An AAMI Webinar:

Steam Sterilization Process Risk Assessment

Speaker:
Martha Young, MS, BS, CSPDT

March 3, 2011
12:00 noon – 1:00 pm EST
11:00 am – 12:00 pm CST
10:00 – 11:00 am MST
9:00 – 10:00 am PST
17:00 – 18:00 GMT

Presented by:
AAMI
Association for the Advancement of Medical Instrumentation
Risk analysis = Risk assessment + Risk management + Risk communication
Objectives

- How to identify the source of a sterilization process failure.
- How to determine the likelihood that those failures will occur.
- The consequences if that failure does occur.
- How to prepare the facility to manage the failure.

Questions?

- To submit a question, please type your question at the bottom of the Q&A box on your screen and press “Enter,” or press *1 on your telephone keypad.
The Joint Commission (TJC)

Standard IC.01.03.01
• “The hospital identifies risks for acquiring and transmitting infections.”

Element of Performance #4
• “The hospital reviews and identifies its risks at least annually and whenever significant changes occur with input from, at a minimum, infection control personnel, medical staff, nursing, and leadership.”

The Joint Commission

Standard IC.01.04.01
• “Based on the identified risks the hospital sets goals to minimize the possibility of transmitting infections.”

Element of Performance #4
• “The hospital’s written infection prevention and control goals include the following: Limiting the transmission of infections associated with the use of medical equipment, devices and supplies.”
The Joint Commission

Standard LD.04.04.05
• “The hospital has an organization-wide, integrated patient safety program within its performance improvement activities.”

Element of Performance #10
• “At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment.”

The Joint Commission: 2011 Hospital Accreditation Standards (HAS)

The Joint Commission
National Patient Safety Goals

NPSG.07.05.01
• “Implement evidence-based practices for preventing surgical site infections.”

Element of performance #3
• “Implements policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention [CDC] and/or professional organization guidelines).”

The Joint Commission: 2011 Hospital Accreditation Standards (HAS)
The Joint Commission
National Patient Safety Goals

NPSG.07.05.01
• “Implement evidence-based practices for preventing surgical site infections.”

Element of performance #4
• “As part of the effort to reduce surgical site infections:
  -Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.”

Centers for Disease Control and Prevention (CDC) Guideline
Guideline for the Prevention of Surgical Site Infections, 1999
• “Inadequate sterilization of surgical instruments has resulted in SSI outbreaks…. The importance of routinely monitoring the quality of sterilization procedures has been established. Microbial monitoring of steam autoclave performance is necessary and can be accomplished by use of a biological indicator.”
The Joint Commission
Leadership (LD) Standards Applied to Processing:
• “The hospital considers clinical practice guidelines when designing or improving processes.” (LD.04.04.07)
• “The hospital provides care, treatment, and services in accordance with licensure requirements, laws and rules, and regulations.” (LD.04.01.01, EP2)
• “Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.” (LD.04.03.07)

Sterilization Risk Analysis
• Be proactive
• Do a sterilization risk analysis each year
• Do not wait for a sterilization process failure to do this analysis
• Stay up-to-date on manufacturers’ instructions for use
• Stay up-to-date on evidence-based and professional organization guidelines
Evidence-Based Guidelines


Also available to order through AORN and in the future through IAHCSMM at AAMI membership prices

A free PDF of future amendment(s) may be downloaded by visiting [http://www.aami.org/publications/standards/st79.html](http://www.aami.org/publications/standards/st79.html), which also includes information on how to update your copy of ST79.

