



Loaner Instrumentation: Keeping Patient Safety First!

by Rose Seavey, RN, MBA, CNOR, ACSP

Objectives

After completion of this self-study activity, the learner will be able to:

1. Describe why loaner instrumentation is a growing concern for the OR and Sterile Processing.
2. Define patient safety issues and ethical responsibilities associated with loaner instrumentation.
3. Write a policy for handling loaner instrumentation.
4. Design a practical program for enforcing your loaner instrumentation policy.

Many thanks to the team at 3M Health Care for working with Managing Infection Control to provide the following accredited course. IAHCSP has awarded one and one-half (1.5) contact points for completion of this continuing education lesson toward IAHCSP recertification. The CBSPD has preapproved this inservice for one and one-half (1.5) contact hours for a period of five (5) years from the date of publication, and to be used only once in a recertification period. This inservice is 3M Health Care Provider approved by the California Board of Registered Nurses, CEP 5770 for one (1) contact hour. This form is valid up to five (5) years from the date of publication. Instructions for submitting results are on page 92.

Managing Infection Control and 3M Health Care will be working collaboratively to provide continuing education courses in monthly editions of Managing Infection Control.

Test Questions

True or False

1. Loaner instrumentation is a not a concern in most healthcare facilities.
2. When borrowing instruments, it is the using facility's ethical responsibility to ensure the items are safe to use on its patients and that the process is properly documented and fully traceable to the patient.
3. A major responsibility of healthcare providers is to minimize patient risks while increasing patient safety.
4. Implants may be released before the results of the biological indicator have been read.
5. The American Society for Healthcare Central Service Professionals (ASHCSP) and the International Association of Healthcare Central Service Materiel Management (IAHCSP) published a joint position paper on effectively managing loaner instruments and implants.
6. The selected staff responsible for the management of loaner instruments and implants must be trained and knowledgeable of all aspects of this process.
7. Items received as single-use devices should be in the original packaging from the vendor.
8. An implant is a device that is placed into a surgically or naturally formed cavity of the human body but removed within 30 days.
9. Implants require additional attention to the sterilization and quality control process because they are foreign bodies left behind; consequently the threat of surgical site infection is greater.
10. Flash sterilization should not be used for implantable devices.

Does this sound familiar to you?

The Operating Room (OR) staff calls down to the Sterile Processing Department (SPD) at 7 a.m. to announce the orthopedic manufacturer's representative just dropped off the pans of instruments and implants for a

surgical procedure scheduled at 8 a.m. the same day! The SPD staff goes to the OR to find not one or two trays of instruments, but as many as 10 or more trays needing to be processed!

There is definitely something wrong with this picture, but it happens almost every day in facilities all across the nation. How can we do our patients justice and ensure safe patient care when we are not given enough time to process loaner instrumentation and implants the same way we treat the ones we own? What if it was you or your loved one having the procedure done? Wouldn't you want it processed and documented correctly? I certainly would.

When loaner instrumentation comes in as a stat (the day of the case) the sterile processing technicians have to stop what they are doing to address the situation. This urgent situation causes a distraction to the routine, takes them away from their other customers and may result in errors or omission of tasks. As a result, not only are the patients on whom the stat loaners were used possibly affected, but it may also result in negatively affecting other patients in some way.



Introduction

Loaner instrumentation is on the rise and, unfortunately, is becoming common practice in most hospitals and ambulatory surgical centers. Healthcare facilities frequently need to borrow surgical instruments or implants for specialty operative procedures for a variety of reasons. Surgical technology is constantly changing. Sometimes a procedure is done so infrequently that a facility cannot afford to purchase all of the instruments, such as for specialties like pediatrics. It is also impractical for each healthcare organization to own every instrument and implant needed for every surgical procedure or desired by individual physicians due to exposure to new technology.

This article will provide guidelines for creating a policy on loaner instrumentation and implants. It will also cover patient safety issues and the ethical responsibilities of healthcare providers in regard to loaner instrumentation and implants.

Experiences, efforts, documents and strategies used at The Children's Hospital of Denver (TCH) will be shared in this article. It is the author's hope that readers can use the information to help strengthen and enforce policies on loaner instrumentation at their healthcare facilities. After all, I may someday be a patient in *your* facility.

