head-covering options. Regardless of the type of alternative head covering selected, a surgical head covering that is contaminated with blood, body fluids, or other potentially infectious materials must be removed immediately and disposed of, or if reusable, laundered by a health care-accredited laundry facility.[1] When determining the amount of disposable or reusable hijab head coverings to order, health care employers should remember that replacement head coverings need to be provided in the event of contamination. The perioperative team member should be aware that the surgical head covering will need to be removed if contaminated and before leaving the facility so that she can plan for her cultural needs to be met.

Although modesty is a core value in the Islamic faith, preference for female hair and neck covering can vary by culture, age, and degree of adherence to religious practices.[5] Perioperative leaders should collaborate with the individual perioperative team member making a request for religious accommodation and the facility's human resources professional(s) to ensure that both the perioperative team member's and the health care organization's needs are met and are in the best interest of patient safety.

Amber Wood, MSN, RN, CNOR, CIC, is a perioperative nursing specialist in the AORN Nursing Department, Denver, CO.

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Isolation precautions for perioperative patient visitors

QUESTION

When a patient is in isolation, should their visitors follow the same precautions as perioperative team members?

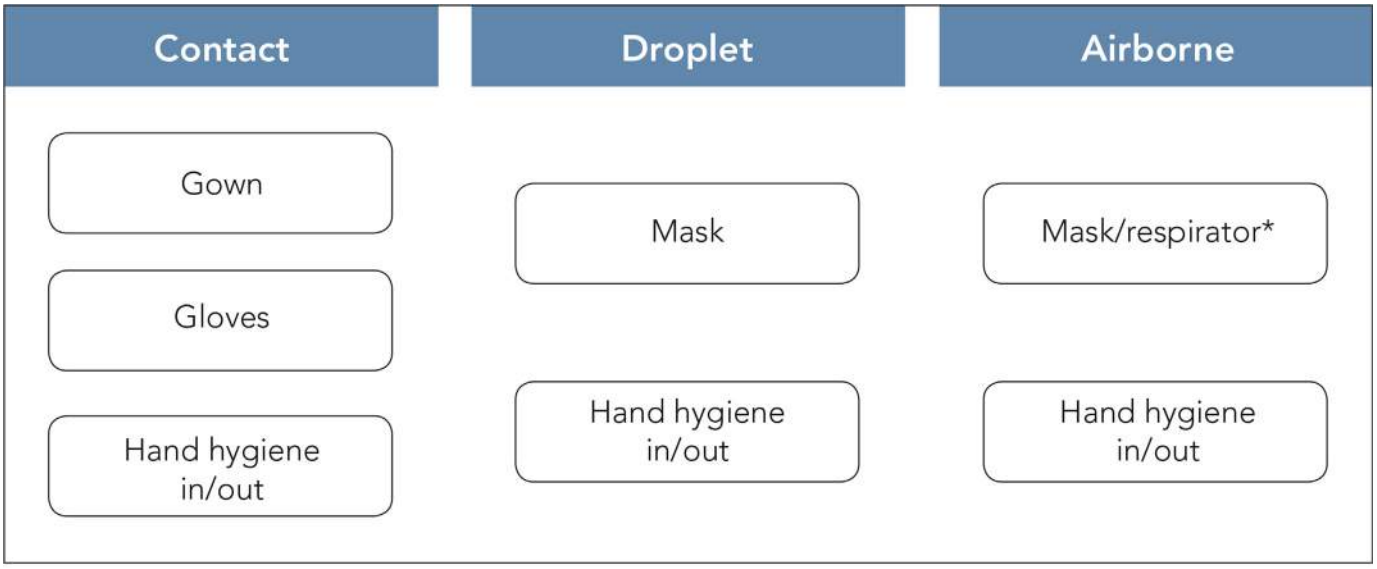
ANSWER

Nursing personnel should instruct patient visitors to perform hand hygiene before and after entering the patient's room or treatment bay and to wear personal protective equipment appropriate for the isolation type (ie, contact, droplet, airborne). Figure 5 shows what is required for each type of isolation. A multidisciplinary team, including infection prevention and perioperative nursing personnel, should develop policies and procedures for patient visitor isolation precautions in the perioperative setting.

According to the Society for Healthcare Epidemiology of America's (SHEA)[1] *Isolation Precautions for Visitors*, use of isolation precautions by patient visitors should be determined by the specific pathogen requiring isolation, any underlying infectious conditions, and the amount of the microorganism present in the facility and surrounding community (endemicity). Because of the lack of evidence in this area, the multidisciplinary team should evaluate the following when establishing policies and procedures:

- annual infection prevention risk assessment;
- regional rates of disease and epidemiologically important diseases (eg, carbapenem-resistant Enterobacteriacae);
- specific patient population needs, such as pediatrics;
- visitor interaction with patients and other visitors;
- need for individual patient assessment; and
- need for heightened precautions during an outbreak or with novel or virulent pathogens.[1]

Visitors to perioperative patients on contact precautions should perform hand hygiene on entry and exit of the patient room or treatment bay and wear a gown and gloves.[1] In their guidance, SHEA recommends using isolation precautions for visitors of patients who are in isolation because of colonization or



* Use of respirators are more effective with training and fit testing, which may be not be feasible for patient visitors.