Print and save to your hard drive

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Evidence-Based Guidelines

AORN Perioperative Standards and Recommended Practices (2011)

- Recommended Practices for Sterilization in Perioperative Practice Setting
- Recommended Practices for Selection and Use of Packaging Systems for Sterilization
- Recommended Practices for Cleaning and Care of Surgical Instruments and Powered Equipment
- Recommended Practices for Cleaning and Processing Flexible Endoscopes and Endoscope Accessories

[www.AORN.org](http://www.AORN.org)
Evidence-Based Guidelines

Centers for Disease Control and Prevention (CDC)
• Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008
  - Available at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html
• Guideline for the Prevention of Surgical Site Infections, 1999
  - Available at http://www.cdc.gov/ncidod/dhp/pdf/guidelines/SSI.pdf

OSHA (Occupational Safety and Health Association)
• Employee focus
• Safety requirements
• Fines for noncompliance
• Workers can report issues
• Training is mandated
• Both Federal and individual State regulations
Environmental Protection Agency (EPA)

- Regulates disinfectants used on noncritical surfaces (low- and intermediate-level disinfectants) and gaseous sterilants
- Manufacturers must register before sale or distribution and submit specific data about the safety and effectiveness of each product
- EPA requires users “to follow explicitly the labeling directions on each product”
  - “It is a violation of federal law to use this product in a manner inconsistent with its labeling.”

CDC Guideline for Disinfection and Sterilization in Healthcare Facilities:2008 p. 56

U.S. Food and Drug Administration (FDA)

- FDA's Center for Devices and Radiological Health (CDRH) is responsible for regulating firms who manufacture, repackage, relabel, and/or import medical devices sold in the U.S.
- Regulates high-level disinfectants and liquid chemical sterilants used on critical or semi-critical medical devices; also sterilization equipment that uses steam or gaseous chemical sterilants

http://www.fda.gov

CDC Guideline for Disinfection and Sterilization in Healthcare Facilities:2008 p. 56
Steam Sterilization Process

- Cleaning/decontamination
- Packaging and preparation
- Loading
- Choosing the correct cycle for the load
- Properly functioning sterilizer
- Quality and quantity of sterilant
- Unloading
- Sterile storage and transportation
- Aseptic presentation

Steam Sterilization—Update on the Joint Commission’s Position

User Concerns

State surveyors will look at these critical steps of reprocessing
- Cleaning and decontamination
- Sterilization
- Storage and return to sterile field

The Joint Commission Perspectives®, July 2009, Volume 29, Issue 7
Steam Sterilization Process Risk Assessment

The Joint Commission (TJC)

Standard IC.02.02.01

• “The hospital reduces the risk of infections associated with medical equipment, devices and supplies.”

• “Failure to properly clean, disinfect, or sterilize and use or store medical equipment, devices, and supplies not only poses risks for the person seeking health services, but also carries the risk for person-to-person transmission of infections.”

Immediate Revision to IC.02.02.01 in Oct. 2009

• Clarification of two Elements of Performance (EP)
  – EP 1—Cleaning and low-level disinfection
  – EP 2—Intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies
    • Moved to EP2 to show their importance so now they are scored like sterilization, not like cleaning
    • Score as category “A” which reflects the direct and serious potential impact on patients and residents

The Joint Commission. 2011 Hospital Accreditation Standards (HAS)
The Joint Commission
Revision to IC.02.02.01

- TJC will survey with goal of creating a culture of safety and reducing hospital-acquired infections (HAIs)
  - Orientation, training and competency of staff reprocessing medical devices
  - Levels of staffing and supervision
  - Standardization of process regardless of whether it is centralized or decentralized
  - Reinforcing the process (adherence of organization’s procedures to manufacturer’s guidelines)
  - Ongoing quality monitoring

Quality Process Improvement

(Consolidated Text)
Section 11
Quality Process Improvement

- Effective means of improving the performance of the process
- Identifies performance measures and process monitors for steam sterilization for continuous quality improvement
- Continuous Quality Improvement (CQI) should encompass these areas:
  - Decontamination
  - Preparation and packaging
  - Sterilization
  - Quality control
  - Sterile storage
  - Product distribution

Quality Process Improvement

- Performance measures for:
  - Decontamination (Section 11.2.3)
  - Rigid sterilization containers (Section 11.2.4)
  - Flash sterilization (now called immediate-use) (Section 11.2.5)
Quality Improvement

Risk analysis =
Risk assessment +
Risk management +
Risk communication

Objective is to identify the risks to reduce the likelihood of a sterilization process failure