So, what's the problem?

The management of loaner instrumentation and implants is recognized as a growing concern by many perioperative professionals. Whether you are borrowing instruments from a vendor or another facility, it is the using facility's ethical responsibility to ensure the items are safe to use on their patients and that the process is properly documented and fully traceable to the patient.

A major responsibility of healthcare providers is to minimize patient risks while increasing patient safety. In the operating room, this is particularly important in regard to surgical wound infections. A vital way to help avoid surgical wound infections is to present surgical items that are free of contamination at the time of use.¹ If you borrow instruments from another institution or a vendor, you are responsible for ensuring these items are free of contamination when used on your patients.

Loaner instrumentation is a huge concern for sterile processing personnel who are responsible for decontaminating, packaging, sterilizing, storing, tracking and issuing medical/surgical devices and equipment for those who provide direct patient care.

Timing is everything

I believe you will agree, the biggest concern with loaner items is the lack of time given to properly process the

items. The user facility should have adequate time to reprocess the items following the original manufacturer's instructions for cleaning, assembling, packaging and sterilizing. If there are implants, we must have the results of the biological indicators (BIs), a process requiring a minimum of three hours, before we can release them for use. According to the new Association for the Advancement of Medical Instrumentation (AAMI) standard *Comprehensive guide to steam sterilization and sterility assurance in health care facilities* ANSI/AAMI ST79:2006, 10.6.3, "The sterilization of implantables should be closely monitored and each load containing implants should be quarantined until it is verified that BI testing has yielded negative results."²

In addition, product testing should be performed on all loaner instrumentation "as a part of a complete quality assurance program to ensure the effectiveness of the sterilization process and to avoid wet packs."² This testing involves placing multiple BIs and chemical indicators (CIs) in areas of the loaner instrumentation packaging considered to be the coldest spot or greatest challenge for sterilant penetration, labeling as a product test, placing it in a typical load, processing it according to the medical device manufacturer's instructions, and documenting the results. Loaner instruments should not be routinely processed until this testing shows negative BIs and acceptable CIs.

Controls must be in place for successful management of these instruments and implants. Also, the policies that are written to guide staff in handling these borrowed items must be enforced. This is not new information. However, due to the lack of time given in most cases, the staff may take shortcuts, and these shortcuts (i.e. flashing of instruments and implants) get built into the routine or become habit.

You can make a difference

How did we get to the place where it is "normal procedure" to flash large amounts of instruments and implants? This is an example of what some might refer to as "normalized deviance" or a "slippery slope," meaning, the wrong way of doing things gets done so routinely that it becomes the accepted/common way, even though we recognize it as not correct. For our patients' sake we cannot let this kind of reprocessing behavior continue to slide downhill.

What can we do about it? It starts with someone having the passion, moral standards and the willingness to make a difference for the patients. We need to continue to push the right buttons until the process is improved. When we see something wrong, it is our moral and

ethical responsibility as healthcare providers and professionals to do something about it. We need to reconstruct the culture now. Our patients' safety is literally in our hands.

Help is available

In 1995, the American Society for Healthcare Central Service Professionals (ASHCSP) and the International Association of Healthcare Central Service Materiel Management (IAHCSMM) published a joint position paper on effectively managing loaner instruments and implants. In April 2004 this original paper was updated to help sterile processing professionals handle problems associated with loaners.³

The position paper developed by the two professional central service organizations addresses issues we as healthcare professionals face daily in effectively managing loaner instrumentation and implants. These up-to-date guidelines should be used to develop policies and procedures to improve day-to-day handling of these instruments and implants. Emphasis should first be placed on developing a standardized system that will allow all involved parties to access information easily.

The following is a synopsis of the proposal created and adopted by ASHCSP and IAHCSMM.