Reference

Munoz-Price, Banach S, Bearman DB, et al. Isolation precautions for visitors. Infect Control Hosp Epidemiol. 2015;36(7):747-758.

Figure 5. Isolation precautions for perioperative patient visitors.

infection with methicillin-resistant *Staphylococcus aureus* (MRSA) or vancomycin-resistant *Enterococcus* (VRE) if these organisms are endemic to the facility, meaning that the facility is not experiencing a higher than usual number of patients with MRSA or VRE, and if the visitors are not interacting with multiple patients.[1] Visitors to patients with MRSA or VRE infection or colonization who are interacting with multiple patients may increase the risk for transmission of these organisms, and these visitors should follow isolation precautions.[1] In the perioperative setting, patient visitors have a high number of contacts with other visitors and patients in common waiting areas, depending on the layout and flow of patients through perioperative phases of care. As such, perioperative patient visitors should follow isolation precautions and perform hand hygiene when entering and exiting the patient's room or treatment bay to reduce the risk for transmission of pathogens to other patients in common waiting areas.

Similarly, extended-stay visitors to inpatients with MRSA or VRE infection or colonization may have been exempted from following isolation precautions in the inpatient unit because of the impracticality of this practice (ie, parent sleeping in room while wearing gown and gloves).[1] When the inpatient is transferred to the perioperative setting, the extended-stay visitor will be at an increased risk for transmitting MRSA or VRE to other visitors and patients in the common waiting room and should follow isolation precautions and perform hand hygiene when entering and exiting the patient's room or treatment bay. This change in practice may be confusing to the extended-stay visitor, so perioperative team members should explain the rationale of the different settings increasing the risk for MRSA or VRE transmission to other patients. An alternative solution is for the extended-stay visitor to wait in the inpatient room rather than the waiting room in the perioperative area.

Perioperative visitors to patients requiring droplet precautions should perform hand hygiene when entering and exiting the patient's room or treatment bay and wear a mask. [1] According to SHEA, visitors may be exempted from wearing a mask if they have significant documented exposure (eg, household contact) to the symptomatic patient and are not ill themselves.[1] Visitors who are ill should be restricted from the health care facility.[1] If the patient is in contact isolation in addition to droplet precautions, the visitor should wear a gown and gloves, even if exempted from the mask requirement for droplet precautions.

Visitors of perioperative patients requiring airborne precautions should perform hand hygiene when entering and exiting the patient's room and wear a mask.[1] Although an

N95 respirator may be worn by the visitor, respirators are most effective when the wearer is fit tested and trained on how to wear the respirator.[1] Visitors may be exempted from wearing a mask if they have significant documented exposure to the symptomatic patient and are not ill themselves.[1] The visitor to a perioperative patient requiring airborne precautions should be informed of the risk of exposure and the perioperative nurse should document the education provided to the visitor.[1] Visitors who are ill and visitors without significant documented exposure to the symptomatic patient should be restricted from visiting.[1] Restriction of visitors in the perioperative setting may not be feasible, especially for pediatric patients, because of the emotional distress that pediatric patients experience when parents are not present and the need for a patient guardian or representative to provide consent for treatment. Restriction of visitors is also not practical in outpatient surgery settings in which the patient needs a visitor for transport. The multidisciplinary team should consider these barriers to visitation restriction in the perioperative setting when establishing policies and procedures for airborne precautions.

Amber Wood, MSN, RN, CNOR, CIC, is a perioperative nursing specialist in the AORN Nursing Department, Denver, CO.

Reference

1. Munoz-Price, Banach S, Bearman DB, et al. Isolation precautions for visitors. *Infect Control Hosp Epidemiol.* 2015;36(7):747-758.

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PURPOSE/GOAL

To provide the learner with knowledge guidelines related to personnel wearing hijabs in the OR and isolation precautions for perioperative patient visitors.

OBJECTIVES

To what extent were the following objectives of this continuing education program achieved?

1. Discuss practices that could jeopardize safety in the perioperative area.
   Low 1. 2. 3. 4. 5. High

2. Discuss common areas of concern that relate to perioperative best practices.
   Low 1. 2. 3. 4. 5. High

3. Describe implementation of evidence-based practice in relation to perioperative nursing care.
   Low 1. 2. 3. 4. 5. High

CONTENT

4. To what extent did this article increase your knowledge of the subject matter?
   Low 1. 2. 3. 4. 5. High

5. To what extent were your individual objectives met?
   Low 1. 2. 3. 4. 5. High

6. Will you be able to use the information from this article in your work setting?
   1. Yes 2. No

7. Will you change your practice as a result of reading this article? (If yes, answer question #7A. If no, answer question #7B.)

7A. How will you change your practice? (*Select all that apply)*
   1. I will provide education to my team regarding why change is needed.
   2. I will work with management to change/implement a policy and procedure.
   3. I will plan an informational meeting with physicians to seek their input and acceptance of the need for change.
   4. I will implement change and evaluate the effect of the change at regular intervals until the change is incorporated as best practice.
   5. Other: _____

7B. If you will not change your practice as a result of reading this article, why? (*Select all that apply*)
   1. The content of the article is not relevant to my practice.
   2. I do not have enough time to teach others about the purpose of the needed change.
   3. I do not have management support to make a change.
   4. Other: _____

8. Our accrediting body requires that we verify the time you needed to complete the 1.2 continuing education contact hour (72-minute) program: _____