Risk Analysis

• Part of a quality process is a risk analysis because sterilization is a process in which you cannot determine its effectiveness by inspection and testing of each product, so use the following to determine the effectiveness of the sterilization process
  – Validated process (validated by equipment and medical device manufacturers)
  – Monitor routinely with physical monitors, biological indicators (BIs) and chemical indicators (CIs)
  – Maintain equipment
Risk Analysis

- Risk assessment (since sterility assurance is a probability function, it must be assumed that at some time a failure will occur)
  - Identify source of sterilization failure
  - Estimate likelihood that such a failure will occur
  - Assess the consequences if that failure does occur
  - Assess how to prepare the facility to manage the failure

Actions to take when biological indicators, chemical indicators, or physical monitors indicate a failure

Section 10.7.5
ANSI/AAMI ST79:2010
Figure 12—Decision tree for conducting investigations of steam sterilization process failures

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Variables Affecting the Outcome of Steam Sterilization Process

Table 8

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment malfunction</td>
<td>10%</td>
</tr>
<tr>
<td>Utilities</td>
<td>5%</td>
</tr>
<tr>
<td>Operator</td>
<td>85%</td>
</tr>
</tbody>
</table>

Personal Communication, Charles Hancock, President, Charles O. Hancock Associates, Inc.

Table 8—Checklist for identifying reasons for steam sterilization process failures

- Operator errors (85%)
  - Incorrect use and interpretation of monitoring tools
  - Selection of incorrect cycle for load contents
  - Use of inappropriate packaging materials or packaging technique
  - Incorrect loading of sterilizer

ANSI/AAMI ST79:2010 & A1:2010 Section 10.7.5 Table 8
Table 8—Checklist for identifying reasons for steam sterilization process failures

- Sterilizer (10%) or Utility Malfunctions (5%)
  - Poor steam quality or quantity
  - Incomplete air removal
  - Inadequate cycle temperature
  - Insufficient time at temperature
Table 8—Checklist for identifying reasons for steam sterilization process failures

<table>
<thead>
<tr>
<th>Operator errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect use and interpretation of monitoring tools</td>
</tr>
<tr>
<td>• Incorrect physical monitors for the load</td>
</tr>
<tr>
<td>• Incorrect use of BI or BI PCD</td>
</tr>
<tr>
<td>- Incorrect selection of BI or BI PCD for the load</td>
</tr>
<tr>
<td>- Incorrect placement of BI PCD in the load (e.g., another pack was placed on top of the PCD)</td>
</tr>
<tr>
<td>- Incorrect incubation of BI</td>
</tr>
<tr>
<td>- Misinterpretation of BI result</td>
</tr>
<tr>
<td>- Incorrect documentation of BI result</td>
</tr>
<tr>
<td>• Incorrect use of Class 5 integrating CI PCD or Class 6 emulating CI PCD</td>
</tr>
<tr>
<td>- Incorrect selection of CI PCD for the load</td>
</tr>
<tr>
<td>- Incorrect placement of CI PCD in the load (e.g., another pack was placed on top of the PCD)</td>
</tr>
<tr>
<td>- Misinterpretation of Class 5 integrating CI result or Class 6 emulating CI result</td>
</tr>
<tr>
<td>- Incorrect documentation of Class 5 integrating CI result or Class 6 emulating CI result</td>
</tr>
<tr>
<td>• Incorrect use of internal CI</td>
</tr>
<tr>
<td>- Incorrect selection of internal CI for the load</td>
</tr>
<tr>
<td>- Misinterpretation of internal CI result</td>
</tr>
<tr>
<td>- Incorrect documentation of internal CI results</td>
</tr>
<tr>
<td>• Incorrect storage of any Cs or Bls</td>
</tr>
<tr>
<td>• Failure to check physical monitors for functionality before running cycle</td>
</tr>
<tr>
<td>• Use of broken media ampoule or ampoule with missing spore strip</td>
</tr>
<tr>
<td>• Use of BI PCD or CI PCD that is missing the BI or CI</td>
</tr>
<tr>
<td>• Use of defective CI (e.g., a CI that is expired, faded, shows a partial color change because of incorrect storage, or has been previously exposed to the sterilant)</td>
</tr>
</tbody>
</table>