- ▶ A partnership must be developed between the vendor, SPD and the OR. This joint venture must be built on mutual trust and cooperation. Healthcare facilities should provide vendors with information regarding time requirements for pre-procedure and post-procedure processing, and these time requirements should be adhered to by the vendors. Vendors should be able to supply specific directions for any sterilization, including flash sterilization recommendations if necessary. SPD should maintain a record of each tray that is used, including time in and out, and other processing specifics.
- ▶ There should be policies and procedures created in collaboration with vendors and/or other healthcare facilities to address the systematic management of loaner instrumentation and implants from acquisition to disposition. These policies and procedures should include ordering, transport-in, check-in, pre-procedure processing, charging (if applicable), post-procedure processing, check-out and transport-out.
- ▶ The selected staff responsible for the management of loaner instruments and implants must be trained and knowledgeable of all aspects of this process.
- ▶ Facilities should develop policies and procedures that can be used as guidelines to methodically manage loaner instrumentation and surgical implants. This would include items loaned from other healthcare facilities and vendors for specific surgical procedures, as well as items consigned by a vendor to a healthcare facility and stored in-house for their use.

- ▶ The guidelines should discuss acquisition of loaner instrumentation to include: initial request, communication, transportation and designated receiving area (decontamination area).
- ▶ Accountability and record-keeping to include:
 - Instrument delivery to healthcare facility with sufficient time to permit in-house disassembly, cleaning, packaging and sterilization of the instruments before the scheduled surgery in accordance with policy and procedures.
 - Inventory list and manufacturer's reprocessing instructions.
 - Date and time of receiving the instrumentation as well as date and time of procedure and surgeon's name.
 - Quality checks.
 - Cleaning and decontamination after use.
 - Maintaining complete records.
- ▶ Disposition of items to include:
 - Returning items to vendor or other healthcare facility.
 - Documentation.
 - Arrangement for replacement of damaged or lost instruments and used implants.
- ▶ Other considerations:
 - Items received as single-use devices should be in the original packaging from the vendor.
 - Instrument tracking software is helpful in managing loaner instrumentation.⁴

One hospital that is taking a strong stand

The Children's Hospital of Denver (TCH) is a private, not-for-profit, 220-bed community hospital that was founded in 1908. The hospital has 17 operating rooms and performs approximately 14,000 surgical procedures per year. The TCH mission is, "To improve the health of children through the provision of high quality, coordinated programs of patient care, education, *research and advocacy*."

TCH's original written policy on loaning/borrowing/returning of instruments was written many years ago based on the ASHCSP/IAHCSP position paper. Dutifully, per Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, the policy was reviewed or revised every couple of years. Of course, having a policy on loaner instrumentation is one thing, but enforcing it is another story.

Earlier last year, SPD initiated a meeting with the OR to discuss the need to update loaner instrumentation policy and the need to enforce it. Since enforcing the policy would be the

hard part, we decided to include representation from infection control, quality/patient safety, risk management and the chief of surgery in this effort. All of the parties were interested in helping to improve patient safety when dealing with surgical instrumentation and implants.

Updating the policy to meet revised standards

Our initial order of business was for all to become familiar with the revised recommendations addressed in the 2006 release of the following two national documents:

- ▶ Association of periOperative Registered Nurses (AORN) recommended *Practices on Sterilization in Perioperative Practice Settings*, and
- ▶ AAMI's *Comprehensive guide to steam sterilization and sterility assurance in health care facilities* ANSI/AAMI ST79:2006.

Once we all understood the major changes, we worked on incorporating them into our policy and spelling out some of the consequences if the policy was not followed. One of the most important recommendations that both organizations addressed is the need to quarantine surgical implants until the results of the biological indicator is read as negative. Of course, we added that statement into our revised policy.

What makes implants so special?

First we needed to understand exactly what an implant is. According to the Food and Drug Administration (FDA), an implant/implantable item is defined as "a device that is placed into a surgically or naturally formed cavity of the human body if it is intended to remain there for a period of 30 days or more. FDA may, in order to protect public health, determine that devices placed in subjects for shorter periods are also 'implants'." [21 CFR 812.3(d)]²

Implants require additional attention to the sterilization and quality control process because they are foreign bodies left behind; consequently the threat of surgical site infection is greater.² There is a higher degree of risk of infection to patients with an implant because:

- ▶ "First, they are left behind at surgery, so if there are microorganisms on them, these will remain in the body. Infections associated with implants may not be evident for up to a year after surgery.
- ▶ "Second, the placement of an implant often means the removal of tissue, with interruption of blood supply and significant manipulation of the tissues immediately adjacent to the implant, creating an area of potential safety for microorganisms to multiply, further increasing the risk of infection.

