Reducing Flash Sterilization - A long but important process in the OR
Union Memorial Hospital

Program/Project Description
At the beginning of the journey, we did not have a handle at all on what, or how many items we were flashing in our department. We had log books at each sterilizer as the practice for documentation of the flash cycle. We took the sterilizer tape and compared it to the log book. The problem was that the log book and the actual sterilizer tapes showed two different things. The nurses were not documenting cycles. Using the log books we did not have a true picture of the Flash Sterilization process that was going on in our operating room., but we knew we were flashing more than we wanted to.

Our goal was
1. To decrease flash sterilization to the lowest possible use
2. Educate staff on the safe processes needed for flash sterilization
3. Provide our patients with a high standard of care.

PDSA: Plan, Do, Study, Act
Our process at Union Memorial Hospital is PDSA (Plan, Do, Study, Act). We started by presenting staff with the initial data and the process for safe flash sterilization. We introduced the process change requiring documentation of the process on the actual sterilizer tape. We collected the tapes each day and put the data in an Access Database. We reviewed the data with the managers and team monthly. We found that there were items that were flashed routinely and persons who needed routine reinforcement of the process. We presented the data to the managers for communication to their teams monthly. We also shared the data with our Infection Control Department. We justified purchasing additional instrument, rigid containers and were able to hold vendors accountable to provide loaner trays the night before the procedure for processing.

Solution
• Developed method to track accurately flashed items. Elimination of documentation log: required documentation to be placed on sterilizer tape with actual cycle parameters.
  Reviewed tapes daily and placed information in database for monthly reports.
  Continued communication with staff with individual follow up

Measurable Outcomes
• Improved documentation for flash cycle by follow up and education, Flash champions, and OR Leadership support.
• Decreased “Flash Cycles” by evaluation of actual needs leading to appropriate purchases of required instrumentation.
• Decreased number of implants flashed by requiring vendors to bring in trays the night before and putting trays in rigid containers to avoid holes in packaging.
• Shut down 3 sterilizers – cost savings recognized through decreased utility costs, sterilizer testing supplies, and preventive and maintenance costs.
Sustainability.
- Continue “follow up” with individuals by managers to improve documentation
- Continue to track items and determine needs for additional purchase or placement in rigid containers
- Continue to educate staff in Best Practices
- Goals:
  - 100% compliance with documentation
  - Flash only when necessary using safe practices and processes.

Role of Collaboration and Leadership.
We report to the IC committee and Nursing leadership who review the data and supported the initiative. We were able to purchase additional instruments in this time of uncertain economic circumstance. Additionally, the OR Director, OR Managers, OR Infection Prevention and Nursing Executive supported purchase of rigid containers to eliminate the possibility of holes in wraps, which were experienced in some loaner and heavier instrument trays.

They continue to support us by attending team meetings, morning reports, and keeping the topic on the top of the priority list.

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Flash Sterilization Cycles

Our Flashing Of Implants Experience

Goal – Never flash implants

* May 2010 - 6 implant trays had holes in wrapper
2007 to 2008  26 % decrease in the number of Flash Cycles
2008 to 2009  47% decrease in the number of Flash Cycles.
2009- Oct 2010  54% decrease in the number of Flash Cycles