Selection of incorrect cycle for load contents (containment device or medical device manufacturer’s instructions for use not followed)

<table>
<thead>
<tr>
<th>Use of inappropriate packaging materials or packaging technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Incorrect packaging or containment device for the cycle parameters</td>
</tr>
<tr>
<td>• Incorrect preparation of containment device for use (e.g., incorrect filters, valves, or bottom tray)</td>
</tr>
<tr>
<td>• Use of a paper–plastic pouch, woven or nonwoven wrapper, or towel in a 270°F to 275°F (132°C to 135°C) gravity-displacement cycle</td>
</tr>
<tr>
<td>• Use of a tray that does not allow air removal and steam penetration</td>
</tr>
<tr>
<td>• Use of a wrapper that is too large for the application</td>
</tr>
<tr>
<td>• Placement of a folded paper–plastic pouch inside another paper–plastic pouch</td>
</tr>
<tr>
<td>• Placement of a paper–plastic pouch inside a wrapped set or containment device without verification of adequate air removal and steam penetration by product testing</td>
</tr>
<tr>
<td>• Incorrect placement of basins in set (i.e., basins are not aligned in the same direction)</td>
</tr>
<tr>
<td>• Failure to use nonlinting absorbent material between nested basins</td>
</tr>
<tr>
<td>• Preparation of textile packs that are too dense to sterilize with the cycle parameters chosen</td>
</tr>
<tr>
<td>• Inadequate preconditioning of packaging materials (i.e., not holding package materials at 68°F to 73°F (20°C to 23°C) for 2 hours before use)</td>
</tr>
</tbody>
</table>

Incorrect loading of sterilizer

<table>
<thead>
<tr>
<th>Incorrect loading of sterilizer</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stacking of containment devices if not recommended by manufacturer</td>
</tr>
<tr>
<td>• Stacking of perforated instrument trays</td>
</tr>
<tr>
<td>• Incorrect placement of instrument trays (i.e., not laying instrument trays flat or parallel to the shelf)</td>
</tr>
<tr>
<td>• Incorrect placement of paper–plastic pouches (e.g., placing pouches flat instead of on edge; not allowing sufficient space between pouches; not placing pouches with plastic sides facing one direction)</td>
</tr>
<tr>
<td>• Incorrect placement of basins (i.e., not placing basins on their sides so that water can drain)</td>
</tr>
<tr>
<td>• Incorrect placement of textile packs (i.e., not placing them on edge)</td>
</tr>
<tr>
<td>• Placement of packages too close together, impeding air removal and sterilant penetration in the load</td>
</tr>
</tbody>
</table>
### Table 8—Checklist for identifying reasons for steam sterilization process failures (continued)