Flash sterilization should not be used for implantable devices.

- ▶ “Third, because there is interrupted blood supply, antibiotics cannot easily get to the microorganisms if they do multiply enough to cause a clinical infection.
- ▶ “Fourth, the implant itself may be vital to continuing function of a body system, such as would occur with a total joint replacement, vascular graft, or intraocular lens placement. An infection may not be curable with the implant in place, and removing it could cripple or kill the patient.”⁵

AAMI’s newest master document on steam sterilization has specific recommendations on the release criteria for implants (10.6.3): “As with all cycles, the sterilizer operator should review the sterilizer chart or printout and the results of other indicators that have been used to monitor the sterilization process. The load should be quarantined until the results of the BI testing are available (CDC, 2003a).”²

AORN’s updated policy concurs with the AAMI recommendation. On p. 632 AORN states: “When an implantable device is sterilized at a health care facility, a biological indicator should be run with the load and the implant should be quarantined until the results of the biological indicator are known.”¹

AAMI addresses what needs to happen if there truly is not enough time to wait for the results of the BI due to an emergency situation. AAMI’s position states: “When documented medical exceptions dictate (e.g., the need for trauma-related orthopedic screw-plate sets), it could be necessary to release an implantable device before the BI results are known. In this case, the release of the device before the BI results are known should be documented; the BI result obtained later should also be documented. It is critical that this documentation be fully traceable to the patient. Releasing implants before the BI results are known is unacceptable and should be the exception, not the rule. Emergency situations should be defined in written guidance developed in consultation with infection prevention and control, the surgeon, and risk management.”

What about flashing?

AORN does not recommend flash sterilization of implants:

“Flash sterilization should not be used for implantable devices. Implants are foreign bodies, and they increase the risk of surgical site infections. Careful planning, appropriate packaging, and inventory management in cooperation with suppliers can minimize the need to flash sterilize implantable medical devices. When an implantable device is sterilized at a health care facility, a biological indicator should be run with the load and the implant should be quarantined until the results of the biological indicator are known. If an emergency situation makes flash sterilization unavoidable, a rapid-action biological monitoring device should be used along with a class V chemical integrator. The implant should not be released until the rapid-action indicator provides a negative result. After the rapid-action negative result is obtained, the implant can be released for use in the immediate situation.”¹

When asked how AORN would recommend quarantining the implant when flash sterilized and while waiting for the rapid-action biological monitoring device in an emergency situation, Ramona Conner, RN, MSN, CNOR, Perioperative Nursing Specialist for the AORN Center for Nursing Practice, stated: “The sterilized implant can be placed on a corner of the back table and segregated from the rest of the sterile field until the rapid-readout BI is ready to read. When the BI result is negative, then the implant can be placed in the patient. If the BI result is positive, the implant hasn’t been used and the rest of the sterile field hasn’t been contaminated.”⁶

AORN also states that when flash sterilizing the following information should be documented and traceable to each patient:

- ▶ Device(s) processed;
- ▶ Patient receiving item(s);
- ▶ Reason for flash sterilization.¹

At TCH we make every effort to avoid flashing of implants. For instance, we will try to move the schedule around if we have back-to-back cases to try and give us enough time to properly reprocess the necessary items. Also, if there is an anticipated need to use an instrument set with implants in it (e.g., pectus stabilization bars) for back-to-back cases, and we cannot get another set in, we will wrap and sterilize additional implants separately. That way, at least we have the implants sterile with the BIs read out in advance.

The definition of an emergency we use at TCH is anything that is “life or limb threatening.” In some emergency cases in which the quarantine of implants cannot be maintained, we may be asked to release implants prematurely, before the BI has been read out. In that case we complete an exception form for premature release of implants (See Figure 1 on p. 86.)