<table>
<thead>
<tr>
<th>Poor steam quality or quantity</th>
<th>Sterilizer or utility malfunctions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wet steam</td>
<td>Improper insulation of steam lines</td>
</tr>
<tr>
<td></td>
<td>Malfunction of trap in steam line or no trap in steam line</td>
</tr>
<tr>
<td></td>
<td>Malfunction of drain check valve or no drain check valve</td>
</tr>
<tr>
<td></td>
<td>Steam contact with a cold load</td>
</tr>
<tr>
<td></td>
<td>Too much water in steam produced at boiler</td>
</tr>
<tr>
<td>Superheated steam</td>
<td>Improper heatup of chamber</td>
</tr>
<tr>
<td></td>
<td>Desiccated packaging materials (e.g., towels)</td>
</tr>
<tr>
<td></td>
<td>Steam pressure too low for the temperature</td>
</tr>
<tr>
<td></td>
<td>Excessive reduction of steam pressure too close to sterilizer</td>
</tr>
<tr>
<td></td>
<td>Faulty steam control valve or pressure reducer control valve</td>
</tr>
<tr>
<td>Other steam problems</td>
<td>Variations in steam pressure because of clogged filter, poorly engineered piping, or excessive demands</td>
</tr>
<tr>
<td></td>
<td>Out-of-calibration pressure gauges and controllers</td>
</tr>
<tr>
<td></td>
<td>Clogged steam lines</td>
</tr>
<tr>
<td></td>
<td>Clogged steam supply strainer</td>
</tr>
<tr>
<td></td>
<td>Clogged chamber drain line, strainer, or chamber drain screen</td>
</tr>
<tr>
<td></td>
<td>Malfunction of valves</td>
</tr>
<tr>
<td>Incomplete air removal</td>
<td>Inadequate vacuum or vacuum depth or other air removal system</td>
</tr>
<tr>
<td></td>
<td>Clogged chamber drain line, strainer, or chamber drain screen</td>
</tr>
<tr>
<td></td>
<td>Clogged vent lines</td>
</tr>
<tr>
<td></td>
<td>Leak caused by faulty door gasket</td>
</tr>
<tr>
<td></td>
<td>Leak in other areas of chamber</td>
</tr>
<tr>
<td></td>
<td>Plugged, faulty or incorrectly adjusted control valves</td>
</tr>
<tr>
<td></td>
<td>Low steam pressure</td>
</tr>
<tr>
<td></td>
<td>High water temperature</td>
</tr>
<tr>
<td></td>
<td>Inadequate water supply pressure</td>
</tr>
<tr>
<td></td>
<td>Clogged water supply strainer</td>
</tr>
<tr>
<td></td>
<td>Trapping of air by the load</td>
</tr>
<tr>
<td></td>
<td>Incorrect cycle parameters for the load</td>
</tr>
<tr>
<td>Inadequate cycle temperature</td>
<td>Out-of-calibration temperature gauge</td>
</tr>
<tr>
<td></td>
<td>Long heatup time for large loads (i.e., heat lag)</td>
</tr>
<tr>
<td></td>
<td>Clogged chamber drain line, strainer, or chamber drain screen</td>
</tr>
<tr>
<td></td>
<td>Variations in steam pressure because of clogged filter, poorly engineered piping, or excessive demands on steam supply</td>
</tr>
<tr>
<td></td>
<td>Presence of noncondensable gases in steam line and load</td>
</tr>
<tr>
<td></td>
<td>Inadequate steam supply pressure</td>
</tr>
<tr>
<td></td>
<td>Clogged steam supply strainer</td>
</tr>
<tr>
<td>Insufficient time at temperature</td>
<td>Out-of-calibration control timer</td>
</tr>
<tr>
<td></td>
<td>Inappropriate cycle parameters for the load being processed</td>
</tr>
<tr>
<td></td>
<td>Come-up time of less than 1.5 minutes in a 270°F to 275°F (132°C to 135°C) gravity-displacement cycle</td>
</tr>
<tr>
<td></td>
<td>Oversized load</td>
</tr>
</tbody>
</table>
Risk Analysis

• Risk management
  • Determine which of the sterilization failures identified require management because they are the biggest risk
  • Select and implement the plans or actions needed to ensure those failures are controlled
  • AAMI ST79 describes the accepted means of managing these risks throughout the document

Risk Analysis

• Risk communication
  - Sterile processing department (SPD)/central sterile supply department (CSSD) informs operating room (OR) and infection control practitioners (ICP) of the risk analysis and the plan of action
Risk Analysis of the Sterilization Process Resource

- Risky business: Risk analysis in CSSD by Sue Klacik (IAHCSMM representative to AAMI and co-chair of the PCD working group)
- Published in Healthcare Purchasing News August 2010
- An additional inservice on this topic will be published in healthVIE.com in May 2011

Risk Analysis of the Sterilization Process

- Team consists of
  - CSSD personnel who are working in the department and should be able to
    - Identify risk
    - Reasons for the risk
    - Determine which risk is the biggest threat
    - Suggest ways to reduce this risk
Risk Analysis of the Sterilization Process

• Team capability will depend on
  – If the department policies and procedures meet evidence-based and professional organization guidelines
  – If the manufacturer’s instructions are up-to-date
  – Training and competencies

Correct or Incorrect Packaging?