Figure 1. The Children's Hospital

EXCEPTION FORM FOR PREMATURE RELEASE OF IMPLANT

In an emergency situation, an implant may be used prior to the results of the BI being available (3 hours). This form is to be completed and returned to SPD when an implant has been flashed in the OR and used without the BI results known.

DATE: _____	Procedure Time: _____	Flash Time: _____	Used Time: _____
CIRCULATOR RN: _____			
ITEM(S) : _____ (Be Specific)			
Items sterilized in SPD:	Yes	No	
PATIENT: _____			
SURGEON: _____			
Notified of premature release:	Yes	No	
PROCEDURE: _____			
REASON FOR PREMATURE RELEASE: _____ _____			
WHAT COULD HAVE PREVENTED PREMATURE RELEASE OF THIS ITEM? _____ _____			
PERSON COMPLETING REPORT: _____			
DATE: _____		DATE RETURNED TO SPD _____	
Perioperative Record documentation on final BI results documented: Yes No			
Date: _____			
Original copy: Director of Sterile Processing Department		Copy: Infection Control	

Exception form for premature release of implants

If an implant has to be flashed or taken from the SPD area before the BI could be read in the case of an emergency, we document it on this form. This form contains the pertinent information about the incident, including the reason for premature release and what could have prevented premature release of the item. We included this into our policy and added that a copy of the exception form goes to infection control and risk management for additional monitoring.

We will routinely (e.g., monthly) review all exception forms with Infection Control, Quality Performance, Risk Management and the Perioperative Services Operations Team to look for ways to decrease the need to flash implants. Having actual data instead of anecdotal information should help in our efforts to follow the AAMI guidelines and provide safer patient care. If we see the need, we may request to purchase more of a certain instrument/ implant set or at least the additional implants so that we can have them put up sterile in case of back-to-back cases.

Another item we will look for with this data is scheduling of back-to-back “like” cases. With block scheduling, frequently the same surgeon may operate all day. If back-to-back “like” cases are happening frequently with the need to prematurely release implants, we may look at any opportunity to put one of the other cases between the “like” cases. That will give SPD enough time to reprocess and read out the BI. If we borrow from a particular vendor that repeatedly

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does not bring the implants in sufficient time to correctly reprocess the sets and obtain BI results, that also will be obvious on the review.

Enforcing the policy

Before we could sink our teeth into enforcing the newly revised policy, we knew we had to educate all involved parties on what the policy actually said and what the changes were. We also wanted to discuss what the consequences were if the policy was not followed. We believed the best way to do this was to get everyone in the room at the same time and discuss the changes and the intent to enforce the policy. We organized a 90-minute meeting and provided plenty of advance notice so that we could get be sure to get on people's calendars early. The people invited to the meeting were:

- ▶ Chief of Orthopedic Surgery
- ▶ Chief of Neuro Surgery
- ▶ All vendors that provide loaner instrumentation
- ▶ Infection Control (Epidemiology)
- ▶ Risk Management

- ▶ Quality Performance
- ▶ Nursing Administration
- ▶ Surgery in Chief
- ▶ Perioperative Services
 - Director
 - Specialty Service Leaders for Orthopedics and Neurology
 - OR Education and Quality leaders
- ▶ Sterile Processing.

We were very pleased with the response to the invitation, especially from the vendors. The manufacturer representatives we deal with all the time were particularly interested in what we had to say and what was expected of them. Unfortunately, we did not get the physician representation for which we had hoped. However, we were invited later to give the presentation at the weekly orthopedic meeting. Since almost all of the orthopedic doctors and other team members attend that meeting, it actually gave us a larger audience with whom to share the information. As you might imagine, there was some

lively discussion at both of those meetings. We had a lot of information to share and put together an agenda.

Figure 2. TCH Loaner Instrumentation Meeting Agenda

1. Introductions (sign in sheet)
2. Opening Comments (Recommended practice changes—Evidenced based Practices—consistency on loaner instruments)
 - q. Packet contents
 - i. Agenda
 - ii. ST79:2006 Section 10 tutorial summary—AAMI (Association for the Advancement of Medical Instrumentation)
 - iii. ASHCSP/IAHCSSM position paper on Loaner Instrumentation
 - iv. Loan borrowing/returning of equipment, instruments, and supplies (including implants) policy
 - v. Loan borrow transfer form
 - vi. AORN 2006 RP on flash sterilization
 - vii. TCH Exception form for premature release of implants
 - viii. Care and cleaning of surgical instruments and power equipment policy
 - ix. Guidelines for sales representatives...While in The Children's Hospital booklet
 - x. Sales representative—TCH administrative policy
3. AAMI ST79 Section 10 Quality Control summary of changes
4. DVD What's All the "Steam" About. (20 minute video on why the changes)
5. Changes in P&P to comply with AAMI and TCH's initiative for Pt. Safety/Best practices initiatives and ASHCSP/IAHCSSM *Position paper*
 - a. Acquisition
 - b. Accountability—Vendor, SPD, OR
 - c. Delivery—to Decontamination only
 - d. Timelines—24 hour prior to surgery
 - i. Sterilization verification
 - ii. BI results before release of Implants—(AORN RP, AAMI standards)
 - iii. Weight (TCH—20 # wt. Limit—Care and cleaning of instruments VIII B pg. 4 of 5)
 - e. Responsibilities
 - f. Documentation
 - i. Loan borrow form
 - ii. Exception form for premature release of implants
 - iii. Variance report
 - g. Definition of "Emergency"
6. Open discussion/questions

The turning point

The meetings were a big turning point in our handling of loaner instrumentation. It was very helpful to educate the vendors, surgeons and other healthcare professionals about the changes in the newest recommendations. This permitted them to talk the same language and truly understand "why" we do the things we do in regard to loaner instrumentation and implants. Our policy includes a statement that we will not be responsible for any shipping/handling costs for items not delivered within the specified timeframe. In our kick-off meetings we walked through what should happen when a loaner set of instruments/implants are needed and how the protocol should be followed.

Following proper protocol

When a case is scheduled that requires a loaner tray of instruments, the physician (or designee) should notify the vendor of the date and time of the surgery. The vendor, in turn, should contact the OR and SPD to let them know when to expect to receive the items.

The items should be delivered directly to the decontamination area at least 24 hours before the case is schedule to start. In all cases, wrapped or not, the instruments must be considered contaminated. These items are usually transported in a mostly "uncontrolled" environment (i.e., trunks of cars, public transportation, etc.). Yes, even if the trays have been "sterilized" by another facility, you must reprocess starting with the decontamination process. Why do you have to reprocess items wrapped in another facility?

- ▶ You must have the record of the sterilization process and quality assurance measures.
- ▶ Your patient deserves to know you have monitored the process.
- ▶ You do not know if the integrity of the package was protected during handling and transportation.

The vendor must provide an inventory list as well as manufacturers' written instructions for disassembly, cleaning, packaging and sterilization of the devices. If no inventory sheet is sent with the set, we will not be responsible for "lost" items.

Wearing proper Personal Protective Equipment (see Figure 3), the SPD person should check for accuracy of original order, log receipt of loaner instruments on loan borrow transfer form (see Figure 4 on page 90), verify types and quantities, and visually inspect for damage.

At TCH we have a policy that states no tray is to weigh more than 20 pounds, including wrapping or container. Because of ergonomic reasons, container manufacture written instructions, and both AAMI and AORN recommendations, we enforce this tray weight limitation. See article “Just Say No! Don’t Get Weighed Down By Instrument Sets That are Too Heavy” in the April 2006 issue of *Managing Infection Control*.⁷ We weigh any loaner trays to ensure they are not over the limit (see Figure 5 on page 90). If the total weight of a tray is more than 20 pounds, we ask the vendor to separate it for us; or we will separate it ourselves, wrapping/containerizing some items separately. Since the vendor is likely to be in the OR at the time of the scheduled case, they are more than happy to help decide how to separate overweight sets.

Figure 3. Personal protective equipment.



Figure 4. Loan borrow transfer form.