Incorrect: No validated FDA-cleared instructions for use from either manufacturer for this packaging technique
Risk Analysis of the Sterilization Process

• Team using Post-it® Notes will
  – Identify risk that could lead to potential sterilization process failures
  – Categorize them (i.e., sterilization, packaging, decontamination)

• Rate the issues (0-3, 1-5, 1-10) (higher number, higher risk)
  • Probability of occurrence
  • Potential severity or risk of failure (how much harm if this happens)
  • Likelihood of an undetected failure (not knowing of failure increases the chance that an unsterile instrument is used)
Risk Analysis of the Sterilization Process

- Team using Post-it® Notes will
  - Rate the issues (0-3, 1-5, 1-10) (higher number, higher risk)
    - Preparedness (Is the department prepared for this failure?)
    - Risk scored is the total of these numbers
      - Those with the highest number are selected for risk management

Risk Analysis of the Sterilization Process

- Team develops ideas or suggestions to eliminate the risk (risk management) using Post-it® Notes
  - Concentrate on one issue at a time
  - Each team member votes on their preferred suggestion to eliminate this risk based on discussions and a review of resources and constraints
  - Final task is to correct the problem and report the action (risk communication)
### Sterilization Risk

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability of Occurrence</th>
<th>Potential Severity or Risk of Failure</th>
<th>Undetected Failure</th>
<th>Preparedness</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loaner set with implants arrives too late to quarantine implant until BI result available</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Original loaner set container placed inside a generic rigid sterilization container</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

Steam Sterilization Process Risk Assessment
### Sterilization Risk

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability of Occurrence</th>
<th>Potential Severity or Risk of Failure</th>
<th>Undetected Failure</th>
<th>Preparedness</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not sure which instruments require extended cycles</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>11</td>
</tr>
</tbody>
</table>

### Sterilization Risk

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability of Occurrence</th>
<th>Potential Severity or Risk of Failure</th>
<th>Undetected Failure</th>
<th>Preparedness</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peel pouches placed flat on cart</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Bowie-Dick Test run on Floor</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>
Sterilization Risk

- Loaner set with implants arrives too late to quarantine implant until BI result available
- Original loaner set container placed inside a generic rigid sterilization container
- Not sure which instruments require extended cycles
- Peel pouches placed flat on cart
- Bowie-Dick Test run on floor

7 (3rd priority)
8 (2nd priority)
11 (1st priority)
7 (easily eliminated)
6 (easily eliminated)

Risk Management

- Not sure which instruments require extended cycles
- Obtain up-to-date instructions for use using One-source at 6 month intervals
- Post list of cycles by sterilizer
- Train employees
- Update policies and procedures
- Install program in computers or if have computer program, update
- File instructions for use so easily accessible

Note: Obtaining up-to-date instructions for use will assist in correcting this issue: Original loaner set container placed inside a generic rigid sterilization container
Risk Communicate

- Not sure which instruments require extended cycles
- Communicate actions to the OR and infection preventionist (IP) so the OR can assist in providing up-to-date instructions for use and understand the importance of obtaining these for newly purchased instruments

Risk analysis =
Risk assessment +
Risk management +
Risk communication

Revisit at least yearly or if changes are made

Or

More frequently if determined necessary by the hospital
Eliminating Risks of a Sterilization Process Failure

Improving Patient Safety

Questions?

• To submit a question, please type your question at the bottom of the Q&A box on your screen and press “Enter,” or press *1 on your telephone keypad.
Closing Reminders

• Please be sure to fill out the evaluation form at http://aami.confedge.com/ap/survey/s.cfm?s=Steam

• Save the date for a new AAMI webinar, Steam Sterilization Process Failures, June 8, 2011, from 11:00 am-12:00 noon EDT. The program will cover:
  – How to use sterilization process monitors
  – How to investigate sterilization process failures
  – Actions to be taken to address sterilization process failures
  – How to prevent sterilization process failures
  – Registration will be available soon!