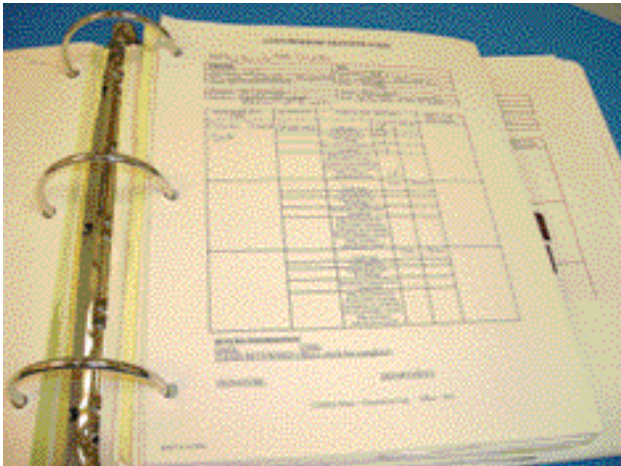
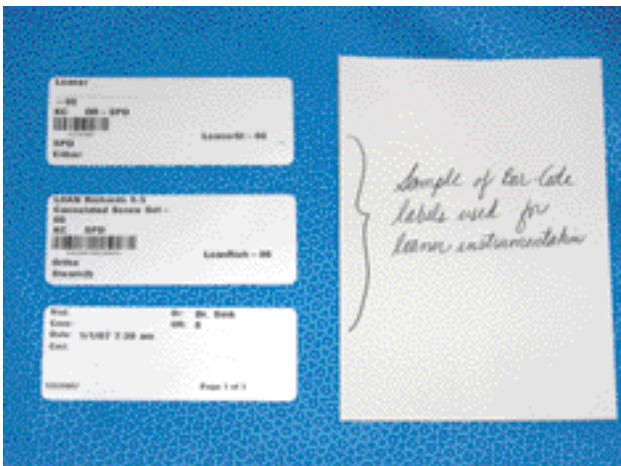


Figure 5. Weighing a pack.



Figure 6. Bar code labels.



TCH utilizes the loaner module on our bar code system that allows us to create and print specific labels to help track these borrowed instruments. After packaging the loaner instruments, we label them with the tray name, the vendor, and surgical case (see Figure 6 left). This has been extremely helpful in keeping track of where each set is at any given time.

After the items are used in the OR and returned to SPD for terminal sterilization, we do a final instrument count, call the vendor, and document the date and time they were picked up. We keep these documents for one year, just in case any questions or issues come up.

Summary

Our policy changes have been very helpful in spelling out the accountability and consequences. The record-keeping has also been invaluable in our efforts to *improve patient safety* related to loaner instrumentation. Having the various healthcare providers (including the vendors) involved and on the same page in this effort is a must if you want a successful loaner program.

We sometimes live in a parallel universe...We make excuses by saying we can't do that, but what we need to say is we **HAVE** to do it. Do not just "hint and hope" the changes will happen. You can be the change agent to make it happen. It is time to put away the excuses and do what is morally right. Start with sharing your concerns with Infection Control and Quality Performance in your facility. Share the issues and "excuses" with them and ask for their help. You play an extremely big part in infection prevention, and you can make a difference in establishing a successful loaner program and improving patient safety. After all, isn't that what you would want if those instruments were going to be used on you? I know I would!

Ordering Information

AAMI

ANSI/AAMI ST79:2006, *Comprehensive guide to steam sterilization and sterility assurance in health care facilities*

Order code: ST79 or ST79-PDF

Available in an attractive binder featuring sturdy metal rings, ledger-weight pages and a laminated tab for each section for easy navigation. AAMI will issue revised pages that can be substituted into the binder when changes are made.

Also available in PDF format and as part of AAMI's electronic CD and subscription products.

Price/Member discount price: \$200/\$100

AAMI documents can be purchased through AAMI by credit card using the following four options:

1. Internet: <http://marketplace.aami.org>
2. Call: 800.332.2264, ext 217 or 703.525.4890, ext 217
3. Fax: 703.525.1424
4. Mail: AAMI, Customer Service Center, 1100 N. Glebe Road, Suite 220, Arlington, VA 22201-5762

AORN

AORN Standards can be purchased through AORN using the following options:

1. Internet: www.aorn.org/bookstore/ordering.htm
2. Call: 800.755.2676, ext 1 or 303.755.6304 ext 1 (Monday-Friday, 8 a.m. to 4:30 p.m. MST)
3. Fax: 303.750.3212
4. By mail: AORN, Inc., Customer Service/Book Orders, 2170 South Parker Road, Suite 300, Denver, CO 80231-5711

Payment can be made by VISA, MasterCard, American Express or Discover, either online or by mail/fax/phone.

By authorized PO, and AORN will bill you (\$100 minimum purchase). Sorry, we cannot accept POs for education conferences or services. (Not available for online orders.)

A CD-rom of the standards is available for the first time this year.✦

References

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2. The Association for the Advancement of Medical Instrumentation. Comprehensive guide to steam sterilization and sterility assurance in health care facilities. ANSI/AAMI ST79:2006.
3. ASHCSP/IAHCSMM position paper on Loaner Instrumentation (April 2004), located on the web site: <http://www.ashcsp.org/ashcsp/news/Joint%20paper%20on%20loaner%20instruments.pdf> or http://www.iahcsmm.com/current_issues-joint_paper_loaner_instrumentation.htm.
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Sterile Process and Distribution CEU Information

CEU Applicant Name _____

Address _____

City _____ State _____ Zip Code _____

The CBSPD (Certification Board for Sterile Processing and Distribution) has pre-approved this inservice for one and one-half (1.5) contact hours for a period of five (5) years from the date of publication and to be used once in a re-certification period. Successful completion of the lesson and post test must be documented by facility management and those records maintained by the individuals until re-certification is required. **DO NOT SEND LESSON OR TEST TO CBSPD.**

For additional information regarding Certification contact: CBSPD, 2 Industrial Park Road, Suite 3, Alpha, NJ 08865 or call 908.454.9555 or visit Web site at www.sterileprocessing.org.

IAHCSMM has awarded 1.5 contact points for completion of this continuing education lesson toward IAHCSMM recertification.

Nursing CE Application Form

3M Health Care Provider Approved by the California Board of Registered Nurses, CEP 5770 for 1 contact hour. This form is valid up to five years from the date of publication.

1. Make a photocopy of this form.
2. Print your name, address and daytime phone number and position/title.
3. Add your social security number or your nursing license number.
4. Date the application and sign.
5. Answer the CE questions.
6. Submit this form and the answer sheet to:
Workhorse Publishing
Managing Infection Control
PO Box 25310, Scottsdale, AZ 85255-9998
7. Participants who score at least 70% will receive a certificate of completion within 30 days of *Managing Infection Control's* receipt of the application.

Application

Please print or type.

Name _____

Mailing Address _____

City, State, Country, Zip _____

Daytime phone () _____

Position/Title _____

Social Security or Nursing License Number _____

Date application submitted _____

Signature _____

Offer expires April 2012

On a scale of 1-5, 5 being Excellent and 1 being Poor, please rate this program for the following:

- 1) Overall content _____
- 2) Met written objectives _____
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<04/07>

6. Conner, Ramona, AORN Center for Nursing Practice, phone interview 10/7/2006.
7. Seavey, Rose. Just Say No! Don't Get Weighed Down By Instrument Sets That are Too Heavy. *Managing Infection Control*, April, 2006 Volume Six Issue 4.



Rose Seavey, RN, MBA, CNOR, ACSP, is the Director of the Sterile Processing Department at The Children's Hospital of Denver. Ms Seavey is an active member of the Association of periOperative Registered Nurses (AORN) and currently sits on the National Nominating Committee. She was honored with AORN's award for Outstanding Achievement in Clinical Nurse Education in 2001. She served as the President of the American Society of Healthcare Central Service Professionals (ASHCSP) in 2003 and is the 2002 recipient of ASHCSP National Educator of the Year award. Ms Seavey is a member of several AAMI working group committees that are developing recommended practices and is currently a co-chair for the AAMI ST8, Hospital steam sterilizers. In addition she has lectured and authored many articles on various topics relating to perioperative services and sterile processing, locally, nationally and internationally.

ANSWERS

- | | |
|------|-------|
| 1. F | 6. T |
| 2. T | 7. T |
| 3. T | 8. F |
| 4. F | 9. T |
| 5. T | 10. T |

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